Quality Attestation for Clinical Ethics Consultants: Perspectives from the Field

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In the September-October 2013 issue of the *Hastings Center Report*, the Quality Attestation Presidential Task Force of the ASBH proposed a quality attestation process for clinical ethics consultants through the use of a portfolio and oral examination.[1] The Task Force is to be commended for navigating the debate in clinical ethics consultation (CEC) credentialing, certification, and accreditation through the use of this two-step model. I will focus my comments on the portfolio portion of the quality attestation model in order to provide clarification on its use and evaluation. More specifically, I will suggest that although portfolios do enable the evaluation of a candidate's skills and effectiveness, that candidate must have a clear understanding of the accepted parameters of professional competence in the field in order to construct the portfolio itself. This is an important clarification that must be explicit if a portfolio process is to be used such that an objective basis may be established for its evaluation.

Portfolio assessment has been in use in education for more than two decades.[2] In that time, some consensus has developed as to the general content that should be represented in a portfolio that will illustrate the candidate's competency and skills. The Task Force has done an excellent job capturing the majority of the content areas that should be included in any portfolio designed to demonstrate competence and skill in CEC.[3] The Task Force has done this while accommodating the wide variation in the backgrounds and disciplines of those presently performing CEC. The Task Force also rightly notes that such variation is appropriate to accommodate so long as the "end result is within the accepted parameters of professional competence."[4]

Unfortunately the Task Force is not explicit as to whether the ASBH's *Core Competencies* is to serve as the accepted parameters of professional competence. They suggest that the *Core Competencies* serve as *an* outline for some widely accepted notion of the qualifications that permit a clinical ethics consultant to practice.[5] However, without stating explicitly that the *Core Competencies* will, for the purposes of the Task Force's recommendations, serve as the widely

accepted notion of the qualifications for CEC, the candidate is left to construct a portfolio absent this critical understanding of what will serve as the basis for the evaluation of the portfolio itself. The danger here is that in casting the net wide to include the variation in the backgrounds and disciplines of those presently performing CEC, the Task Force may have too quickly sacrificed the tremendous work done to assess the *accepted* parameters of professional competence.[6] Two examples within the Required Elements for CEC Quality Attestation Portfolio serve to illustrate this point: (a) six case discussions of consultations, and (b) six one-page descriptions of *additional* cases that evidence CEC experience.

Among the required elements for a candidate's CEC Quality Attestation Portfolio are six case discussions of consultations in which the candidate acted as lead or co-lead and authored or coauthored documentation. Although the Task Force notes that "at a minimum, the following elements should be included in the write-up: case narrative, synopsis, relevant ethical issues, assessment, recommendation, and outcome,"[7] these recommended minimal standards are absent the substantive recommendations of the Core Skills and Knowledge for Clinical Ethics Consultation, of the Clinical Ethics Consultation Affairs (CECA) committee in 2009. Furthermore, to my point concerning the ambiguity about the role of the *Core Competencies* in relationship to accepted parameters of professional competence, the Core Skills and Knowledge recommendations from the CECA based its work on the *Core Competencies*. The substantive work of the CECA Report that gets precisely at the matter of what constitutes professional competence in both skill and knowledge should form the basis for the candidate's demonstration of professional competence in his or her case discussions. Secondly, with a nod to the *anticipated concerns* noted by the Task Force, the final portfolio element should address CEC experience on routine cases, rather than focus on CEC experience in relationship to a *range* of clinical settings.[8] In other words, quoting my own mentor, Dr. Glenn Regalie, "Common things are common." Thus, the candidate's one page descriptions of cases should focus on the types of cases that are often seen in CEC and/or on "settled" cases in the literature in an effort to truly assess professional competence and skill.

This raises a secondary issue for Catholic health care in that even if the Task Force did plan to utilize the *Core Competencies* document as the accepted parameter of professional competence, the *Core Competencies* alone may not address the entire scope of skills necessary for portfolio design and evaluation of ethicists working in Catholic health care.[9] Additional required elements will need to be added to the CEC Quality Attestation Portfolio for use in Catholic health care such as those found in the Catholic Health Association's, "Recommended Qualifications and Competencies for System Ethicists in Catholic Health Care

and for Facility/Clinical Ethicists in Catholic Health Care."[10]

The idea of a two-step model for quality attestation for clinical ethics consultants is an elegant approach to identify individuals who are qualified to perform in this role. I agree with the authors that CEC is a "high stakes endeavor" with corresponding professional obligations for which a Quality Attestation Portfolio and Oral Examination is critical to the field.[11] I encourage the Task Force to reexamine or make more explicit the connection between substantive work done in this area on the matter of CEC skills and competencies among their ASBH colleagues and to form a necessary collaboration with CHA to expand its scope to include the significant number of ethicists working in Catholic health care who will require a more expanded and specific portfolio and oral examination process.

