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Quality Attestation *for* Clinical Ethics Consultants:

A Two-Step Model from the American Society for Bioethics and Humanities

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Abstract

Given the importance of clinical ethics consultation to patient care, the people doing it should be asked to show that they do it well. An ASbH task force proposes a method for assessing them.

Clinical ethics consultation is largely outside the scope of regulation and oversight, despite the importance of the practice. For decades, the bioethics community has been unable to reach a consensus on whether there should be accountability in this work, as there is for other clinical activities that influence the care of patients. Over the last decade, however, there has been an evolution in sentiment. Resistance to some form of credentialing or certification has been tempered by data showing that CEC practice patterns vary unacceptably and that some of those engaged in CEC have questionable qualifications.[1] Because these findings show that CEC may be placing patients at risk, the question of evaluating practitioners has resurfaced with a growing consensus in favor of creating a standardized system for proactively assessing the knowledge, skills, and practice of clinical ethicists.

The evolution in thinking is consistent with broader forces in modern health care, including the patient safety movement, quality improvement practices, and pay for performance measures, the last of which calls for assessing interventions initially to demonstrate effectiveness and ultimately to exhibit targeted improvement. Increasingly, patients in hospitals and in accountable care organizations are asked to rate their providers. All of these metrics hold providers responsible for the process and outcomes of their interventions, yet there has been surprisingly little attention to CEC.

The American Society for Bio-ethics and Humanities (ASBH), the primary society of bioethicists and scholars in the medical humanities and the organizational home for individuals who perform CEC in the United States, as well as for many bioethics professionals from outside the United States, believes that CEC is a significant activity and that its practitioners should demonstrate competence at it. To that end, ASBH has initiated a two-step *quality attestation* process as a means to assess clinical ethics consultants and help identify individuals who are qualified to perform this role. This article describes the process.

Clinical Ethics Consultation

CEC is a high-stakes endeavor. Consultants have many of the privileges and responsibilities of clinicians who provide care to patients. Although CEC is not clinical practice in the conventional sense, its analytic and deliberative process can affect decisions about care and influence patient case management. In order to perform their activities, clinical ethics consultants have access to families and the medical record, and they are often called upon to mediate conflict and provide assistance at times of great stress and emotional need. They

must be trained to avoid the risk of imposing their values and judgments. The authority of the clinical ethics consultant is not derived only from institutional appointment; it is conferred by education and skill.

As defined here, quality attestation is the review of an individual's ability to carry out CEC practice. Review will encompass an assessment of education, skills, and experience to ascertain whether an individual can perform a consultation independently or serve as a lead consultant when the process is team based.

Quality attestation is to be distinguished from the process of privileging individuals locally within a health care institution and from formal board certification, which generally occurs at a national level and involves a psychometrically validated written examination. Quality attestation is intermediate between these two levels of assessment. It focuses on individuals, in contrast to the assessment of academic bioethics training programs and fellowships under the rubric of accreditation, which is under way under the aegis of the Association of Bioethics Program Directors.

The development of this consensus process toward quality attestation began in 2011 with an ASBH presidential initiative launched in response to growing interest among its membership.[2] With the support of its board of directors, ASBH initiated a dialogue with its membership, its Clinical Ethics Consultation Affairs (CECA) Committee, and Clinical Ethics Consultation Affinity Group to delineate a process of assessment that would attest to the skills and ability of properly trained and competent clinical ethicists.[3]

The process ASBH has developed involves two sequential, interrelated steps. The first is the submission of a portfolio delineating educational and case-consultation experience. The second is an oral examination, based in part on the content of the portfolio. These methods were chosen to assess individuals from multiple disciplines who utilize a variety of consultation models—a diversity that ASBH values.

Through a process of broad consultation with key stakeholders and the ASBH Board of Directors, Joseph Fins, the 2011-2013 president of ASBH, created a Quality Attestation Presidential Task Force (QAPTF) and named twelve experts in CEC from diverse disciplines, backgrounds, geographic locales, and practice settings to serve on it. The group also included Fins, the immediate past and future presidents of ASBH, and the chair of CECA. All are published widely in clinical ethics, most have served in leadership roles for consultative services, and some have directed training programs in clinical ethics.

