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Society for Bioethics Consultation
Task Force on Standards for Bioethics Consultation

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Core Competencies for Health Care Ethics Consultation

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I. INTRODUCTION

What was the SHHV-SBC Task Force on Standards for Bioethics Consultation?

The Society for Health and Human Values-Society for Bioethics Consultation (SHHV-SBC) Task Force on Standards for Bioethics Consultation included 21 scholars in the field of health care ethics, policy, and patient care. These scholars came from a variety of professional fields including medicine, nursing, law, philosophy, and religious studies. In addition to representatives of SHHV and SBC, representatives from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Medical Association, the Society for Healthcare Consumer Advocacy of the American Hospital Association, the Department of Veterans Affairs, the Association of Professional Chaplains, and the American Association of Critical-Care Nurses served on this Task Force. Funded by a grant from The Greenwall Foundation and contributions from numerous other organizations, centers, and networks, the mission of the Task Force was to explore standards for health care ethics consultation.[1] The work of the Task Force was motivated by the belief that when patients, health care providers, or others seek the assistance of health care ethics consultants, ethics consultants should be competent to offer that assistance.

What was the focus of the Task Force?

The focus of the Task Force was health care ethics consultation. The report is divided into five main sections that: (1) define the nature and goals of ethics consultation (i.e., what ethics consultation ought to be and aim to achieve); (2) identify the types of skills, knowledge, and character traits (core competencies) that are important for conducting ethics consultations; (3) address the emerging area of organizational ethics consultation; (4) discuss the importance of evaluating ethics consultations; and (5) underscore some of the special obligations of consultants and institutions.[2]

At the outset, three points should be noted:

- Ethics committees and individual ethicists typically offer services that include education, research, policy development, and consultation. This report addresses only issues surrounding consultation.
- *Standards*, for the purposes of this work, refers to the *core competencies* that the Task Force has identified as necessary for doing ethics consultation. Though there may be considerable overlap between competencies required for ethics consultation and those necessary for other ethics services, the latter are not addressed in this report.
- The report remains neutral on the question of whether ethics consultation is best performed by individuals, teams, or committees.[3]

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[1] See Appendix 1 for a complete list of the organizations that provided financial support for this project.

[2] We are indebted to the Strategic Research Network on Health Care Ethics Consultation project, which was funded by the Social Sciences and Humanities Research Council of Canada, for the idea of looking at the skills, knowledge, and character traits that are important for health care ethics consultation. This project resulted in *The Health Care Ethics Consultant* (Baylis, 1994) which was made available to members of this Task Force at the outset of our project.

[3] Throughout this text, we refer to all who do ethics consultations, whether as individuals or as part of a team or committee, as *consultants*.

Who is the intended audience for the report?

The report is relevant for (1) those who do ethics consultation, (2) educational programs that help to prepare individuals, teams, or committees to do ethics consultation, and (3) health care organizations that offer ethics consultation services.

How was the report developed?

The Task Force functioned as a consensus panel. It held six three-day meetings over a two-year period from May 1996 to March 1998. The major objectives of the first two meetings were to provide background information on ethics consultation and to identify issues that needed to be addressed in subsequent meetings. In meetings three and four, subcommittees met to discuss the skills, knowledge and character traits required for consultation. Competency standards and certification issues were also addressed. A preliminary report was then drafted and discussed at meeting five. More than 1,400 copies of a discussion draft then were distributed to various members of the bioethics community. Their feedback was collected and incorporated into a major revision of the report which was circulated and discussed by Task Force members at meeting six. A revised draft was distributed again following the meeting. A final draft was then reviewed and approved by all Task Force members. Because the Task Force was sponsored by SHHV and SBC and included the president of the American Association of Bioethics in its membership, the report was then reviewed and adopted by the American Society for Bioethics and Humanities, the successor to these three organizations, on May 8, 1998.

For a more detailed account of the process, please see Appendix 3.

II. CORE COMPETENCIES FOR HEALTH CARE ETHICS CONSULTATION

II. Core Competencies for Health Care Ethics Consultation

1. The Nature and Goals of Ethics Consultation

1.1 Defining Ethics Consultation

What is health care ethics consultation?

Health care ethics consultation is a service provided by an individual or a group to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict regarding value-laden issues that emerge in health care.[4] This uncertainty or conflict may have both cognitive and affective dimensions.[5] Health care ethics consultation has two related domains, clinical ethics and organizational ethics. This report is on clinical ethics consultation, which focuses on: (1) issues that arise in specific clinical cases and (2) policy consultation regarding patient care issues (e.g., a policy concerning guidelines for life-sustaining treatment).[6] The report acknowledges the growing demand for organizational ethics consultation and discusses its relationship to clinical ethics consultation in section 3 below.

What are the typical issues that ethics consultants must be prepared to address?

Health care ethics consultants frequently help sort through the ethical dimensions of complex clinical cases. These may involve such issues as: (1) beginning of life decisions (e.g., abortion, the use of reproductive technologies), (2) end of life decisions (e.g., withholding or withdrawing treatment, euthanasia, assisted suicide), (3) organ donation and transplantation, (4) genetic testing, and (5) the spread of sexually transmitted diseases. These issues have moral and legal dimensions that may involve, among other things, patient autonomy, informed consent, competence, health care provider rights of conscience, medical futility, resource allocation, confidentiality, or surrogate decision making. The actual cases that give rise to these questions frequently also have complex interpersonal and affective features, such as guilt over a loved one's sickness or impending death, disagreement among health care providers, possible conflicts of interest, or distrust of the medical system. Increasingly, ethical issues regarding clinical care are raised

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[4] Throughout this document we use the terms *ethics* and *morals* (and all their variations) interchangeably. 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 conflict or uncertainty 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). Also, we use *health care provider* as an umbrella category to refer to all those involved in patient care (including physicians, nurse practitioners, nurses, social workers, chaplains, nurses aides, technicians, and others).

[5] These affective dimensions will sometimes involve cases in which parties seeking consultation know what ought to be done but find it very difficult to do so for either intrapersonal or interpersonal reasons. This could occur because the choice the parties face is so daunting (e.g., agreeing to have life support withdrawn from a loved one) or because they find themselves in a difficult interpersonal relationship.

[6] Throughout this document, *ethics consultation* should be taken as referring to both case and policy consultation.

or complicated by organizational factors (see section 3 below).[7]

Due to the complexity of these ethical issues, health care providers, patients, families, or surrogates may request assistance to help think through questions or resolve conflicts that may be present. Typically, these ethical issues emerge in one or more of the relationships between:

- the patient and provider (e.g., patient or provider rights, autonomy, informed consent, confidentiality, competence)
- the patient, the family or surrogate, and the provider (e.g., proxy decision making, best interest, advance directives)
- the providers (e.g., physician-nurse relationship, inter-service disputes) or the health care organization and the provider, patient, family and/or surrogate (e.g., resource allocation, do-not-resuscitate orders, discharge and outplacement)
- the various communities and any of the above (e.g., societal values, the intersection of a particular community's values and organizational missions, patient/provider relationship).

In what context do these issues emerge?

These multifaceted ethical issues emerge in our society against a complex background of developing health care technologies and evolving societal, communal, institutional, professional, and individual values. Increasing racial, ethnic, and religious diversity further compounds this plurality of values. An expanding array of possible treatments poses difficult decisions for patients, providers and the broader community. At the same time, scarcity of resources, the need for cost containment, and the influence of market forces raise equally complex questions about which treatments should be available and for whom. These decisions must be made in a pluralistic society in which individuals have the right, based on the value of autonomy, to pursue their own conception of the good. Pluralism is present in most contemporary health care settings where a wide variety of people from different professional, cultural, and communal backgrounds are present. Since judgments concerning what "should be done" will inevitably reflect the values that underlie them, it is easy to see how value uncertainty or even conflict can arise in this pluralistic context. Thus, this context largely gives rise to the need for ethics consultation and, as we discuss below, informs its role in contemporary health care settings.

How does this context inform the role of ethics consultation in contemporary health care settings?

As we have seen, societal values frame the context in which ethics consultation occurs and, therefore, shape the appropriate role for ethics consultation in contemporary health care settings. Individuals, for example, do not give up the right to live by their own moral values when they become patients or take up the practice of health care. These rights set boundaries that must be respected in ethics consultation, and they often suggest who has decision-making authority in different types of cases. Discussions of these boundaries, not surprisingly, comprise a large portion of the bioethics literature (e.g., explorations of informed consent, autonomy, confidentiality, privacy, resource allocation, and conscientious objection). Indeed, helping to identify the implications of these rights and who has decision-making authority in particular cases is an important role for health care ethics consultation in our society.

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[7] These include, for example, pressures stemming from scarcity of resources and the need for cost containment.

Societal values are often reflected in law and institutional policy, which are also part of the context that frames ethical issues that emerge in contemporary health care settings. Law and institutional policy, therefore, also inform a proper understanding of ethics consultation, and they are widely discussed in the bioethics literature. Many states, for example, have legislation that governs the application of advance directives and outlines procedures for surrogate decision making in the absence of such directives. Similarly, institutions have policies that are applicable in certain types of cases, such as guidelines on life-sustaining treatment or requests for organ or tissue donation. Helping to identify the implications of law and institutional policy for particular cases, then, is also an important role of ethics consultation in contemporary health care settings. Still, though ethics consultation must be informed by law and institutional policy, challenges to these two domains may be appropriate at times.[8]

What is the most appropriate approach to health care ethics consultation in this context?

There are a number of approaches to ethics consultation in the bioethics literature. Most of these fall between one extreme that might be termed the *authoritarian approach* and another that might be termed the *pure facilitation approach*.[9] For illustrative purposes, we will briefly characterize these two extremes, point out their inadequacies, and then outline an alternate approach, "ethics facilitation," that we believe is appropriate for ethics consultation in our society. In characterizing this approach, we only describe its core features. We are not attempting to give a detailed model that will apply to every type of consultation and that excludes all other models.[10] The ethics facilitation approach is consistent with a variety of different methods and models for ethics consultation.