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[1] Kodish, E *et al.*, "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics and Humanities," *Hastings Center Report* 43, no. 5 (2013): 26-36.
[2] Seldin, P. *The Teaching Portfolio: A Practice Guide to Improved Performance and Promotion/Tenure Decisions.* 3rd Edition. (Bolton, MA: Anker, 2004). Also, 2nd Edition, 1997 and 1st Edition, 1991.
[3] Kodish, "Quality Attestation for Clinical Ethics Consultants," 30; Hutchings, Pat, ed., *The Course Portfolio: How Faculty Can Examine Their Teaching to Advance Practice and Improve Student Learning.* (Washington, DC: American Association for Higher Education, 1998); and Urbach, F. "Developing a Teaching Portfolio." *College Teaching* 40 (1992): 71-74.
[4] Kodish, "Quality Attestation for Clinical Ethics Consultants," 31.
[5] Kodish, "Quality Attestation for Clinical Ethics Consultants," 29.
[6] Clinical Ethics Consultation Affairs Committee. "Report to the Board of Directors of the ASBH on Certification, Accreditation, and Credentialing (C/A/C) of Clinical Ethics Consultants." *C/A/C Report* (October, 2010): Appendix B.
[7] Kodish, "Quality Attestation for Clinical Ethics Consultants," 30, 31.
[8] The Task Force did make a general recommendation in the *Anticipated Concerns* portion of the *Hastings Center* article by suggesting that "We have sought to articulate standards commensurate with routine practice, not esoterica and not the complicated cases that become the object of academic dispute," but did not reference this specifically in the "required elements" of the portfolio, see: Kodish, "Quality Attestation for Clinical Ethics Consultants," 34.
[9] Hamel, R., Slosar, J.P., and Repenshek, M. "Answering the Call from ASBH's Second Edition of Core Competencies in Ethics Consultation." *AJOB* 13, no. 2 (February 2013): 18-19.
[10] CHA. "The Ethics Role in Catholic Health Care." See: www.chausa.org/docs/defualt-source/general-fildes/cha-ethicsrole-pdf?sfvrsn=2 access on January 6, 2014.
[11] Hamel, R. "Ethical Currents—Strengthening the Quality of Ethics Consultants and Consultation." *HCEUSA* 21, no 4 (Fall 2013): 28-29; Repenshek, M. "Continuous Quality Improvement Initiatives in Ethics: A Proposed Communication Tool." *HCEUSA* 20, no. 4 (Fall 2012): 2-12; Repenshek, M. "Attempting to Establish Standards in Ethics Consultation for Catholic Health Care: Moving Beyond a Beta Group." *HCEUSA* 18, no. 1 (Winter 2010): 5-14.

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Any reader of *Quality Attestation for Clinical Ethics Consultation* who is familiar with clinical ethics consultation will share with the authors their basic premise: there is a need to ensure quality and quality improvement in the process of clinical ethics consultation. As the authors comment, this is the one activity that occurs within the health care setting for which the practitioners are neither licensed, credentialed, nor certified. The authors, I believe, are correct in asserting that there is a need to ensure the competence of practitioners engaged in this practice.

If they have the diagnosis correct, have they created an appropriate treatment plan? I suspect that the answer to that question entails a more detailed response. My first reaction to reading the essay was that this is the hospital standardization movement reborn. Readers of the Christopher Kaufmann's *Ministry and Meaning* will recall his discussion of the reaction of Catholic hospitals to the efforts of the American College of Surgeons to impose a set of patient care standards in all hospitals in which surgery was performed. Should Catholic hospitals accept a set of standards established by a secular organization? In the current situation the question needs to be posed whether the quality attestation process proposed by the American Society for Bioethics and the Humanities (ASBH) can accommodate practitioners who perform case consultations in a manner consistent with the *Ethical and Religious Directives for Catholic Health Care Services?* Practitioners within Catholic hospitals may also be guided, at least in part, in the process of case consultation by core values such as compassion, human dignity and the sacredness of life. Are such religious and ethical guidelines consistent with the core competencies and skills set forth by the ASBH? That to my mind is an open question.