A cooperative agreement was forged with the Cleveland Clinic Department of Bioethics to serve as the administrative home of the initiative, given that department's prior work articulating a competency-based assessment process, previously presented at the 2009 ASBH annual meeting in Washington, D.C.[4] Eric Kodish, chair of the department, and Fins drafted a grant proposal to launch this project for consideration by the Josiah Macy Jr. Foundation, which awarded initial support to enable this white paper.

During the academic year of 2012-2013, the QAPTF met three times and had regular teleconferences. This article is the result of its collective work and has been approved by

CECA and the ASBH Board of Directors as the basis for ASBH's continued development of a quality attestation process.

History

The pursuit of a quality attestation process represents an evolution in thinking.[5] The movement toward credentialing and certifying clinical ethicists began in 1991 after the Joint Commission for Accreditation of Health Care Organizations issued standards requiring that hospitals provide a mechanism for resolving ethics and value questions that arise in the care of patients.[6] In response to that requirement, early advocates for certification proposed a medical staff model of CEC privileges.[7] John La Puma and David Schiedermayer addressed the qualifications of clinical ethics consultants; they argued that consultants should have substantial experience caring for patients and have instruction in medical humanities, health law, and moral reasoning.[8] John Fletcher and Diane Hoffman, recognizing the influence consultants had in decisions regarding patient care, called for the establishment of standards in education, training, and consultation for ethics consultants and ethics committees.[9]

Many others contributed to the discourse on these issues in the 1990s, and various perspectives were published in the fall 1993 issue of the *Cambridge Quarterly of Healthcare Ethics*. Giles Scofield, in his examination of the roles of clinical ethicists, argued that they serve as teachers rather than as mediators or consultants and that clinical ethics should not be professionalized.[10] Others responded with commentaries that challenged his arguments and proposed alternative views on the roles of clinical ethicists and the establishment of standards.[11]

In 1998, ASBH published Core Competencies for Health Care Ethics Consultation, which outlines the knowledge base and skill set that consultants should possess to conduct ethics consultation.[12] That document forms the basis of the assessment process envisioned by the quality attestation process.

By way of background, the ASBH Task Force on Standards for Bioethics Consultation framed the core competencies published in 1998 as voluntary guidelines, rather than as required competencies, due to conflicting perspectives about the qualifications and training of clinical ethics consultants and the logistics of certification.[13] The task force noted several drawbacks to the certification of ethics consultants, including the risk of elevating certified individuals as authorities in ethical decision-making, concerns about developing a reliable test to measure required competencies, and the political and practical challenges of developing a bureaucratic system to manage certification.[14]

The evolution from the first to the second edition of *Core Competencies* reflects the robust discourse about certification of ethics consultants and the accreditation of clinical ethics training programs over the years. Commonly expressed concerns about certification and accreditation include the potential to undermine the rich multidisciplinary traditions and perspectives within ethics consultation, a shift toward regulation that could undermine ethical considerations,[15] qualms about how to manage practicing ethicists who may not meet new standards, and challenges related to training requirements in an interdisciplinary field.[16]

In 2007, a national survey of U.S. hospitals on ethics consultation practices underscored the need for standards in training and expertise among consultants.[17] The data indicated that ethics consultation was prevalent within U.S. hospitals, that consultants came from a variety of disciplines, and that consultants had little to no formal training. In a commentary on the survey, Nancy Dubler and Jeffrey Blustein reiterated the need for the professionalization and standardization of clinical ethics consultants, drawing parallels to the required standards of other clinical disciplines that are essential to patient care.[18]

Formal discourse on the topic continued, and in 2009, *HEC Forum* dedicated an issue to ethics consultant credentialing and certification. Many contributors supported the need for standards and quality measures and acknowledged the shift toward the professionalization of clinical ethics consultants.[19] Others accepted the need for standards but cautioned about losing the heterogeneity among consultants.[20] Jeffrey Spike proposed the accreditation of training programs, rather than the certification of individual consultants, to account for the multidisciplinary nature of clinical ethics.[21]

In 2009, the National Working Group for the Clinical Ethics Credentialing Project published a consensus statement on clinical ethics consultant standards and evaluation and credentialing measures,[22] and the ASBH Clinical Ethics Task Force published an educational guide for CEC.[23] ASBH's Clinical Ethics Consultation Affairs Committee continues the work of that task force by drafting, as a step toward professionalization, a code of ethics for clinical ethics consultants and by exploring the development of standards for individual consultants.