The authoritarian approach. The defining characteristic of the authoritarian approach to ethics consultation is its emphasis on consultants as the primary moral decision makers at the expense of the appropriate moral decision makers. Ethics consultation can be authoritarian either with respect to process or outcome. To illustrate the inadequacies of an authoritarian approach to the outcome of consultation, consider a case in which a competent, well-informed adult patient refuses treatment on religious grounds (suppose the patient is a Jehovah's Witness and the treatment involves blood products). Imagine that the ethics consultant is very sensitive to the process of consultation and talks to involved parties, addressing the factual, conceptual, and normative issues raised by the case. The consultant then recommends that the patient be given treatment against his

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[8] Indeed, sometimes institutional policies or laws will themselves be at odds with deep societal values. Some people would argue, for example, that this was the case with abortion before it was legalized or is presently the case with physician-assisted suicide.

[9] We are not claiming that anyone actually does ethics consultation in either of these two ways. Rather, we are characterizing two extreme approaches for illustrative purposes. Most approaches fall between these two extremes, but tendencies toward one or the other can be found in the literature (Aulisio, Arnold, & Youngner, 1998).

[10] As with attempts to characterize nursing or medical practice, or any other activity, there is likely to be controversy at the margins. We are interested here in giving a normative characterization of the core features of ethics consultation. Also, the ethics facilitation approach will not be applicable to every type of consult. Purely informational consults, for example, will not involve facilitation between multiple parties, as in a request for clarification regarding the institutional policy on withdrawing life-sustaining treatment.

wishes, arguing that the patient's religious beliefs are false. As this case illustrates, an authoritarian approach to the outcome of consultation makes the ethics consultant the primary moral decision maker and displaces the appropriate moral decision maker, in this case the patient. This approach places the personal moral values of the ethics consultant over those of the other parties in the case. By misplacing moral decision-making authority, this approach fails to recognize the appropriate boundaries for ethics consultation, as fundamentally established by the rights of individuals in our society.

To illustrate the inadequacies of an authoritarian approach to the process of consultation, consider a case in which a family and health care team disagree over continued treatment of a critically ill adolescent. Suppose that the health care team believes that continued treatment is futile, while the family hopes for the patient's miraculous recovery. Imagine that the ethics consultant, after talking to the attending physician and reviewing the chart, sides with the health care team, and recommends that treatment be discontinued. The consultant does not reach this decision based on personal moral views, but rather from an understanding of the controversial concept of "futility" as discussed in the bioethics literature. This approach is authoritarian in its process because it excludes relevant parties from moral decision making. It fails to open lines of communication between the family and the health care team in order to work toward a consensus that falls within the boundaries set by societal values, law, and institutional policy.[11]

The pure facilitation approach. The sole goal of the pure facilitation approach is to forge consensus among involved parties. To illustrate the inadequacies of this approach, imagine that consultants facilitate a consensus between a patient's family and the health care team to override the applicable wishes of the patient as expressed in a valid advance directive. The patient has become unconscious; no other relevant new information has become known. Though the consultants are inclusive and achieve consensus, they do so without clarifying the implications of societal, legal, and institutional values for the case, which have been discussed in detail in the bioethics literature. As the case shows, by merely facilitating consensus, consultants risk forging a consensus that falls outside acceptable boundaries. In this case, the consensus amounts to a violation of the patient's right to self-determination.

The ethics facilitation approach. We believe an ethics facilitation approach is most appropriate for health care ethics consultation in contemporary society. The ethics facilitation approach is informed by the context in which ethics consultation is done and involves two core features: identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus.

To identify and analyze the nature of the value uncertainty or conflict underlying the consultation, the ethics consultant must:

- gather relevant data (e.g., through discussions with involved parties, examination of medical reords or other relevant documents)
- clarify relevant concepts (e.g., confidentiality, privacy, informed consent, best interest)
- clarify related normative issues (e.g., the implications of societal values, law, ethics, and institutional policy for the case)
- help to identify a range of morally acceptable options within the context.

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[11] Some recent legal cases have raised concerns about a proper approach to ethics consultation (Fletcher & Spencer, 1997, pp. 270-275). One case, *Gilgunn v. Massachusetts General Hospital*, appears to have been handled in this authoritarian manner (Capron, 1995, pp. 24-26).

Health care ethics consultants also should help to address the value uncertainty or conflict by facilitating the building of consensus among involved parties (e.g., patients, families, surrogates, health care providers).[12] This requires them to:

- ensure that involved parties have their voices heard
- assist involved individuals in clarifying their own values
- help facilitate the building of morally acceptable shared commitments or understandings within the context.

In contrast to the other approaches, the ethics facilitation approach recognizes the boundaries for morally acceptable solutions normally set by the context in which ethics consultation is done. In contrast to the authoritarian approach, ethics facilitation emphasizes an inclusive consensus-building process. It respects the rights of individuals to live by their own moral values by not misplacing moral decision-making authority or acceding to the personal moral views of the consultant. In contrast to the pure facilitation approach, ethics facilitation recognizes that societal values, law, and institutional policy, often as discussed in the bioethics literature, have implications for a morally acceptable consensus. The ethics facilitation approach is fundamentally consistent with the rights of individuals to live by their own moral values and the fact of pluralism. It, therefore, responds to the need for ethics consultation as it emerges in our society.

What is the role for ethics consultants in guiding discussion among morally acceptable options?

Some cases will have a number of options that are acceptable to involved parties. This raises the question of what role consultants may play in guiding discussion among these options, especially when they see a particular option as optimal. Suppose, for example, that a competent terminally ill patient 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 will wait for a time before having treatment withdrawn in order to appease the family, but really does not want to do so.

It would appear, then, that there are at least two morally acceptable options in the case. The consultant may wish to discuss with the family the importance of having the patient's values respected. The consultant may guide discussion here in a way that enhances the decision-making authority of the patient which is well established by societal values and law (and presumably by institutional policy as well) and confirmed in the bioethics literature.

Suppose, however, that in the above case, the ethics consultant shares the personal moral values of the patient: Treatment should be withdrawn because longer life is not desirable under the circumstances. It is impossible for ethics consultants to be value neutral. Consultants will typically have their own moral views about the issues in case consultations and about how cases would be best resolved. These views will inevitably influence their consultation work. We think that it is important that consultants make it clear to other involved parties both when they are offering moral judgments based on their own values and the reasons underlying their position. The line between guiding and driving discussion is very difficult to draw, much like the line between persuasion and manipulation in informed-consent discussions. Ethics consultants, then, need to be sensitive to this and should not usurp moral decision-making authority or impose their values on other involved parties. This requires that consultants be able to identify and articulate their own moral views and develop self-awareness regarding how their views affect consultation.

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[12] By *consensus* we mean agreement by all involved parties.

What if consensus among the involved parties cannot be reached?

When asked to provide guidance in what seems like an intractable conflict, consultants, by using facilitation, mediation or other conflict resolution techniques, can often help involved parties come to a mutually agreeable solution. For example, conflict can sometimes be resolved by ensuring that all participants have a similar understanding of the clinical facts, bringing in outside persons who might be able to elucidate cultural or religious values, or brainstorming to develop alternative solutions.

Unfortunately, in some cases a consensus cannot be reached. Where consensus cannot be reached, the proper course of action can sometimes be determined by answering the question, "Who should be allowed to make the decision?" Societal values often indicate who should be allowed to make the decision in the absence of consensus. As several of the cases above underscore, the right of a competent and well-informed patient to refuse treatment typically establishes decision-making authority even if some family members or health care providers disagree with the decision. Similarly, the right of conscientious objection typically gives a health care provider the authority to refuse to participate in a procedure that would seriously violate his or her conscience even if a patient and/or family wants the provider to participate.

Not all cases, however, allow for the identification of an appropriate decision maker. Where the appropriate decision maker cannot be identified, the involved parties should have recourse to established and fair mechanisms for resolving the dispute. This may include institutional procedures for dispute resolution, such as utilizing the social work department to seek a state appointed guardian, or it may mean convening a quality review board in cases of alleged professional misconduct. As a last resort, involved parties may turn to the courts.

What are the goals of health care ethics consultation?

The general goal of health care ethics consultation is to:

- improve the provision of health care and its outcome through the identification, analysis and resolution of ethical issues as they emerge in clinical cases in health care institutions.

This general goal is more likely to be achieved if consultation accomplishes the intermediary goals of helping to:

- identify and analyze the nature of the value uncertainty or conflict that underlies the consultation
- facilitate resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of those involved[13]

Successful health care ethics consultation will also serve the goal of helping to:

- inform institutional efforts at policy development, quality improvement, and appropriate utilization of resources by identifying the causes of ethical problems and promoting practices consistent with ethical norms and standards[14]
- assist individuals in handling current and future ethical problems by providing education in health care ethics.[15]

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[13] From Fletcher and Siegler (1996, p. 125).

[14] *Ibid.* As this goal suggests, ethics consultation provides opportunities for education, research and policy development even as it seeks to resolve ethical questions that arise in specific clinical cases.

[15] *Ibid.*

1.2 The Process of Ethics Consultation

The process of ethics consultation, broadly construed, starts with a request for consultation and concludes with an evaluation. This process raises complex and often controversial moral and political questions as well as simple practical ones. Though the central focus of this report is the core competencies for doing ethics consultation discussed in section 2 below, we think it is important to address the following normative questions concerning the process of ethics consultation:

- Who should have access to ethics consultation services?
- Should patients be notified if a consult is called?
- Should ethics consultations be documented?
- Must a consultation service have a mechanism for case review?

The answers to these questions have implications for how the potentially competing rights and responsibilities of patients, families, surrogates, health care providers, and health care institutions are balanced. They also will help determine whether an ethics consultation service can function effectively in particular health care institutions. In sorting through these process issues an appropriate balance must be struck between a formal, legalistic approach that tries to fashion rigid rules to capture every case and an approach that appeals only to abstract principles that are so general that they do not give genuine guidance.

In an effort to avoid these two extremes, we offer the following guidance:

Access. Patients, families, surrogates, health care providers, and other involved parties should have access to ethics consultation services. We think that 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 ethics consultation by patients, families, or surrogates should be honored as a matter of policy. Whereas consultations requested by health care providers or others should be provided, we realize that reasonable people may disagree about whether these consultations may be limited (e.g., whether it is appropriate for an attending physician to limit consultants' direct access to patients or surrogates). Exceptions to a general policy of open access should be carefully considered and clearly delineated in the institution's ethics consultation policy.