There is a second question that must be asked of the treatment plan designed by the ASBH. By what right or authority does ASBH claim hegemony over authenticating the practice of every one engaged in health care ethics consultation? They claim that commercial interests will enter this open market and that there is no other professional organization better equipped to meet this need within American health care. My underlying concern here is not so much directly focused on the ASBH, but rather that this entire effort conducted under the aegis of the ASBH is really a process of medicalizing health care ethics consultation. The quality attestation process is largely, although in fairness not exclusively, led by physicians. The need for health care ethics consultation arose, at least in part, to overcome the paternalism associated with the practice of medicine in the 1950s, 1960s and 1970s. Quality attestation falls somewhere between privileging and board certification, issues associated with the practice of medicine (27). A master's degree in a relevant discipline is required. There is no specified

training in ethics required for attestation. Ethics training is incidental to the requirements for attestation. Where professionally trained ethicists were instrumental in the development of health care ethics consultation, they are now to be replaced by medical professionals with incidental training in ethics. The oral review of the candidate's performance of case consolations is to be done in a manner similar to the "U.S. Medical Licensing Exam, Step 2 Clinical Skills Exam." Once again a medical model prevails. Health care ethics consultation occurs in a medical context, but it is not and should not be confused with the practice of medicine or medical decision-making. They are related but distinct functions.

The ASBH's *Core Competencies for Health Care Ethics Consultation* is an important contribution to the quality improvement of case consultation. Like the quality attestation process, it focuses on the qualities and expertise of the practitioner. There is another model for the improvement of health care ethics consultation that focuses not on the skills of the practitioner, but rather on the process or method of health care ethics consultations. The CASES methodology developed by the Center for Ethics in Health Care of the Veterans Administration is also an extremely important contribution to this conversation. Whether a focus on competencies and skills or a focus on methodology is more likely to enhance the quality of health care ethics consultation remains, at least to my mind, an open question requiring significant further discussion.

I applaud the work of the ASBH. They have brought attention to an important quality issue within American health care. I think they have the diagnosis correct. However, I also think their treatment plan may require a second or third opinion. The methodological approach of the CASES model requires much further investigation. Perhaps a hybrid of a methodological approach with an emphasis on the skills and competencies of practitioners is where this discussion needs to go. Clarity regarding religious and cultural issues needs to be established. This is a profitable and productive conversation. It is too soon to cut it off.

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In the September-October 2013 issue of the *Hastings Center Report*, Eric Kodish, Joseph Fins, and associates propose that, given the importance of clinical ethics consultation to patient care, those doing it should be asked to show they do it well.[1] This is the latest development in the field of clinical ethics consultation, which probably began with the formation of the Society for Bioethics Consultation in 1986. When that body merged with two other bioethics associations to form the American Society for Bioethics and Humanities (ASBH) in 1998, strong

support for clinical ethics consultation continued in the new organization.

A guide to basic skills and knowledge necessary for competent clinical ethics consultation was published by ASBH in October of that same year and updated with a slightly different title in 2010.[2] In 2008, the ASBH president initiated the Clinical Ethics Consultation Affairs (CECA) standing committee to advise the board on issues related to health care ethics, including the topic of certifying health care ethics consultants. In 2009, ASBH published another resource, *Improving Competencies in Clinical Ethics Consultation.*

Do you hear that clattering noise? It's the sound of a field professionalizing. Like the dry bones in Ezekiel, these are the bones of a new specialty, over time assembling into what will become the culture and practice of professionals who are trained, experienced, certified in and good at clinical ethics consultation. There will be life in those bones.

We are now at the beginning of that process. As with anything in the nascent stages, how all the parts fit together and what the final version will look like is not absolutely clear. Here are some questions that don't seem to be settled yet.

What constitutes good quality in ethics consultation? We know what detracts from a good consult: a consultant with an enlarged ego; insufficient time or lack of clarity about the goal of a consultation (both of which are implicated in the 'curbside consult'); inadequate knowledge of ethical norms or the law; inability to facilitate discussion among the interested parties. These are just a few quality dampeners in clinical ethics consultation. But if the opposite of these are present—a modest and well-prepared consultant or team, adequate time and clarity of goals, ability to facilitate compassionately—do we know what makes a good consult? Do we measure it by the outcome, by the family's satisfaction, the clinician's satisfaction or a combination of all three? Is it purely procedural?