Justification

As other activities in health care have been subjected to methods of measuring quality, it has become ever more apparent that there are no basic qualifying, certifying, or credentialing requirements for clinical ethics consultants. A consensus has been emerging that CEC should not escape examination and scrutiny. There is no entrance examination and no prescribed educational requirement that qualifies one to conduct CEC, even though CEC is often a high-stakes endeavor that influences clinical practice in critical aspects of health care, such as end-of-life decisions and claims about medical futility. This status quo is no longer acceptable.[24]

To integrate and conform to the expectations of the quality movement in health care and to address the need for standards in an area of expertise that draws from many disciplines, there must emerge some widely accepted notion of the qualifications that permit a clinical ethics consultant to practice. These capabilities are outlined in *Core Competencies*.

The lack of basic qualifying steps is not a result of inadvertence. The discussion of entrance qualifications has, understandably, been divisive within the field. Bioethics is a field composed of an amalgam of disciplines. Bioethicists (and, specifically, clinical ethics consultants) come from medicine, law, philosophy, religion, nursing, social work, health policy, and many other backgrounds. Because of CEC's inherent multidisciplinarity,

developing a unitary set of entrance requirements for a varied constituency has presented formidable challenges.

But as noted, there has been some general agreement about the definition and core competencies of CEC. *Core Competencies* defines ethics consultation as "a set of services provided by an individual or a group in response to questions from patients, families, surrogates, health care professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care."[25] CEC is a recognized mechanism in health care institutions for addressing ethical questions and conflicts.[26] CEC, in which a clinical ethics consultant interacts with a patient or family member and places documentation in the patient's medical record, has been given special attention in *Core Competencies*,[27] as it has greater potential to directly help or harm the patient. Therefore, it is important that clinical ethics consultants are qualified to serve in this role. Given the immediate and direct effect CEC can have on patients, family members, and medical providers, its practioners must be held to standards of excellence, as are all other members of the health care team and their interventions.

> Given the immediate and direct effect CEC can have on patients, family members, and medical providers, its practitioners must be held to standards of excellence, as are all other members of the health care team.

Through the quality attestation process, we are attempting that first building block of competence—of assuring that the person intervening as a clinical ethics consultant is educationally prepared and has the capability to fill that role. It is an approach to ensuring readiness for engaging in CEC. While clinical ethicists in health care organizations provide other ethics-related services in addition to consultation (such as educating health care professionals about ethics, developing ethics-related organizational policies, providing an ethics perspective while serving on organizational committees, initiating proactive ethics services, and producing scholarly work or research in ethics[28]), *Core Competencies* focuses on CEC because it recognizes CEC as a "high stakes" activity.[29] Accordingly, the attestation of clinical ethics consultants focuses on the *practice* of consultation. It is anticipated that the skills and knowledge necessary to provide competent and effective CEC are likely to considerably overlap with those needed to perform the other ethics-related services mentioned above.[30]

CEC is generally requested by health care professionals but may also be requested by patients and families. CEC is rarely requested when decisions about patient care are progressing smoothly and there is consensus about goals and directions. A call for consultation is a call for help in a situation typically characterized by an ethical conflict, a lack of clarity, or a developing or full-blown conflict. Resolution may be achieved by clarifying the stakeholders' values and providing information about institutional policy, procedures, and applicable law. Conflict can be resolved or managed by facilitation or mediation that elicits the positions and interests of the agents and actors within the boundaries of public policy and law and acknowledges all stakeholders in choosing among available options and reaching consensus. Obviously, managing this complex practice requires a substantial level of knowledge and skill.

Clinical ethics consultants must "be trained to engage in finding information; interviewing the stakeholders; amplifying the voices of the patient and family; explaining, facilitating, and, when appropriate, mediating solutions; documenting the process appropriately; engaging in a quality improvement process; serving as an educational resource."[31] How can we determine that an individual has developed these skills and this deep knowledge base, and yet honor and respect the differences in training and experience? To structure an inquiry into professional preparedness, we need to agree on the range of tasks, aptitudes, information, and skills that will be employed as a clinical ethics consultant, no matter the basic discipline in which the individual has been schooled.