Notification. Patients or their surrogates (in cases of incompetent patients) should be notified that an ethics consultation has been called in situations where their participation in decision making is ethically required. Notification means giving the reason for the consultation, describing the process of ethics consultation, and inviting the patient to participate as desired. The attending physician should also be notified when patient involvement is ethically required because the attending physician is ultimately responsible for patient care. Anyone (patient, surrogate, family, or health care provider) can refuse to participate in an ethics consultation, although a refusal is often a sign of a serious breakdown in communication and trust. Whether ethics consultations may go forward when patients refuse to participate is more controversial. In some cases, consultants may be able to help health care providers think through the ethical dimensions of the case even when patients (or other involved parties) refuse to participate. In these cases, confidentiality should be respected in a way that is consistent with consultation achieving this goal (e.g., names or other specific identifiers could be omitted).

There are consults that do not automatically demand patient involvement, such as a consult called to resolve a dispute between two health care providers or to provide information. Suppose a provider requests clarification concerning the informed consent policy or requests help resolving a question concerning conscientious objection to participation in a procedure. Exceptions to the guideline that patients should be notified that a consultation has been called should be clearly spelled out in the consultation service's policies. What should be avoided in all cases is a weakening or usurpation of legitimate decision-making authority, whether it is that of patients or health care providers.

Documentation. Ethics consultations should be documented either in the patient record, or in some other permanent record. The results of consultations ethically requiring patient involvement should be communicated to patients. All consultation services should have a policy specifying the degree and type of documentation required for consults. Such documentation promotes accountability, optimizes communication, and facilitates quality improvement.

Case review. Ethics consultation services should have a mechanism for case review to promote accountability. This process will also promote one of the goals of ethics consultation outlined above: to inform institutional efforts at policy development, quality improvement, and appropriate utilization of resources. If consultations are provided by individuals, retrospective review of those consultations by a full committee could serve this purpose. More formal evaluation methods could also serve this goal (see section 4).

Finally, it is important that each consult service clearly specify its procedures, justify them, and periodically reevaluate how they are meeting overall service and institutional objectives and values.

2. Core Competencies for Health Care Ethics Consultation

2.1 Core Competencies: The Rationale

The ultimate concern of this Task Force is quality improvement in ethics consultation. Patients, families, surrogates, and health care providers deserve assurance that when they seek help sorting through the ethical dimensions of health care, ethics consultants are competent to offer that assistance. Given the nature and goals of ethics consultation as we have described them above, we believe consultants must possess certain skills, knowledge, and character traits to perform competently. We begin by identifying these core competencies and looking at how they could be distributed among individuals, teams, and committees. Then we highlight a variety of ways individuals or groups might acquire these core competencies. Some involve formal education or training whereas others involve less traditional means such as self-study or firsthand experience. The latter were especially important for those doing consultation before adequate formal educational and training opportunities were available. Indeed, we recognize that many of those who have worked in the field for a long period of time have acquired the requisite competencies.

We also do not claim that our discussion of ways of acquiring core competencies is exhaustive nor do we believe that any particular way of acquiring a given competency should be preferred. What is important is that ethics consultants have the competencies it requires. The supplemental education or training that any individual may need to acquire a particular competency will be contingent upon at least two factors: (1) their professional background, experience, and personal qualities and (2) the capacity in which they do ethics consultation, whether as an individual consultant, as part of a consultation team, or as part of a full ethics committee.

In this report, we do not take a position on whether ethics consultation is best done by individuals, teams, or committees. Each method has certain strengths and weaknesses. The committee method, though cumbersome, has the strength of involving a wider variety of perspectives. The individual method, while lacking the variety of perspectives afforded by a committee, is well suited to bedside consultation. The team method exhibits to a lesser degree each of these strengths and weaknesses.

Individual consultants. Where ethics consultation is offered by an individual consultant, the consultant should have all of the core competencies required for ethics consultation (see sections 2.2 and 2.3). This will vary from individual to individual as each brings different strengths to ethics consultation based on their professional backgrounds, life experience, and personal qualities. Ethics consultants normally will need to supplement their professional backgrounds in order to complement the competencies that they already possess. For example:

- Clinicians might have to supplement their professional strengths to acquire advanced knowledge of moral reasoning and skill in ethical analysis, advanced knowledge of bioethical issues and concepts, basic knowledge of ethics-related health law, and advanced skill in building moral consensus.
- Lawyers with expertise in ethics-related health law might need to acquire basic knowledge of the clinical context, advanced knowledge of moral reasoning and skill in ethical analysis, advanced knowledge of common concepts and issues in bioethics, and advanced skill in resolving moral uncertainty or conflict.
- Philosophers with a specialization in ethics may need to acquire basic knowledge of the clinical context, advanced skill in enabling various parties to communicate effectively and to be heard by others, advanced listening and communication skills, basic knowledge of ethics-related health law, and various

other skills and knowledge identified by this Task Force.[16]

Consultation teams. In a consultation team, the team should embody the full range of core competencies required for ethics consultation as identified in sections 2.2 and 2.3 below. Since these core competencies will be distributed among the team, less of a demand is placed on any individual team member. Depending on the team's composition, individuals may need training so that the team has the full range of competencies. Using the earlier example, suppose a consultation team included a philosopher, a lawyer, and a clinician. In this case, team members may need to obtain additional group process and interpersonal skills, advanced knowledge of the health care organization's relevant policies, and other skills or knowledge as needed.

Although there are certain core competencies that need only be possessed by one or more members of the team, there is certain basic knowledge and skill that every member of the team should possess. This is needed because of small group dynamics and the importance of each team member being able to fully participate in case discussions. Thus, in addition to what the group collectively must embody, each consultation team member should take steps to acquire the basic competencies outlined in Tables 1 and 2 under the heading "Every Team Member Needs."

Ethics committees. A great strength of ethics committees is that they typically are multidisciplinary. Like consultation teams, the ethics committee should collectively have the full range of core competencies for ethics consultation. Since core competencies in ethics committees will be distributed over a larger number of people, the demand placed on any particular member is less than for consultation teams, and far less than for individual consultants.

Because a committee, like a consultation team, is more than the sum of its parts, it is important that each member have certain basic skills and knowledge for addressing the types of issues that often come before it. This is especially important for enabling different viewpoints to be heard in the committee's discussion. In addition to the core competencies that the group must collectively possess, every ethics committee member should have the basic competencies listed in Tables 1 and 2 under the heading "Every Committee Member Needs."

2.2 Core Skills for Ethics Consultation

We believe that ethics consultation requires three categories of skills: (1) ethical assessment skills, (2) process skills, and (3) interpersonal skills. We distinguish between *basic* and *advanced* skills in each of these categories. For the purposes of this work, *basic skill* is defined as the ability to use the skill in common and straightforward cases. *Advanced skill* is defined as the ability to use the skill effectively in more complex cases. The distinction between basic and advanced skill is necessarily vague and somewhat arbitrary. Those with advanced skill could have either a more highly developed skill to handle more difficult cases or more complex skills. In patient interviewing, for example, being able to take a history is considered a basic skill, while attending to an anxious patient's affect while taking a history or negotiating treatment options with patients who abuse drugs are considered more advanced skills. The purpose of the distinction is to provide general guidance regarding the type and level of skills required for ethics consultation, leaving the task of more detailed operational definitions to those who provide educational and training opportunities.

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[16] These examples were chosen only because they make it relatively easy to see the strengths that each individual will bring in virtue of their professional background and how they will need to supplement those strengths in light of the core competencies we discuss below.

Ethical assessment skills. In order to identify the nature of the value uncertainty or conflict that underlies the need for consultation, the consultant should have the ability to:

- discern and gather relevant data (e.g., clinical, psychosocial)
- assess the social and interpersonal dynamics of the case (e.g., power relations, racial, ethnic, cultural, and religious differences)
- distinguish the ethical dimensions of the case from other, often overlapping, dimensions (e.g., legal, medical, psychiatric)
- identify various assumptions that involved parties bring to the case (e.g., regarding quality of life, risk taking, unarticulated agendas)
- identify relevant values of involved parties.

Among the skills necessary to analyze the value uncertainty or conflict, the consultant must have the ability to:

- access the relevant knowledge (e.g., bioethics, law, institutional policy, professional codes, and religious teachings)
- clarify relevant concepts (e.g., confidentiality, privacy, informed consent, best interest)
- critically evaluate and use relevant knowledge of bioethics, law (without giving legal advice), institutional policy (e.g., guidelines on withdrawing or withholding life-sustaining treatment), and professional codes in the case.

To critically evaluate and use relevant knowledge, the consultant must also have the ability to:

- utilize relevant moral considerations in helping to analyze the case
- identify and justify a range of morally acceptable options and their consequences
- evaluate evidence and arguments for and against different options
- recognize and acknowledge personal limitations and possible areas of conflict between personal moral views and one's role in doing consultation (e.g., this may involve accepting group decisions with which one disagrees, but which are morally acceptable).

To acquire basic skill in ethical assessment, one needs training and experience in identifying and analyzing ethical issues. This can be acquired through: bioethics intensive courses; conferences and seminars in bioethics; bioethics presentations or in-services at one's local institution; traditional academic courses in bioethics, ethics, or moral theology; structured mentoring processes or independent studies; self-education; or educational programs that are offered by regional bioethics networks.[17]

To acquire advanced ethical assessment skills, one normally needs a longer period of education and training. Some ways of acquiring advanced ethical assessment skills include: fellowship programs that have significant emphasis on developing such skills in the clinical setting; some regional bioethics programs that have developed more advanced courses and seminars in this area; structured clinical practicums or mentoring processes that emphasize skills of ethical assessment in actual case consults; and advanced academic programs in ethics, bioethics, or medical humanities—provided they have significant emphasis on ethical analysis.[18]

In addition to programs in bioethics, other academic programs, such as those in philosophy and theology or religious studies, have traditionally offered special-

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[17] See Appendix 2 for a list of departments, centers, regional networks and other organizations that submitted materials to help complete this project. See also Thornton and Callahan's (1993) report of *The Hastings Center* on bioethics education.

[18] *Ibid.*

ized courses in ethical analysis. A series of individual courses or the completion of degree requirements in these programs is likely to provide advanced skills of ethical assessment for these purposes.