How should consultants prepare themselves? As it is now, clinicians become consultants in a range of ways. Some have been on their ethics committees for a long time, and have repeatedly been asked to help at the bedside. Over time, these have become persons of practical wisdom. Others have attended accredited programs, where book learning is combined with mentored experiences, getting the kind of supervision a chaplain resident or social worker gets on the way to certification in those professions. This type of preparation may more deliberately give a person the philosophy and language the Quality Attestation process looks for. It may or may not make a better consultant.

What will happen in hospitals without a certified clinical ethics consultant? The effort to improve the quality of ethics consultations is a good one and the research is certainly there indicating that quality varies in consultation. We know that some people doing consultations do it better than others. What we don't know is whether some consultation is better than

none. If people who do not have a sufficiently robust practice in ethics consultation to become certified simply stop consulting, it's not obvious that patients, families, doctors, nurses and others who currently take advantage of "uncertified" clinical ethics consultation are better off.

Lingering questions

Dignity Health has forty hospitals, and experienced ethics committees in each. Of the dozen or so individuals who sent a letter of intent to submit a portfolio (the first step in the QA process), all five who were 'randomly' chosen to proceed were men. If those who refine the process are mostly of one gender, there may be a skewed viewpoint in the resulting attestation process. In the second step, the oral examination is planned to take place at the annual meeting of the ASBH. Tight budgets and travel costs may make it less likely for people to be able to enter that second stage.

As with any developing field, whether it's emergency medicine, palliative care or clinical ethics consultation, things take time. These are some of the questions we hope are answered as the bones of the QA process come to life.

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[1] Eric Kodish and Joseph J. Fins with Clarence Braddock III, Felicia Cohn, Nancy Neveloff Dubler, Marion Danis, Arthur R. Derse, Robert A, Pearlman, Martin Smith, Anita Tarzian, Stuart Youngner, and Mark G. Kuczewski, "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics and Humanities," *Hastings Center Report* 43, no. 5 (2013): 26-36.

[2] ASBH's *Core Competencies for Clinical Ethics Consultation* (1998) became its *Core Competencies for Health Care Ethics Consultation* in 2010, a 57 page monograph with four sections.

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Introduction

There is a discrepancy in how one demonstrates professional competencies between clinicians and ethicists. Ethicists heretofore have had no credentialing or licensure process governed by a professional agency. With a degree of irony, unlike physician and nurse colleagues, ethicists do not have a code of ethics. These hallmarks of a health profession are guideposts that inform institutions in privileging and credentialing providers. Their lack in the field of ethics signifies a gap in demonstrating to institutions and the community at large accountability and professionalism in ethics.

Moreover, much ink has been used in attempting to describe and establish quality standards in the performance of ethics consultation. Various metrics have been proposed, but with different definitions of practice, no consensus around conducting ethics consults (save for a few 'emerging standards'), variable structures and personnel doing the work, and no accountability to regulatory agencies (governmental or not, tied to

reimbursement or not), the likelihood of externally binding standards remains elusive.

In this context, the American Society for Bioethics and Humanities (ASBH) charged a task force with the responsibility of crafting a process to assess ethics consultants' competency as a mechanism of ensuring quality in ethics consultation.[1] This effort is in addition to the development and publication of the recommended competencies for health care ethics consultation.[2] For its part, CHA sought to enhance the conversation around competencies and quality in ethics for Catholic health ministries.[3] The ASBH quality attestation process described is a valiant effort to bring dimensions of accountability and professionalism to those who practice ethics consultation in health care, but it raises many questions and may have limited import to the work of ethics in Catholic health care.

Quality Attestation & Quality Improvement

On the one hand, I agree with the basic premise of the quality attestation process. That is, quality improvement is important for ethics consultation services. Furthermore, I agree that the competencies of those doing ethics work is essential to having confidence in consistent quality consultation services.

The quality attestation process as described is robust and as such a good exercise for those engaged in and managing the work, especially for those early in their ethics careers. The quality attestation portfolio (step 1) and oral examination (step 2) reflects - in a rigorous way - the approach with which I am familiar regarding hiring ethicists. It remains to be seen, however, whether the desire for inclusiveness waters down meaningfulness of the process; and whether such "attestations" are transferable from institution to institution, or setting to setting.