Assessment Criteria

Reviewing CEC preparedness presents myriad challenges. The most effective review would require a senior skilled clinical ethic consultant to attend each consultation as a silent witness and assessor. However, consultations are not on set schedules; they must accommodate providers, patients, and family members and may involve multiple meetings to reach resolution. Given these factors, on-site contemporaneous review is not feasible. But, given the demands of clinical excellence, some alternative means of evaluation is necessary.

Any method of assessment would need to identify an effective means to assess and document that an individual has sufficient knowledge and skills to competently conduct CEC independently and a means to attest that an individual can be trusted to perform this work effectively and independently. CEC attestation must be fair and practicable. The two-step method we have developed is intended to accommodate the diversity of the ASBH membership, and others who engage in clinical ethics consultation, by offering diverse opportunities to demonstrate competence. (It should be stressed that ASBH membership is not a prerequisite for undergoing the quality attestation process.) We initiate this process appreciating that these initial thoughts will evolve and become refined over time as proof of principle is demonstrated and experience is gained by working through the details of assessment and evaluation and gaining the ongoing input of our colleagues.

Required Elements for CEC Quality Attestation Portfolio

Educational qualifications

Candidates are expected to have at least a master's degree in a relevant discipline. Candidates without a master's degree but with significant CEC experience must provide additional evidence of their qualifications for consideration.

Portfolios should include the following

- curriculum vitae or resume
- copies of diplomas or comparable documents
- summary of candidate's education and training related to ethics consultation
- summary of CEC experience, with time frames and settings
- summary of candidate's philosophy of CEC, in 500 words or less

- three letters of evaluation from individuals with responsibility for clinical oversight who are knowledgeable about the candidate's ethics consultation activities
- six case discussions of consultations in which candidate acted as lead or colead and authored or coauthored documentation, with discussions that
  - ○ demonstrate CEC practice in a variety of clinical settings
  - ○ demonstrate CEC practice on a variety of ethical issues
  - ○ include a case narrative, synopsis, relevant ethical issues, assessment, recommendation, and outcome
  - ○ provide evidence of competency using sources such as redacted chart notes, database summaries, memos to colleagues, minutes of case conference or ethics committee meeting, and policies written by applicant related to his or her consultations
- six one-page descriptions of *additional* cases that evidence CEC experience in a wide range of clinical settings and/or with a wide range of ethical issues, with descriptions to include
  - ○ date
  - ○ type of requester
  - ○ clinical setting
  - ○ethicalissues
  - ○ resolution

A. Portfolio

I. Rationale and design—We have selected the portfolio review as the first step for evaluating the quality of the individual consultant, not in the abstraction of an examination, but in the real context of his or her work. The submission and evaluation of a CEC portfolio is intended to achieve several objectives: to demonstrate evidence that a candidate has achieved a level of general competence as a clinical ethics consultant in a variety of clinical settings, regarding a wide range of ethical issues, and in a collaborative manner; to document that a candidate has a sufficient level of ability to function independently in CEC; and to provide evidence from a candidate that he or she is able to engage in what has been described as an "entrustable" professional activity.[32]

A portfolio is defined as "a purposeful collection of student work that exhibits to the student and/or others the student's efforts, progress, or achievement in (a) given area(s). This collection must include student participation in selection of portfolio content; the criteria for selection; the criteria for judging merit; and evidence of student reflection."[33] Portfolio review enables the simultaneous evaluation of an applicant's skills and effectiveness in CEC.

The concept and use of a portfolio to assess professional skills has some precedent in the health care field, particularly in psychiatry.[34] Similarly, Martin Smith and colleagues have suggested that preparation and review of a portfolio can be a useful approach for demonstrating the ability of clinical ethics consultants to use their consultative competency in applying knowledge and skills across a broad spectrum of cases and in a variety of clinical settings.[35] A consultation portfolio should serve to demonstrate an ability to address a range of ethical issues. It should also serve to demonstrate that consultants have worked collaboratively with others within an organization (for example, with the hospital ethics committee, hospital administration, pastoral caregivers, and social workers).[36]

Individually created portfolios present a singularly useful platform for assessing the qualifications of individuals who have trained in a variety of fields. Portfolios permit a wide variation in the bases of bioethics knowledge as long as the end result is within the accepted parameters of professional competence.