It should be noted that skills of ethical assessment in ethics consultation involve the identification and analysis of ethical issues that emerge in particular clinical cases. In these programs, case-based teaching is important. For the purposes of ethics consultation, identifying and analyzing the ethical dimensions of actual cases as they emerge in clinical settings provide a critical supplement, or even alternative, to classroom-based approaches. Conversely, clinically based approaches need to provide the knowledge (see section 2.2 below) and analytical tools traditionally imparted through classroom-based approaches.

Process skills. Though also important for ethical assessment, process skills focus on efforts to resolve the value uncertainty or conflict as it emerges in health care settings.

Process skills include the ability to facilitate formal and informal meetings. Ethics consultants must be able to:

- identify key decision-makers and involved parties and include them in discussions
- set ground rules for formal meetings (e.g., the length, participants, purpose, and structure of such meetings)
- express and stay within the limits of ethics consultants' role during the meeting
- create an atmosphere of trust that respects privacy and confidentiality and that allows parties to feel free to express their concerns (e.g., skill in addressing anger, suspicion, fear or resentment; skill in addressing intimidation and disruption due to power and/or role differentials).

Process skills also include the ability to build moral consensus. Ethics consultants must be able to:

- help individuals critically analyze the values underlying their assumptions, their decision, and the possible consequences of that decision
- negotiate between competing moral views
- engage in creative problem solving.

Process skills likewise require the ability to utilize institutional structures and resources to facilitate the implementation of the chosen option.

Lastly, process skills demand the ability to document consults and elicit feedback regarding the process of consultation so that the process can be evaluated.

Interpersonal skills. Interpersonal skills are critical to nearly every aspect of ethics consultation in individual patient cases. Interpersonal skills include the ability to:

- listen well and to communicate interest, respect, support, and empathy to involved parties[19]
- educate involved parties regarding the ethical dimensions of the case
- elicit the moral views of involved parties
- represent the views of involved parties to others
- enable involved parties to communicate effectively and be heard by other parties
- recognize and attend to various relational barriers to communication.[20]

Process and interpersonal skills are acquired primarily by "doing." There is no substitute for the role of experience in their development. One may be able to discuss how to facilitate a formal meeting, for example, but until one actually gains experience in facilitating formal meetings, one will not adequately develop the skill.

Basic interpersonal and process skills should be engendered through educa-

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[19] See Lipkin, Putnam, and Lazare (1995, pp. 3-19).

[20] *Ibid.*

tional and training opportunities that are interactive and experientially based. Presentations and in-service sessions at one's local institution which include role-playing a case consultation, or running a simulated meeting would be good ways to begin to acquire basic process and interpersonal skills. Short intensive courses

Table 1: Skills for Ethics Consultation

Ethics consultants must have a variety of "basic" skills, which are used in straightforward cases, and "advanced" skills, which may be required in more complex cases.

Skill Area	Individual/ at Least One Member of the Group Needs	Every Team Member Needs	Every Committee Member Needs
1. Skills necessary to identify the nature of the value uncertainty or conflict that underlies the need for ethics consultation (see p. 13)	Advanced	Basic	Basic
2. Skills necessary to analyze the value uncertainty or conflict (see p. 13)	Advanced	Basic	Basic
3. The ability to facilitate formal and informal meetings (see p. 14)	Advanced	Basic	Basic
4. The ability to build moral consensus (see p. 14)	Advanced	Basic	Basic
5. The ability to utilize institutional structures and resources to facilitate the implementation of the chosen option (see p. 14)	Basic	Not Required	Not Required
6. The ability to document consults and elicit feedback regarding the process of consultation so that the process can be evaluated (see p. 14)	Basic	Not Required	Not Required
7. The ability to listen well and to communicate interest, respect, support, and empathy to involved parties (see p. 14)	Advanced	Basic	Basic
8. The ability to educate involved parties regarding the ethical dimensions of the case (see p. 14)	Basic	Not Required	Not Required
9. The ability to elicit the moral views of involved parties (see p. 14)	Advanced	Basic	Basic
10. The ability to represent the views of involved parties to others (see p. 14)	Advanced	Basic	Basic
11. The ability to enable the involved parties to communicate effectively and be heard by other parties (see p. 14)	Advanced	Basic	Basic
12. The ability to recognize and attend to various relational barriers to communication (see p. 14)	Basic	Basic	Basic

focused on developing these skills should also be adequate. Course work in interpersonal communication, psychology, sociology, education, or social work, provided that it includes significant interactive components, should engender basic skill in these areas as well.

The acquisition of advanced interpersonal and process skills will typically require a longer period of development and greater experience using these skills in ethics consultations. Advanced skill in these areas should equip one to handle more complex situations such as dealing with angry or confused family members or patients, or hostile or unwilling health care professionals. As mentioned above, the development of these skills is tied to hands-on experience. Formal training in specific techniques such as mediation, conflict resolution, or facilitation is one way to obtain advanced interpersonal and process skills. Other ways of obtaining these skills include supervised clinical practicums, mentoring processes (apprenticeships with effective modeling), or fellowship programs that emphasize developing process and interpersonal skills in ethics consultation. Programs in bioethics, medical humanities and other programs such as those in the social and behavioral sciences may engender advanced skill in these areas provided they include significant and relevant experiential components.

2.3 Core Knowledge for Ethics Consultation

In addition to the skills delineated above, we believe that the nine knowledge areas indicated below are required for ethics consultation. These nine general knowledge areas overlap, and the list of subheadings will need to be revised over time due to advances in technology or changes in health care practice. In the bulleted lists, we highlight those areas that are important for ethics consultation in most institutions and so might be covered in training programs. We are aware, however, that specific issues (e.g., organ transplantation) may arise frequently in some institutions and not at all in others.

We distinguish between "basic" and "advanced" knowledge and between knowledge that should be "brought to the process" as opposed to being merely "available to the process." These terms are defined as follows: *Basic knowledge* is a general, or introductory, familiarity with the area specified. *Advanced knowledge* is a detailed grasp of the area specified. *Brought to the process* means that the individual(s) identified must have the knowledge to the level specified. *Available to the process* means that the individual consultant or at least one member of the group must know how to access advanced knowledge in the area indicated. All consultants should be aware of their own limitations and seek out specialized knowledge when appropriate.

As with the distinction between basic and advanced skill, the distinction between basic and advanced knowledge is necessarily vague and somewhat arbitrary. Again, our purpose is to provide general guidance regarding the type and level of knowledge required for ethics consultation, while leaving the detailed fleshing out to those who provide educational and training opportunities designed to instill that knowledge. Below we consider in turn (1) the knowledge area and (2) how advanced or basic knowledge might be acquired (or be available to the process where relevant). Table 2 lists the level of knowledge in each area that individual consultants or at least one member of a team or committee needs, the knowledge that every team member needs, the knowledge that every committee member ought to have in the relevant area, and the knowledge that an individual or at least one member of a team or committee must know how to access.

Moral reasoning and ethical theory. Knowledge of moral reasoning and ethical theory should include:

- consequentialist and non-consequentialist approaches, including utilitarian approaches; deontological approaches such as Kantian, natural law, rights theories; theological/religious approaches; and virtue, narrative, literary, and feminist approaches
- principle-based reasoning and casuistic (case-based) approaches
- related theories of justice, with particular attention to their relevance to resource allocation, triage, and rights to health care.

For ways to acquire basic and advanced knowledge in this area see the discussion following the section below.

Common bioethical issues and concepts. Knowledge of common bioethical issues and concepts includes:

- patients' rights, including rights to health care, self-determination, treatment refusal, and privacy; the concept of "positive" and "negative" rights
- autonomy and informed consent and their relation to adequate information, voluntary and involuntary, competence or decision-making capacity, rationality, paternalism
- confidentiality, including the notion of the "fiduciary" relationship of provider and patient, exceptions to confidentiality, the duty to warn, and the right to privacy
- disclosure and deception, and its relation to patients' rights, and confidentiality
- provider rights and duties, including the right to conscientious objection and the duty to care
- advance care planning, including advance directives, such as a living will or durable power of attorney, and health care proxy appointments
- surrogate decision making, including decision making involving children or incapacitated/incompetent adults
- end-of-life decision making, including an understanding of do-not-resuscitate orders, withdrawal of life support, withholding nutrition and hydration; concepts of "futility," "death," "person," "quality of life," euthanasia (including the concepts of "voluntary," "involuntary," "active," and "passive" euthanasia), physician-assisted suicide and the principle of "double effect"
- beginning-of-life decision making, including reproductive technologies, surrogate parenthood, *in vitro* fertilization, sterilization, and abortion; the concept of "person," the right to privacy, and the principle of "double effect"
- genetic testing and counseling, including its relation to informed consent, paternalism, confidentiality, access to insurance, and reproductive issues
- conflicts of interest involving health care organizations, providers, and/or patients
- medical research, therapeutic innovation, or experimental treatment, and related issues of informed consent, benefit to patient, benefit to society, and social responsibility
- organ donation and transplantation, including procurement, listing of candidates, and distribution
- resource allocation, including triage, rationing, and social responsibility or obligations to society.

There are many different ways that one might come to have basic knowledge of moral reasoning and ethical theory, and issues and concepts in bioethics. These include: regional bioethics education programs, intensive courses (usually one-week courses), participation in conferences, in-service presentations, seminar sessions, and self-education. Other venues that should be sufficient to give one this basic knowledge include introductory academic courses and independent study in bioethics, ethics, or moral theology specifically tailored to these areas.

Advanced knowledge of moral reasoning/ethical theory and issues/concepts in bioethics for the purposes of ethics consultation could be acquired through: fellowship programs in ethics, moral theology, and bioethics, or an academic course or series of courses designed to give one a detailed grasp of these areas. In addition, some regional bioethics networks offer non-degree educational opportunities designed to give advanced knowledge of issues and concepts in bioethics. Some of these may have significant moral reasoning and ethical theory components as well. The completion of MA or PhD programs in bioethics, philosophy, theology, or medical humanities should be sufficient to give individuals advanced knowledge in these areas—provided that the programs have significant components in both of these knowledge areas.

Health care systems. Knowledge of health care systems includes:

- managed care systems
- governmental systems.

The vast majority of those working in health care contexts will be able to acquire basic knowledge through their work experience. For those who do not spend much time working in a health care context (e.g., some community representatives, clergy, those whose primary work is in the humanities), an introductory course in health administration or self-education should provide basic knowledge in this area.