On the other hand, as suggested, there is much to wonder about with the ASBH quality attestation (QA) process. While diversity (of ethical methodology) has long been claimed as a value-added characteristic of ethics consultation in general, I wonder whether there is simply too much variance. Clinical ethics consultation is not a panacea; so being overly inclusive is a hazard that dilutes what "it" really is. In part, what prompts my worry here is that often an ethics consult is requested without a clear ethical issue.[4] This does not mean an ethics consult is inappropriate, but it does suggest to me that the frameworks and taxonomies used in health care ethics may be inaccurate and imprecise, which makes any quality initiative a difficult task because the proverbial cart is before the horse. As another example, in our institution, we tend to view ethics consultation more as coaching and less as advisement. This view contrasts with other perspectives wherein ethics consultation is precisely advisement or mediation or conflict resolution.[5]

In addition, the QA process seems to equivocate quality *services* with competency of *professionals.* While they

are intimately related, I would not want to reduce one to the other. To my mind, through demonstrating competency in a QA process, an institution may trust an ethicist or ethics consultant in much the same way it might put trust in a provider privileged to perform certain procedures. Perhaps the connection between competency and quality is based on this kind of confidence, but this does not appear to be an explicit connection.

Lastly, the QA process does not make clear how it might be used when assessing team competencies. As suggested in the *Core Competencies*, ethics consultation teams exist and ideally must demonstrate, in total, the range of competencies required. In fact, data suggest that the team approach to consultation is most common and that the individual consultant approach is least common.[6] This begs the question of how one might translate the QA process to team-focused evaluation.

Implications for Catholic Health Care

The QA process, as inclusive as it strives to be, does not emphasize the importance of theological competency, which is a core competency of doing ethics in a Catholic health ministry.[7] Moreover, the QA process presupposes institutional capabilities and standards, which may require operational adjustments (e.g., hiring an ethicist). This is complicated by the fact that different ministries have access to variable resources both in terms of operational budget and philanthropy to help keep ethics services solvent. Many ministries have personnel that are trained for one role (mission integration or spiritual care) but also have ethics-related responsibilities; such individuals may or may not have sufficient training or experience in ethics.

That said, the QA process may have more value for demonstrating the competencies of those engaged in clinical ethics consultation (vs. organizational ethics) as this may be more comparable between Catholic and non-Catholic settings. Nevertheless, there are still select clinical circumstances that would require a degree of theological skill and knowledge, as in perinatal and obstetric settings as well as in locations where physician-assisted suicide is legally available.

Lingering Questions

In addition to some issues I raised above, there are other, broader questions I have. For example, it is not clear how this process will incorporate, embrace, or adjust (if at all) to the transformations that are occurring in health care today. Will ethicists attest to competencies that cultivate ethical decision-making in the setting of population health and across institutions? That said, I applaud the group for having the courage to seize this "confluence" of factors to move in *some* direction on standards of competencies. They should remain steadfast because there will be many more critics, some of whom may be vigorous. It will remain a daunting task. There are many factors out there that may mitigate the group's success.

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[1] Eric Kodish, Joseph J. Fins, et al., "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society

for Bioethics and Humanities," *Hastings Center Report*, Sep-Oct 2013, 43 (5): 26-36.

[2] ASBH, *Core Competencies for Health Care Ethics Consultants*, 2nd edition (Glenview, IL: ASBH, 2011).

[3] Catholic Health Association of the United States, *Striving for Excellence in Ethics: A Resource for the Catholic Health Ministry*, http://www.chausa.org/ethics, (St. Louis, MO: Catholic Health Association and Ascension Health, 2011).

[4] Susan E. Kelly, et al., "Understanding the Practice of Ethics Consultation: Results of an Ethnographic Multi-Site Study," *Journal of Clinical Ethics*, Summer 1997, 8 (2): 136-149.

[5] John Tuohey and Nicholas Kockler, "Aconselhamento ou "coaching"? A consultoria ética no contexto da pós-graduação em educação médica [Counseling or "coaching"? The advice ethics in the context of graduate medical education]", in *Ética e Bioética Clínica no Pluralismo e Diversidade: teorias, experiências e perspectivas, Proceedings from the 8th International Conference on Clinical Ethics Consultation* (São Paulo, Brasil), May 2012, 115-131.