Candidates, knowing that they will be preparing their work for the assessment, will offer individual best practice and focus on achieving excellence given their skills. These portfolios are designed to be showcase portfolios, representing their own selection of their best work, to be used for evaluation of qualification to engage in CEC in the general practice of clinical ethics in the medical context.

As an initial exercise in individual assessment, the portfolio accommodates both those who have learned by doing, as members of ethics committees and consultation services, and those with formal academic credentials or ethics fellowship training. This might be discerned from local institutional assessment or endorsement from individuals with whom candidates have worked.

II. Components and consults—To achieve these objectives, the CEC portfolio should include a curriculum vitae or resume and copies of diplomas or comparable documents as evidence of completion of relevant educational and training programs. It is generally expected that candidates will have attained at least a master’s degree in a relevant discipline. A written summary of one’s education and training related to CEC should be provided. Candidates should give a detailed description of any relevant coursework, exposure to clinical ethics, and supervised consultation experience that occurred during education and training.

Portfolios permit a wide variation in the bases of bioethics knowledge as long as the end result is within the accepted parameters of professional competence.

Others with significant experience and without a master’s-level degree—for example, those who have served as clinical ethics consultants without an educational or training program—must provide additional evidence of their qualifications for consideration.

A written summary of one’s consultation experience should also be provided. This summary should detail the individual’s experience as a clinical ethics consultant since training, specify the time frame during which the candidate has performed consultation, and identify the health settings in which these have occurred.

Candidates should also provide a written statement of their philosophy of CEC in five hundred words or less. The statement should indicate how the candidate achieves the goals of CEC. It can include a description of the consultation process used and might be considered an opportunity for self-reflection. It may be used to address the following questions: What do you consider to be your accomplishments in CEC? How do you recognize and handle your personal beliefs and biases when conducting CEC with others who may or may not share those beliefs? How do you recognize and address institutional biases?

The portfolio should also include six representative consultations in which the candidate has acted as lead or colead (the role should be specified—for example, solo consultant, team leader, or ethics committee chair) and has authored or coauthored the resulting documentation. The sample should identify the varied clinical settings in which the consultant has worked, the colleagues worked with, and the variety of ethical issues addressed. Details should include the reason for the consultation request—that is, the question that needed to be addressed and a brief summary of the background, the ethical analysis, and the recommendations that were given. At a minimum, the following elements should be included in the write-up: case narrative, synopsis, relevant ethical issues, assessment, recommendation, and outcome. In the subsequent oral examination, one or more of these cases may be chosen by the examiners for further discussion and exploration.

Candidates may annotate consult reports to provide commentary that examiners may find useful in assessing a candidate's abilities. For those cases in which candidates believe that they might have done better, candidates can provide a self-critique of what they did and how they might improve. Details in the sample consultation write-ups should be compliant with the Health Insurance Portability and Accountability Act's privacy and security rules.[37] Details should be deidentified; what HIPAA identifies as protected health information should be redacted. The names and details of requesters and other parties, including institutions, should also be removed.

It will be the responsibility of the candidate to present evidence of competency. This can be provided from a number of sources, depending on one's institutional context, including but not limited to redacted chart notes, database summaries, memos to colleagues, or minutes of a case conference or ethics committee meeting. These case consultation notes may be supplemented by policies written by the candidate related to the consultations—for example, a policy on brain death or donation after cardiac death or the development of forms to document a do-not-resuscitate order or record an advance directive. Whatever the source, this evidence will need to show the candidate's understanding of the case and demonstrate an ability to analyze the relevant ethical issues and work towards their resolution. The portfolio should be summative, allowing an assessment of the candidate, and the process of developing and writing it should be formative, improving the candidate's performance.

Candidates must provide onepage descriptions of six additional cases to show evidence of experience in performing CEC in a wide range of clinical settings or regarding a wide range of ethical issues. These descriptions should include the consult date, type of requester, clinical setting, issues, and resolution. They are meant to be brief summaries that provide a

broader perspective on the CEC activities of the candidate. Oral examiners might also ask the candidate to discuss these cases in addition to selections from the six primary cases discussed earlier

Cases may be drawn from any of those in the candidate's career in CEC; that is, at least initially there is no limit on the length of the lookback period for selecting consultation cases. Recognizing that applicable law may vary from jurisdiction to jurisdiction and that procedures and documentation of consults differ at various health care organizations, the candidate should provide additional notes to explain these unique contextual factors. Candidates should also describe the method of CEC in their institutions.