The individual consultant or at least one member of the group must know how to access advanced knowledge in this area when necessary for the purposes of consultation in a particular case. Ethics consultants will need to have access to individuals who have extensive education and/or experience in health care systems. These persons might include officers in the institution or system or individuals with degrees in health administration.

Clinical context. Knowledge of the clinical context includes:

- terms for basic human anatomy and those used in diagnosis, treatment, and prognosis for common medical problems
- various understandings of the terms *health* and *disease* (primarily their value-laden and socially constructed dimensions)
- awareness of the natural history of common illnesses
- awareness of the grieving process and psychological responses to illness
- awareness of the process that health care providers employ to evaluate and identify illnesses
- familiarity with current and emerging technologies that affect health care decisions
- knowledge of different health care providers, their roles, relationships, and expertise
- basic understanding of how care is provided on various services such as intensive care, rehabilitation, long-term care, palliative and hospice care, primary care, and emergency trauma care.

Health care providers will bring with them a detailed grasp of the clinical context. Clinical practicums, self-education, and introductory courses in clinical context should help others to acquire basic familiarity with clinical contexts. In-services, seminars, and conferences designed to introduce non-health care providers to the clinical context will also help individuals to acquire this knowledge.

Ethics consultants should have access to physicians, nurses, and other health care providers who have the advanced knowledge that might be needed in particular cases.

The local health care institution. Knowledge of the local health care institution includes knowing the institution's:

- mission statement
- structure, including departmental, organizational, and committee structure
- range of services and sites of delivery, such as outpatient clinic sites

- ethics consultation resources, including financial, legal, risk management, human resources, chaplain, and patient representatives
- medical research, including the role of the institutional review board, and distinctions between medical research and therapeutic innovation
- medical records, including location and access to patient records.

There is considerable overlap between this area and knowledge of health care systems. The emphasis here is on the local institution. Nearly all those who work in health care contexts will easily be able to acquire basic knowledge of their local health care institution through their professional experience. Basic familiarity in this area could also be acquired through reading the institution's policies and procedures manual or as part of a mandatory orientation session for those who work in the institution.

For advanced knowledge in this area to be available to the process of consultation, health care ethics consultants should know who in the institution to call on should detailed knowledge of some aspect of the institution be needed.

The local health care institution's policies. Knowledge of the local health care institution's policies includes understanding the facility's policies on:

- informed consent
- withholding and withdrawing life-sustaining treatment
- euthanasia (and assisted suicide, if relevant)
- advance directives, surrogate decision making, health care agents, durable power of attorney, and guardianship
- do-not-resuscitate orders
- medical futility
- confidentiality and privacy
- organ donation and procurement
- human experimentation
- conflicts of interest
- admissions, discharge and transfer
- impaired providers
- conscientious objection
- reproductive technology.

For basic knowledge, ethics consultants should be aware of the institution's relevant policies and have a general understanding of their content. One could acquire basic knowledge by reading the policies or through orientation sessions regarding the policies.

An individual should be able to acquire advanced knowledge relevant to these policies through self-education. In-service or seminar sessions on relevant policies could also promote advanced knowledge of relevant policies.

Beliefs and perspectives of local patient and staff population. Knowledge of the beliefs and perspectives of the local patient and staff population includes:

- important beliefs and perspectives that bear on the health care of racial, ethnic, cultural and religious groups served by the facility
- resource persons for understanding and interpreting cultural and faith communities.

The multicultural nature of health care institutions and the patients they serve make knowledge of different cultures and faith communities critical for consultation. Basic knowledge in this area can be acquired through in-service presentations, conferences, and seminars germane to the cultural backgrounds of patient and staff at the local institution.

Ethics consultants should have access to individuals who will have advanced knowledge of the beliefs and perspectives of various members of the patient and staff population. These individuals might include chaplains, social workers, patient representatives, mental health professionals, risk managers, sociologists, and anthropologists.

Relevant codes of ethics and professional conduct and guidelines of accrediting organizations. Knowledge of the relevant codes of ethics and professional conduct and guidelines of accrediting organizations includes:

- codes of conduct from relevant professional organizations (e.g., medicine, nursing)
- local health care facility's code of professional conduct

Table 2: Knowledge for Ethics Consultation

Health care ethics consultants require basic introductory-level knowledge in some areas and more advanced detailed understanding of topics in others. We distinguish between knowledge that individuals or team members must bring to the consultation process ("needs") and knowledge that individuals or team members must have available to the consultation process ("can access"). All consultants should be aware of their limitations so that they know when they need to seek out those who might have specialized knowledge.

Knowledge Area	Individual/ at Least One Member Needs	Every Team Member Needs	Every Committee Member Needs	Individual/ at Least One Member Can Access
1. Moral reasoning and ethical theory as it relates to ethics consultation (see p. 16)	Advanced	Basic	Basic	Not Required
2. Bioethical issues and concepts that typically emerge in ethics consultation (see p. 17)	Advanced	Basic	Basic	Not Required
3. Health care systems as they relate to ethics consultation (see p. 18)	Basic	Basic	Basic	Advanced
4. Clinical context as it relates to ethics consultation (see p. 18)	Basic	Basic	Basic	Advanced
5. Health care institution in which the consultants work, as it relates to ethics consultation (see p. 18)	Basic	Basic	Basic	Advanced
6. Local health care institution's policies relevant for ethics consultation (see p. 19)	Advanced	Basic	Basic	Not Required
7. Beliefs and perspectives of patient and staff population where one does ethics consultation (see p. 19)	Basic	Basic	Basic	Advanced
8. Relevant codes of ethics, professional conduct and guidelines of accrediting organizations as they relate to ethics consultation (see p. 20)	Basic	Not Required	Not Required	Advanced
9. Health law relevant to ethics consultation (see p. 21)	Basic	Basic	Basic	Advanced

- other important professional and consensus ethics guidelines and statements (e.g., presidential commission statements)
- patients' bill of rights and responsibilities
- relevant standards of the JCAHO and other accrediting bodies (e.g., patient rights and organizational ethics standards).

For basic knowledge in this area, one should read the relevant code or manual.

In order for advanced knowledge in this area to be available to the process of consultation, ethics consultants should know who the contact persons might be to discuss the area in question (e.g., the person or persons responsible for the JCAHO survey). They should also know where to find the code or accreditation manual.

Relevant health law. Knowledge of relevant health law (both federal and state constitutional, statutory and case law) includes law governing:

- end-of-life issues such as advance directives (including living wills and proxy appointment documents such as durable powers of attorney), nutrition and hydration, determination of death
- surrogate decision making, including determination of incompetence, appointment of surrogates, and use of proxy appointment documents
- decision making for incompetent patients without family, intimates, or other identifiable surrogates, including medical guardianship and other mechanisms
- decision making for minors, including the need for minors' assent, minors' capacity to consent, and decision making when minors cannot consent
- informed consent
- reproductive issues
- organ donation and procurement
- confidentiality, privacy, and release of information
- reporting requirements, including child, spouse, or elder abuse and communicable diseases

Many of the means to acquire basic knowledge in bioethics as outlined above would also be helpful to acquire basic knowledge of relevant health law. These include: basic courses in health law designed to give an introduction for nonspecialists; independent study courses; regional ethics education programs that give attention to health law; intensive courses (usually one-week or weekend courses) that have health law components; participation in ongoing conferences, in-service presentations, and seminar sessions on health law; and self-education in health law.

Advanced knowledge of relevant health law could be available to the process, if ethics consultants know how to reach legal counsel with expertise in ethics-related health law.

2.4 Character and Ethics Consultation

In addition to the core competencies considered above, all members of the Task Force agree that good character is important for optimal ethics consultation. The rationale for this belief, and opinions about the specific relationship between character and ethics consultation, depend upon a number of issues over which there is controversy among Task Force members. This stems, at least in part, from the close connection between character and conceptions of "the good." When people disagree about conceptions of the good, they are also likely to hold divergent conceptions of character.

In Task Force discussions of character, controversy emerged over whether:

- character is a set of observable behaviors, an internalized inclination to behave in a certain way, or a more fundamental constituent of persons
- certain traits of character are necessary for, or incidental to, the acquisition of certain kinds of skills or knowledge that may be important for various activities

- behavior can be compartmentalized so that bad behavior in one domain does not mean that it will be exhibited in other domains
- the better measure of character involves day-to-day activities or extreme tests such as those times when one must take a stand at considerable personal risk
- evaluations of bioethics consultation or consultants need to focus on more than behavior
- character traits can be correctly defined.

Although the ethics literature historically has included discussions of character, there is little contemporary study of the relationship between character and ethics consultation. This explains, in part, why the Task Force did not attempt to outline a definitive list of character traits that are necessary for ethics consultation. Instead, the Task Force offers the following points and illustrative examples to help advance the dialogue.

By pointing to a connection between character and ethics consultation and including examples, the Task Force does not suggest that all ethics consultants, including Task Force members, possess all of these traits. Also, we do not suggest that character is less important for persons in medicine, nursing, teaching, social work, pastoral care, and other professions or occupations. Nor do we suggest that ethics consultants have or must have better character than others. Nonetheless, the more a consultant possesses and exhibits certain character traits, the more likely the consultation will be effective.[21]

Traits associated with successful consultations. Below are examples of character traits or personal qualities that are believed to be related to success in ethics consultation. It should be noted that character traits cannot be divided into basic and advanced levels. The acquisition and nurturing of character is something persons should strive for over a lifetime. We conclude that all ethics consultants should strive to possess and exhibit these traits:

- *Tolerance, patience, and compassion* are traits that would enable the consultant to "listen well and communicate interest, respect, support and empathy" (skill 7, Table 1). Tolerance and patience help welcome people with difficult problems, those who may be emotionally distraught, or those who have minority views, so that these people can be fully and respectfully heard. Compassion helps the consultant to work constructively with feelings in sometimes tragic situations.
- *Honesty, forthrightness and self-knowledge* are traits that will help prevent the manipulative use of information and help "create an atmosphere of trust" necessary to facilitate formal and informal meetings (skill 3, Table 1). Consultants must be honest about their own limitations, their need for more knowledge, how their agendas and values are shaping the consultation, and the uncertainty about proposed solutions.
- *Courage* is sometimes needed to enable various parties, especially the politically less powerful, to communicate effectively and be heard by other parties (skill 11, Table 1). It is also sometimes required to take positions that are unpopular or contrary to the interests of one's employer or other powerful individuals.
- *Prudence and humility* can inform behavior when rash or novel courses of action are being considered and enable consultants not to overstep the bounds of their role in consultation. These character traits can help consultants acknowledge possible areas of conflict between their personal moral views and their role in doing consultation (skill 4, Table 1).
- *Integrity* can enable consultants to pursue the option or range of options ethically required in the case even when it might be convenient to do otherwise

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[21] As mentioned above, whether character is a set of behaviors or an internalized disposition to behave was something about which the Task Force could not agree.