[6] Ellen Fox, et al., "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics*, February 2007, 7 (2): 13-25.

[7] Cf. "Recommended Qualifications and Competencies for Facility/Clinical Ethicists in Catholic Health Care," www.chausa.org/careers/careers-in-ethics, accessed 10-January-2014; and "Recommended Qualifications and Competencies for System Ethicists in Catholic Health Care," www.chausa.org/careers/careers-in-ethics, accessed 10-January-2014.

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When I began my bioethics training at the Medical College of Wisconsin in the 1990s, the masters' degree was a robust 42-credit course of study. All instruction was on-site at MCW and clinical practice was conducted under the tutelage of experienced MCW physicians at the many affiliated institutions. The coursework included health care law, epidemiology, biostatistics, along with theory and clinical practice related to bioethics. There was also a strong teaching component as our cohort led class discussions, presented grand rounds, and conducted case reviews for the teaching hospital's ethics committee. The ethics consultation course was by invitation of the faculty for students who demonstrated aptitude in the subject matter as well as the appropriate temperament to engage in this difficult work with anxious families and often frustrated physicians.

In the past 15 years, we have seen the proliferation of abbreviated degrees (30 credits seems to be most common) and online instruction where students only rarely, if ever, have in-person instruction and training. The field has opened up to those not living in the vicinity of an academic medical center with a bioethics department. This has made training accessible to physicians and other clinicians in smaller communities and rural areas, which is to be celebrated. At the same time, a degree of any level, including doctoral, which does not include significant clinical practice, cannot be assumed to confer the many intangibles that are necessary for competence to conduct CEC. I was pleased to read that there is another initiative assessing bioethics training programs and fellowships from the Association of Bioethics Program Directors.

ASBH is to be commended for its respect for the variety of disciplines represented in the field, and the task of developing a standard for quality attestation is indeed a daunting one. Even with the proposed model it will be difficult to measure such attributes as the ability to make connections with all types of people, the openness to reconsidering one's own position, and an appreciation for and ability to work with the nuances involved in hospital politics.

I agree with the incremental approach to making attestation the standard, and would suggest some deliberation in these areas:

- The preparation of a portfolio for review appears to be a major undertaking even for those working daily in the field of clinical ethics. Those who provide consultation as part of a team, and in addition to other work in health care, may not have the volume of cases necessary, or the inclination to assemble a portfolio, while

those who are new to the field may be interested in acquiring an attestation of their abilities, but also may lack adequate experience. What inducement will there be for those experienced in CEC to do the work of preparing the portfolio and submitting to an oral examination? How can those with newly minted degrees gain the requisite experience?

- How will attestation be promoted so that it will come to be valued by senior leaders in health care?

- Will there be any variation in what areas of experience are required? For example, those working in regional medical centers or teaching hospitals may need a higher threshold of clinical literacy than those working exclusively in long-term care.

- According to the American Hospital Association, there are 630 Catholic hospitals in the U.S. accounting for 15 percent of the hospital beds. There are many hundreds more nursing homes, hospice programs and clinics operating under Catholic sponsorship. HCEUSA readers are well aware of the additional areas of competency necessary for doing CEC in a Catholic facility including a deep understanding of the *Ethical and Religious Directives for Catholic Health Care Services* and literacy in moral theology. This is obviously outside the scope of ASBH, but it is very important. How might it be addressed?

The need to prepare the next generation of CECs is clear from the statistics regarding the ages of many currently practicing in the field. A systematic approach to quality attestation to guide that preparation will be a good beginning.

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As a member of the American Society for Bioethics and Humanities (ASBH) and the ASBH Clinical Ethics Consultation Affinity Group (CECAG), I have been following the discussions surrounding Quality Attestation (QA) of Clinical Ethics Consultants and the development of the Code of Ethics with great interest. In my role as director of ethics at a 600+ bed Catholic teaching hospital, I wonder how this QA process will impact the development of ethics consultants locally, at a system level, and throughout Catholic health care as well as those just entering the field. I also wonder whether there

ought to be a similar quality attestation in Catholic health care and, if so, whether it ought to extend beyond consultation to provide direct QA also of education and policy development and review. While it would certainly include the *Ethical and Religious Directives* (ERDs) and matters of cooperation and scandal, it would also extend to other critical areas of the ministry of health care, engaging the health care ministry's response to the common good, linking Catholic social teachings and the church's moral tradition.

I agree with the authors of QA that the historic dearth of a standard quality measure for those engaging in clinical ethics consultation (CEC) is no longer acceptable. The lack of a license or board certification such as those held by our physician colleagues or the CPE of our pastoral care colleagues can leave those who inquire about the qualifications of ethics consultants mystified, or worse, questioning our suitability for the work in which we engage. We build relationships with our colleagues and through that our professional reputations and identities over time. Yet the encounters we have with patients, families, and others are comparatively short and often occur in high stakes life and death situations. If questioned about our qualifications in that moment, a statement like "I have a Certificate/Masters/Ph.D. in philosophy/theology/public health" may not provide the inquirer with the answer for which they had hoped and may not inspire confidence or even assure competence. An inability to offer evidence of any formal training in ethics may be even more problematic. Just as many of our colleagues are uncertain of what it is we do, the public may also be unsure and even suspicious of ethics consultation as talk of death panels and rationing swirls episodically in the media and in the blogosphere. The lack of QA may even impact our ability to justify the hiring or training of (additional) ethics consultants. The financial support of an ethics program, even for educational resources, may be impacted, as well as the quality of the program. Individuals or institutions may feel the amount of time spent doing ethics consultation due to a small number of consultations does not justify the time and (inevitable) cost to seek QA.

Implications for Catholic Health Care

The Catholic health care ministry is challenged in the face of this development to discern whether to endorse this QA as necessary or as a mark of excellence in an ethics program and whether, if it is necessary, it is also sufficient. Are the skills necessary for CEC in the setting of Catholic health care significantly different? Or is there simply an additional body of knowledge required in theology and the church's moral tradition? Could a similar process in Catholic institutions be seen as a litmus test for Catholic identity or the alignment of an ethics consultant with church teaching? What about those whose practice (or even a single consultation that occurs across the care continuum) spans multiple dioceses? Would a mandatum a la *Ex Corde Ecclesiae* or something similar be sufficient or even appropriate? Catholic health care ethicists draw from the moral tradition of

the church when they educate patients, families, and staff. Does this amount to an excursion into theology?

Just as the Catholic Health Association (CHA) continues to develop and refine its standards for "Excellence in Ethics" in response to the ASBH's Core Competencies in Ethics Consultation, I believe that Catholic health care will also have to develop its own quality measures for those engaged in CEC. There are many matters that ethics consultants in Catholic health care are called to assess that those in non-Catholic settings may not even consider as ethical issues or would handle in a strikingly different manner. The moral distress of staff when they feel the ERDs are being violated or a practice is occurring contrary to our Catholic identity is profound. There is a particular skill for example in supporting staff in understanding the tradition and how a particular act is or is not supported by that tradition, i.e., that an intervention in a situation of maternal fetal conflict that results in the delivery (and death) of a previable infant does not constitute direct abortion. Those involved in these decisions must be educated about intentionality and the importance of language. An intention and expression of the necessity of aborting an infant to save the life of a mother is quite different than the continuation of labor/delivery of a previable infant in order to address a cure of a proportionately serious pathological condition of a pregnant woman.

If the ASBH QA becomes the norm in health care for those doing ethics consultation, there may be increased liability if Catholic health care does not require the ASBH QA, regardless of whether any other QA or similar process is required by Catholic health care. Often Catholic hospitals are called to articulate that our care of women in cases of sexual assault or maternal fetal conflict is the same standard of care provided in non-Catholic institutions. Within this hermeneutic of suspicion, if ethics consultants in Catholic health care do not obtain the ASBH QA will this too be seen as negligent or subpar? Unlike ASBH there is not a similar national association of Catholic health care ethicists. What sort of body in Catholic health care would administer QA? An additional challenge that ASBH may not face with its hundreds of members which provides a large pool of unbiased examiners is the comparatively smaller and tight knit community of those working in Catholic health care ethics. Many of us work together and collaborate regularly. Many of us trained in the same programs. A large number of us were/are faculty or mentors of one another which could compromise objectivity.

The ASBH QA process requires the examination of these and many other questions by the Catholic health care ministry. Like the ASBH process, I expect that it will take many years and will not be without controversy. Yet we must begin this conversation in earnest lest someone else do it for us.