(skill 5, Table 1). Integrity should inform all behavior of consultants as they strive to fulfill the trust placed in them by health care providers, patients, and families who seek help resolving ethical issues.

Good character, and integrity in particular, is not only important for conducting ethics consultation itself, but also for the credibility of those who will be conducting it. Other professionals and laypersons understandably expect that good character be exhibited by ethics consultants in their professional roles (and indeed in other quasi-public domains). The perception of a person's character in these other areas will inevitably influence one's effectiveness in doing a consult. For example, a physician who developed a reputation for belittling other members of the health care team or routinely disregarding the wishes of competent patients would face a serious credibility problem in performing ethics consultations.

Nurturing character. Most Task Force members also agree that character can be nurtured and that its importance for ethics consultation should be taught and modeled. All Task Force members agree that the controversies surrounding character and consultation identified above need to be acknowledged and discussed as well.

Programs to educate persons for health care ethics consultation should at least:

- encourage reflection about character and its development and explore the possible relationship between character and clinical ethics consultation
- use faculty or mentors who model these important traits of character and who are willing to reflect with students on whether and how character contributed to past successful or unsuccessful consultations
- hold consultants in training accountable for their behavior.

3. Organizational Ethics

3.1 Defining Organizational Ethics

Organizational ethics deals with an organization's positions and behavior relative to individuals (including patients, providers, and employees), groups, communities served by the organization, and other organizations.[22] These positions and behavior may be reflected, for example, in explicit or implicit mission and vision statements, policies, procedures, contracts, agreements, and public and private communications and actions. Ethical issues in organizational behavior have become more evident in recent years with the emergence of a more explicit market approach to medicine. Areas in which value conflict or uncertainty have arisen include billing practices, access to health care, financial incentives for clinicians, restrictions on access to specialists, and marketing. Some examples of organizational ethics consultations follow:

- A financial officer informally requests advice from an ethics consultant in resolving his uncertainty over the development of a procedure for unbundling services for billing purposes in order to increase revenue.
- A health plan medical director requests assistance from an ethics consultation service in negotiating a conflict between the plan's CEO and the plan's physicians over a proposed financial incentive program for clinicians.
- A physician formally requests intervention by a bioethics committee in resolving a conflict with the medical director over whether her patient should receive an experimental therapy not covered by the patient's insurance.

As these examples demonstrate, the resolution of many value conflicts and uncertainties in organizational ethics either requires consideration of values historically considered within the domain of clinical ethics and / or has ramifications for the clinical care of individual patients.

Many of these issues and their potential for conflict have existed for years, but were largely hidden or ignored because of the traditional separation of the functions of providing individual care, improving population health, and financing health care. Practitioners in each area have developed their own ethical traditions and boundaries. Thus, potential conflicts in decision making that stem from differences in these traditions and boundaries—especially between the traditions of clinical ethics and of business ethics—were typically not the subject of bioethics consultation. The intersection between the bedside, community, and boardroom, has become inescapable, however, as the delivery and financing of health care have been increasingly centralized in health care systems and as cost containment has become a national concern. Increasingly, value conflicts and uncertainties cross these three ethical domains, and their resolution can now affect behavior and outcomes in all three domains.

For these reasons, the Task Force believes that no clear and absolute line can be drawn between organizational ethics and clinical ethics. Ethics consultants, then, will increasingly be unable to provide consultation services in one area while ignoring the other. It is thus useful for clinical ethics committees to encourage membership by non-clinical administrators as one way of cultivating mutual respect for and critical analysis of each other's ethical traditions.

Limitations in knowledge. Despite the important relationship between clinical and organizational ethics, the ability of the Task Force to make recommendations

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[22] We want to thank Myra Christopher for her comments on an early version of this section. This newly emerging area has a burgeoning literature, for example, Berkowitz (1996); Biblo, Christopher, Johnson, and Potter (1995); Hofmann (1996); Kotin (1996); Potter, R. L. (1996); Renz and Eddy (1996); and Schyve (1996).

regarding organizational ethics consultation is limited by several factors:

- The state of knowledge about organizational ethics consultation in health care is still developing. Compared with clinical ethics consultation, there is much less descriptive literature about the types of cases encountered and the various efforts to resolve them through consultation.
- The collective education/experience of Task Force members in clinical ethics consultation far outweighs their education/experience in organizational ethics.
- The type of assistance being sought by individuals who request organizational ethics consultation and how those experienced in clinical ethics consultation might be helpful is less well established.

Differences between clinical and organizational ethics. It is also important to bear in mind some differences between the two types of ethics consultation:

- The focus of a request for clinical consultation usually falls within a known list of issues, and knowledge of the basic technical content relevant to the various issues can be mastered by consultants. In organizational consultation, the rapidly changing structure and financing of health care have meant that knowledge about the technical content of the issue under consideration often has to be learned within the context of the consultation itself.
- The party that pays for the consultation in clinical consultation is generally not one of the directly involved parties. In organizational consultation, the party that pays for the consultation—the health care organization—frequently is involved directly in the decision making.
- Consultants in clinical consultation often provide consultation to others who are lateral or below them in the organizational hierarchy. In organizational consultation, those who use consultants' services are often senior leaders who in the organizational hierarchy are higher than the consultants.
- The impact of any resolution in organizational ethics consultation is wider in scope. That is, it will affect many patients, many practitioners, many employees—not just those involved in a specific case. And the impact of the resolution persists over a longer time. Both predicting and monitoring its long-term consequences may be part of the consultation process.

Similarities between clinical and organizational ethics. Though there are differences between clinical and organizational ethics consultation, the context of societal, institutional, communal, professional, and individual values that frames issues in clinical ethics also frames issues in organizational ethics. Moreover, the fundamental goal of organizational ethics consultation and clinical case consultation is the same: to help people resolve uncertainty or conflict regarding value-laden issues. The Task Force believes that the ethics-facilitation approach suggested for clinical ethics consultation may be appropriate for organizational ethics consultation. If this is true, organizational ethics consultation will require many of the same skills and knowledge needed for clinical ethics consultation.

The Task Force acknowledges, however, that the ethics-facilitation approach would need to be adapted to the different issues and concerns raised by organizational ethics, and that other approaches may also be appropriate. Because the differing traditions and boundaries of clinical ethics and business ethics are both relevant in organizational ethics consultation, a resolution based on consensus may be more difficult to achieve than in conflicts or uncertainties that fall entirely within one tradition and its set of boundaries. Moreover, it may be more difficult to identify relevant involved parties for consensus building in organizational ethics consultation. Thus, at a minimum, further exploration of various approaches to organizational ethics issues and their advantages and disadvantages is needed.

The Task Force also notes that although there is a growing emphasis on compliance programs that often address ethical issues, organizational ethics encompasses a scope much broader than the legal sphere. Some decisions that comply with the law may, nevertheless, be considered unethical.

3.2 Some Preliminary Recommendations

At this early stage, it appears that the most salient difference between clinical and organizational ethics consultation concerns the types of issues raised. Clinical ethics consultants will, therefore, need to obtain the additional knowledge to inform, mediate discussion of, and facilitate resolution of uncertainty or conflict regarding value-laden issues in organizational ethics. Organizational ethics consultation may require knowledge about:

- health care business, cost-containment and managed care ethics, including cost shifting, billing practices, financial or administrative incentives on clinicians, resource allocation, definitions of standard or experimental care, and conflicts of interest
- interactions with the marketplace of medicine, including the endorsement of medical products for the purposes of market promotion, and issues raised in marketing health care organizations, such as truth in advertising and promotion of unrealistic expectations
- societal and public health obligations, including serving the medically underserved, antidumping policies, culturally sensitive care, discrimination against or by patients (e.g., based on age, race, gender, sexual orientation, religion, disability, disease, or socioeconomic status), and public disclosure of measures of organizational performance or clinical errors
- scientific and educational health care, including institutional obligations in training future health care providers or in performing research
- general business issues, including relationships with employees (e.g., discrimination in hiring and promotion, conscientious objection of employees), suppliers (e.g., bidding and contracting practices), payers (e.g., cost accounting practices), regulators (e.g., political contributions), shareholders and creditors (e.g., financial reporting), and the public (e.g., conflicts of interest in roles).

Consultation regarding these types of issues will require education in areas ranging from the health care organization's business and administrative structures, the health care system's current structure, the economics of health care (including financing mechanisms and cost-benefit analysis), and the variety of business arrangements in medicine.

Given the early stage in the development of organizational ethics consultation and the lack of experience in this area, we think that more detailed recommendations would be inappropriate at this time. We encourage additional efforts, including both empirical and conceptual research, to define more clearly the scope of organizational ethics consultation; the most effective and efficient organizational structures for its delivery (e.g., its relationship to existing ethics committees); the degree to which it should include preemptive, unsolicited interventions; the appropriate approaches for dealing with organizational ethics issues; and the knowledge and experience that it demands. We also recommend that managed care plans and health care organizations develop methods for identifying and addressing the organizational ethics issues they face.

4. The Importance of Evaluation

4.1 Where Is Evaluation Needed?

A full discussion of the purposes and techniques of evaluation is beyond the scope of this report. The Task Force attaches great importance to evaluation, however, and sees it as an area that should be actively pursued through research and practice. Evaluation of ethics consultation is needed in three areas: the competencies of those who do ethics consultation, the process of consultation itself, and the outcomes of consultation.

Evaluating consultants. It is [illegible] ssess the degree to which individuals have the core competencies described above. This is especially critical for programs that train individuals to do ethics consultation. To the extent that educators are persuaded that these competencies are important for ethics consultation, they should take steps to ensure that their educational objectives cover these competencies and that they have reliable measures for identifying whether those objectives are achieved. For many of the process and interpersonal skills identified above, traditional testing methods, such as essay, short-answer, or multiple choice, may be unreliable. Observing someone perform a consultation (or a mock consultation), for example, will be a better way of assessing facilitation skills than evaluating an essay about how to do a consultation.

Evaluating the process. Evaluation of the consultation process is needed. Above we addressed several important normative questions raised by the process of consultation. We recommended that every ethics consultation service have clearly specified procedures for consultation that are consistent with the position that the Task Force took on those normative questions. Evaluation is important for determining whether the procedures of a consult service are being followed. Chart reviews, for example, could indicate whether consults are properly documented or patient/family surveys could help to confirm that notification procedures are being followed.

Evaluating outcomes. The outcomes of ethics consultation must also be evaluated. This is both the most important and most difficult evaluation area. Evaluating outcomes is an important way to justify and correct recommended competencies for consultants and process procedures. No reliable data, for example, are currently available demonstrating that consultants who possess certain competencies do better consultations. Similarly, there are no reliable data on what methods of ethics consultation best achieve its goals. Moreover, despite the current trend toward instituting quality assurance techniques throughout health care, such efforts have been meager in ethics consultation.

One of the major impediments to evaluating ethics consultation outcomes has been the lack of specification of consultation's goals. Based on the goals delineated above, the Task Force suggests that consultation be evaluated by answering the following questions: [23]

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[23] These correspond roughly to the domains identified by Fox and Arnold (1996). For a fuller discussion of the relevance and importance of evaluation research for ethics consultation see Fox (1996); Fox and Tulsky (1996); Tulsky and Stocking (1996); Tulsky and Fox (1996). These articles resulted from the 1995 conference on Evaluation of Care Consultation in Clinical Ethics, which was supported by a grant from the Agency for Health Care Policy and Research. At the conference there was a recognition that before rigorous evaluation of ethics consultation could be done, there was a need for some consensus on its goals. The conference resulted in a consensus statement on the goals of ethics consultation (see Fletcher & Siegler, 1996).

- Was a consensus reached?
- Was the consensus within the boundaries set by societal values, law, and institutional policy?
- Was the consensus implemented?
- What was the level of satisfaction among participants?[24]

It is too early to endorse specific methods, either quantitative or qualitative, for assessment of ethics consultation. A wide variety of methods should be pursued. Simple qualitative methods, which can be initiated even by consultants without a great deal of expertise in evaluation technique, remain useful. Members of an ethics committee, for example, could review consultations performed by an individual consultant, or an outside consultant could review the ethics committee's activities. These reviews should always be systematic and rigorous with careful attention to purpose and technique. They can serve the purpose of making sure that consultations follow an organization's procedural guidelines and do not result in decisions that reflect consultants' idiosyncratic views.

Quantitative evaluation of ethics consultation also could prove useful in assessing ethics consultations in each of the areas discussed above: the competencies of consultants, the process of consultation, and the outcomes of consultation. Formal quantitative evaluation can help answer questions such as whether certain consultation processes or methods (such as individuals, teams, or committees) best achieve ethics consultation's goals, whether there is a correlation between the competencies of consultants and the outcomes of ethics consultation, and whether relevant ethics policies are more likely to be adhered to in practice if an institution has ethics consultation. Quantitative evaluation requires the development of reliable, valid instruments and careful attention to methodological issues. These assessments should be carried out by those with expertise in evaluation research or quality improvement.[25]

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[24] Satisfaction alone is an inadequate measure of quality in ethics consultation. For example, certain individuals might be quite satisfied with what turned out to be a morally inappropriate course of action (suppose the course of action involved imposing a treatment on a competent patient against her will).

[25] See, for example, Patton (1987) or Fink (1993).

5. Special Obligations of Ethics Consultants and Institutions

Before concluding this report, we address two remaining areas of concern. The first involves the dangers of the abuse of power and conflict of interest by those who do ethics consultation. The second involves institutional obligations to support those who offer ethics consultation services. These two areas are related: Satisfying institutional obligations to support ethics consultation, for example, will decrease the risk that consultants themselves will abuse their position.

5.1 Abuse of Power and Conflict of Interest

By virtue of their role in health care institutions, ethics consultants are both granted and claim social authority to influence:

- the clinical care of patients
- the behavior of health care providers toward families of patients and toward each other
- the behavior of health care institutions toward patients, families, health care providers, and the larger community.

It is therefore inevitable that ethics consultants hold a certain degree of power that, under certain circumstances, can be abused. The potential for abuse of power is not unique to ethics consultants, but instead, a problem for all health care providers. It is inherent in the nature of their role and specialized knowledge, as well as the vulnerability of the persons they serve. The potential imbalance of power imposes a special obligation on ethics consultants not to abuse this power.

Many of the professional or academic backgrounds from which ethics consultants come have codes of conduct governing potential abuse of power. Not all professions and settings do, however, and existing codes are neither uniform nor do they cover the specific role of ethics consultants. For this reason, it is necessary to address some important potential abuses of power:

- Ethics consultants have access to privileged information including highly personal medical, psychological, financial, legal, religious, and spiritual information. The requirements of confidentiality must be respected.
- If ethics consultants have significant personal or professional relationships with one or more parties that could lead to bias, that relationship should be disclosed and/or the consultants should remove themselves from the case.
- Individuals should never serve as ethics consultants on cases in which they have clinical and/or administrative responsibility.
- There is a potential conflict of interest when ethics consultants are employed by a health care institution or their jobs are dependent on the good will of the institution. Giving advice or otherwise acting against the institution's perceived financial, public relations, or other interest may pose potential harm to ethics consultants' personal interests. This issue should be addressed proactively with the health care institution by any individual or group that plans to offer ethics consultation in that institution. If the conflict of interest in an individual case puts ethics consultants in the position of shading an opinion to avoid personal risk, they should either take that risk or withdraw from the case.
- Ethics consultants should never exploit those persons they serve by using their position of power. Ethics consultants, for example, should not take sexual or financial advantage of those they serve.

The above-mentioned cautions should be discussed and explained thoroughly during the training of ethics consultants.

5.2 Institutional Obligations to Patients, Providers, and Consultants

The dangers of abuse of power and conflict of interest can be mitigated if health care institutions take seriously their obligations to those who provide and utilize ethics consultation services. When patients, families, surrogates, or health care providers seek assistance in sorting through the ethical dimensions of health care, they deserve assurance that those who offer that assistance are competent to do so and can offer that assistance free of undue pressure. We have discussed in detail how important it is for those who do ethics consultation to take seriously quality assurance and improvement. We have also underscored the dangers of abuse of power and conflict of interest on the part of consultants. Nonetheless, the burden of satisfying these obligations should not fall solely on the shoulders of those who offer ethics consultation. Health care institutions must be responsible to those who utilize ethics consultation services by providing support for ethics consultants in their institution. This support is needed in three areas:

- Health care institutions should support a clear process by which ethics consultants are educated, trained and appointed, and provide the resources for those who offer ethics consultation to ensure that they have the competencies to perform consultation. This will require support for continuing education and access to core bioethics resources (such as key reference texts, journals, and online services).
- Health care institutions should ensure that those who offer ethics consultation are given adequate time and compensation for non-remunerative activities, and the resources to do ethics consultation properly.
- Health care institutions should seek to foster a climate in which those offering ethics consultation services can carry out their work with integrity (e.g., a climate free of concerns about job security, reprisals, undue political pressure). This should include separating ethics consultation from personnel oversight, so that health care providers see ethics consultation as a resource for addressing ethical uncertainties or conflicts rather than as a disciplinary action, and respecting the independence of ethics consultation and ethics policy initiatives. In such a climate, pressures to abuse power or give in to conflict of interest will be significantly diminished.

III. USING THE TASK FORCE REPORT

Voluntary guidelines. The Task Force unanimously recommends that the content of this report be used as voluntary guidelines. Whether these guidelines are adopted by health care organizations or education and training programs should be based on an informed discussion of the report's merits. The Task Force:

- does not wish certifying or accrediting bodies to mandate any portion of its report
- believes that certification of individuals or groups to do ethics consultation is, at best, premature
- does not intend for its report used to establish a legal national standard for competence to do ethics consultation for the reasons indicated below.

The Task Force endorses voluntary guidelines for a number of reasons. First, as voluntary guidelines, the recommendations in this report reflect the complexity and lack of data surrounding the current state of ethics consultation. Second, voluntary guidelines are sensitive to the wide diversity of institutional settings where consultation takes place (e.g., the needs of large teaching hospitals differ tremendously from those of small community hospitals or long-term care facilities). Third, although they remain tentative, voluntary guidelines can encourage gradual change and stimulate public discussion. Finally, whether voluntary guidelines are adopted depends, at least in part, on the guidelines' merit.

The alternatives to a voluntary model—certification and accreditation—have serious drawbacks that led the Task Force to reject them. The Task Force viewed these drawbacks as strong reasons to endorse the voluntary model.

The drawbacks of certification. The Task Force rejects the certification of individuals or groups to do ethics consultation for many reasons.[26] First, certification increases the risk of displacing providers and patients as the primary moral decision makers at the bedside because it can give the impression that certified individuals have special standing in ethical decision making. Certification, then, could encourage the type of authoritarian approach to ethics consultation the Task Force has rejected.

Second, certification could undermine disciplinary diversity if it fell under the control of a particular discipline and was widely adopted. The Task Force believes that this would be undesirable because the different disciplines involved in ethics consultation each bring identifiable strengths to the process. Philosophers, for example, typically bring a strong background in ethical analysis, while social workers bring excellent facilitation skills. It is important that consultants have the relevant competencies, not that they come from some particular professional or academic field. The Task Force believes that the interdisciplinary nature of the field leads to a more balanced understanding of competencies important for doing ethics consultation.

Third, certification could lead to the institutionalization of a particular substantive view of morality, a certain view of the relation between ethical theory and practice, or one conception of the relative importance of skills that are important for ethics consultation.

Fourth, if certification of individuals or groups were based on standardized

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[26] Certification, for our purposes, refers to documentation by a certifying body, often through standardized testing, that an individual or group has the necessary knowledge, skills, and character to engage in a certain practice. Thus, individuals or groups who are certified can claim that they have the minimal qualifications needed for the practice. Often stronger claims are made for certification, for example, that the uncertified should be barred from practice.

testing, the tests would have to be shown to measure the competencies in question. Considering the level of uncertainty and lack of outcome data, it is unlikely at this time that a sufficiently reliable test could be developed to measure the required competencies.

Finally, certification would also require the development of a new bureaucracy to manage it, with all of the attendant costs and difficulties. This raises serious political and practical difficulties that should not be undertaken without a strong justification and a compelling need.

The drawbacks of accreditation. The Task Force rejects specially accrediting educational programs that would train individuals or groups to do ethics consultation for many of the same reasons that it rejects the certification of individuals or groups to do ethics consultation. The emergence of accredited educational programs could promote the dominance of a particular moral view or technical approach, have an adverse effect on disciplinary diversity, and imply a degree of professionalization that is, in the opinion of the Task Force, premature at best. As with certification, we believe that the practical and administrative costs of accreditation are serious enough that they should not be taken on without compelling need or justification.

Thus, at this time, the Task Force recommends that its report be used only as voluntary guidelines. The specification of "at this time" does not mean that the Task Force contemplates mandatory guidelines at some later time. Rather, the specification means our assessment is based on the current state of knowledge and our recognition that this state is evolving.

One might ask whether the concerns raised about certification and accreditation might not apply equally well to voluntary guidelines. Such an objection misses the spirit of our recommendations. In surgery, we know that perfect sterility is impossible, but no one takes this as a warrant for abandoning all precautions. What we have tried to do is to provide guidance in some very uncharted waters about, among other things, the nature and goals of ethics consultation, the core competencies that are needed to do it, and how those competencies might be acquired.

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APPENDIX 1

Financial Support for the SHHV-SBC Task Force on Standards for Bioethics Consultation

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American Association of Bioethics

American Association of Critical-Care Nurses

American Medical Association

American Nurses Association
Center for Ethics and Human Rights

Association of Professional Chaplains

Baylor University
Center for Ethics, Medicine, and Public Issues

Bioethics Network of Ohio

Brown University
Center for Biomedical Ethics

Case Western Reserve University
Center for Biomedical Ethics

Cleveland Clinic Foundation
Department of Bioethics

Creighton University
Center for Health Policy and Ethics

Davidson College
Department of Medical Humanities

Ethics in Health Care Associates
Toronto, ON, Canada

Gundersen Medical Foundation
La Crosse, WI

Hennepin County Medical Center
Minneapolis, MN

Loyola University of Chicago
Department of Medical Humanities

Medical Ethics Resource Network of Michigan

Michigan State University
Center for Ethics and Humanities

Midwest Bioethics Network
Bioethics Development Group

Oregon Health Sciences University
Center for Ethics in Health Care

The Park Ridge Center

Pennsylvania State University (Hershey)
College of Medicine
Department of Medical Humanities

Society for Bioethics Consultation

Society for Health and Human Values

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Stanford University
Center for Biomedical Ethics

St. Louis University

University of Arkansas for Medical Sciences
Division of Medical Humanities

University of Iowa
College of Medicine

University of Pittsburgh
Center for Bioethics and Health Law

University of Pittsburgh
Consortium Ethics Program

University of Tennessee
Department of Philosophy

University of Texas Medical Branch
Institute for the Medical Humanities

University of Utah

University of Virginia
Center for Biomedical Ethics

Vanderbilt University
Center for Clinical and Research Ethics

Virginia Bioethics Network
Charlottesville, VA

Washington Hospital Center
Washington, DC

West Virginia University
Center for Health Ethics and Law
Robert C. Byrd Health Sciences Center

West Virginia University
West Virginia Network of Ethics
Committees

APPENDIX 2

Academic Departments, Centers, Regional Networks, and Other Organizations That Submitted Education and Training Materials to the Task Force

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School of Medicine
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Charlottesville, VA 22908

Center for Biomedical Ethics
Case Western Reserve University
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Center for Christian Bioethics
Faculty of Religion
Loma Linda University
Loma Linda, CA 92350

Center for Clinical and Research Ethics
Vanderbilt University
School of Medicine and Medical Center
319 Oxford House
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Center for Clinical Bioethics
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Washington, DC 20007

Center for Ethics and Humanities in the Life Sciences
C-208 East Fee Hall
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East Lansing, MI 48824

Center for Health Ethics and Law
West Virginia University
1354 Health Sciences North
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Morgantown, WV 26506-9022

Center for Medical Ethics and Health Policy
Baylor College of Medicine
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Houston, TX 77030-3498

The Center for the Study of Bioethics
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Collaborative Program in Bioethics
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University of Toronto
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Consortium Ethics Program
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Center for Bioethics and Health Law
Pittsburgh, PA 15213

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Department of Philosophy
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Department of Philosophy
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Department of Veterans Affairs
National Center for Clinical Ethics
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White River Junction, VT 05009

Division of Clinical Ethics
Department of Family Medicine
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Florida Bioethics Network
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The Hastings Center
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Institute for the Medical Humanities
University of Texas Medical Branch
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Galveston, TX 77555-1311

The Johns Hopkins University
School of Hygiene and Public Health
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MA Program in Bioethics
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Faculty of Arts and Sciences
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Program in Medical Humanities
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Health Sciences Center/Syracuse
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APPENDIX 3

How the Task Force Report Was Developed

How was the Task Force report developed?

The Task Force functioned as a consensus panel. It held six three-day meetings over a two-year period. The major objectives of the first two meetings were to provide background information on ethics consultation and to identify the issues that needed to be addressed in subsequent meetings. Speakers at the first two meetings addressed the project's history and goals, the Joint Commission on Accreditation of Healthcare Organization's interest in ethics consultation, the sociological nature of professionalization, the current empirical literature on ethics consultation, and previous efforts to develop standards.

Developing a bibliography. A comprehensive bibliography was compiled by doing subject and keyword searches of Medline, Bioethicsline, CINAHL, and the Philosopher's Index using: '*ethics' and 'consultation'; '*ethics' and 'consultant'; and, '*ethics' and 'committees' and 'consultation'. These searches were supplemented by reviewing bibliographies of relevant articles. Other experts in the field were contacted and references were obtained from them.[27] The initial database compiled included more than 1,200 references, approximately 264 of which were deemed relevant to the project. A closer review found approximately 55 entries that focused on topics central to the project. An annotated bibliography of these articles was developed and sent to all Task Force members.

Having reviewed this background information, the Task Force turned its attention in meetings two and three to developing a consensus view of the nature and goals of ethics consultation. Task Force members were surveyed regarding their views of ethics consultation's nature and goals, and a summary of the results were made available. Task Force members also were asked to write short essays on ethics consultation's nature and goals and to submit representative consultations in which they had been involved. Drs. Aulisio, Arnold and Youngner reviewed different approaches to ethics consultation in the literature and Task Force member's essays. The early forms of the ethics facilitation approach described herein emerged from this work. The proposed approach was discussed and modified at meetings four, five, and six.

Forging a further consensus. Having reached a general consensus on the nature and goals of consultation, the Task Force turned its attention to the skills, knowledge and character traits required for consultation. For the third and fourth meetings, subcommittees were convened to deal with each of these areas. A subcommittee was also formed to deal with the emerging area of organizational ethics consultation. Each subcommittee circulated initial drafts, which were then discussed and revised at the meetings. A survey of Task Force members was completed to help the subcommittees decide whether basic or advanced knowledge or skill was needed in the respective competencies identified for clinical ethics consultation.

At meeting three, it became clear that the Task Force needed to address whether the proposed core competency standards should result in certification, licensing, or accreditation. An implementation subcommittee was convened to develop a preliminary proposal for the Task Force. During meetings three and four, a number of other topics related to the question of standards for ethics consultation were

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[27] Drs. Ellen Fox and James Tulsky shared with us the bibliography they developed as part of their empirical project to evaluate ethics consultation (Tulsky & Fox, 1996).

raised. These dealt with the importance of evaluation, conflicts of interests, and special obligations of both consultants and those organizations which employ them. Subcommittees were formed for each topic and asked to write initial drafts which were then discussed and revised at later meetings.

The majority of meetings four and five were devoted to discussions of how consultants might acquire the requisite skill, knowledge, and character traits. The aforementioned skill, knowledge, and character subcommittees were charged with developing draft documents on how to *acquire* the requisite competencies. In order to aid this work, input was solicited from educational and training programs throughout the country.[28] Approximately 40 responses were received. The subcommittee's draft documents were then discussed extensively at the meetings and revised. The subcommittee on models for implementing proposed standards presented its recommendations at meeting four. These were discussed at length and then unanimously endorsed (see "Using the Task Force Report" on page 31).

The preliminary report. A preliminary Task Force report was then drafted for discussion at meeting five. After meeting five, a discussion draft was developed and circulated to the bioethics community for feedback. The discussion draft was sent to every member of the AAB, SHHV, and SBC, as well as to various academic programs, centers, regional networks, and health care organizations and posted on the Web (at the SHHV and Medical College of Wisconsin Web sites). More than 1,400 copies of the discussion draft were distributed. Task Force members also presented the discussion draft in a number of forums, including hospitals, bioethics centers and academic organizations. An entire morning of the Joint National Meeting of the AAB, SHHV, and SBC was devoted to gathering feedback on the discussion draft (November 9, 1997; Baltimore, Maryland). More than 150 people attended this three hour meeting.

Feedback on the Task Force draft was carefully documented. All comments received at the AAB, SHHV, and SBC meeting were noted, as well as all those received by e-mail or hard copy. More than 200 responses were received. All comments were collated by topic and then distributed to Task Force members in advance of meeting six. Based on this input, a subcommittee was formed to discuss possible recommendations regarding the proper process for ethics consultation. The literature on this question was reviewed and a draft written. The sixth meeting was devoted to discussing this issue, as well as both internal and external critiques of the Task Force's discussion draft.

The final report. Based on this input from the bioethics community, major revisions were made to the Task Force report. These included revisions to the nature and goals, character, evaluation, and organizational ethics sections. After meeting six, a revised draft was again distributed to Task Force members and comments were elicited. Conference calls were held to discuss remaining issues. A final draft of the report was reviewed and approved by all Task Force members. The report was then reviewed and adopted by the American Society for Bioethics and Humanities on May 8, 1998.

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[28] This idea was suggested to the Task Force at the spring 1997 SHHV Conference at Loyola University of Chicago. Please see Appendix 2 for a list of departments, centers, regional networks, and other organizations that submitted education or training materials to help the Task Force in this project.