In addition to enabling evaluation of the individual candidate, portfolio submissions will better inform ASBH about current practices and consultative trends on the national level, leading in turn to refinement of the quality attestation process.

III. External evaluations—External evaluations will also form part of the portfolio. Three letters are required from individuals who are responsible for clinical oversight and knowledgeable about the candidate's CEC activities. The letters may come from an ethics committee chair, academic ethics faculty member, direct supervisor, clinical service chief, chief medical officer, chief nursing officer, quality improvement director, chief executive officer, or peer. Candidates may also include copies of evaluations of the candidate's consultations that have been collected using a standardized tool if the consulting service routinely uses such a mechanism. The candidate may also include other information such as publications related to clinical ethics that he or she has authored.

In sum, examiners reviewing the portfolio will be able to distinguish whether the candidate followed established guidelines for CEC: responding in a timely fashion to the request for a CEC from any member of the clinical care team, the patient, or a family member; reviewing the patient's medical record (if appropriate); either interviewing relevant stakeholders or gathering the clinical care team and other consultants to discuss the case; visiting the patient or family (if appropriate—if the patient or family was not visited, a justification should be given); identifying the ethical issues at play and any sources of conflict; involving the patient or family with care providers to promote communication, explore options, and seek consensus, when appropriate; employing discussion of bioethical concepts, practices, and norms and using reason, facilitation, negotiation, or mediation to seek a common judgment about a plan of care going forward; attending to the social, psychological, and spiritual issues that are often at play in disagreements about the proper course of care; triggering a further process with hospital clinical leaders or a bioethics committee to resolve the situation, if necessary; following up with the patient and family after the initial consultation if this is the institutional norm; and recording the process and substance of the consultation, including the consultant's recommendations and their justification, as part of the patient's medical record.[38] All materials submitted by candidates may be subject to a random audit to assure their veracity.

B. Oral Examination

If the review of the portfolio is successful, the candidate becomes eligible for an oral examination, which will be administered at a subsequent ASBH annual meeting. This exam will focus on case discussion as an important component of the quality attestation process. An oral examination enables observation of some of the performance skills of the candidate and allows for knowledge assessment. *Core Competencies* divides the relevant skill domains into interpersonal skills, ethical assessment and analysis skills, process skills, and interpersonal abilities that can be directly observed.[39]

An oral examination can provide direct assessment of interpersonal skills. Such an examination shares some characteristics with the kinds of interviews commonly conducted by the consultant in a CEC. For instance, the candidate will meet the examiners for the first time and communicate with them under stressful circumstances. Basic poise, self-presentation, and verbal abilities will be in evidence. Such observation will serve as an important complement to the portfolio process. At the same time, every effort will be made to minimize conflicts of interest that may develop between a candidate and the examiners by asking for the recusal of examiners who have had a close personal or pedagogical relationship with the candidate and by attending to the risk of a subtle and pervasive bias against an individual merely by virtue of that individual's membership in a group.[40]

Observation of the candidate performing multiple CECs together with an opportunity to question the candidate about his or her actions in those consultations—akin to the process employed on the U.S. Medical Licensing Examination Step 2 Clinical Skills exam—would be ideal. But that kind of observation is so resource intensive that some other evidence must be substituted, at least at this early juncture in the evolution of this assessment process. An oral examination can serve as an immediate way to gather additional confirmatory or contradictory evidence of the skills asserted in the portfolio. The collection of cases and associated questions and comments could also eventually form the content for a psychometrically validated written examination, should future leadership of this initiative decide to move in that direction.

The oral examination protocol is still in development and will be refined as ASBH pilots the quality attestation process and the QAPTF continues its work. Eventually, innovative approaches (like standardized patients in "ethics stations"[41] or the "multiple-mini interview"[42]) could be developed to assess candidates, but these approaches, too, are prohibitively expensive and have yet to be validated for ethics assessment.[43]

For the time being, the oral examination will be based, first, on a discussion of one of the cases that the candidate has included in the written portfolio. This case discussion will help to demonstrate the approach the consultant employs and enable the candidate to illustrate the philosophy of CEC described in the portfolio. By interviewing the candidate in detail concerning this case, the examiners will gain an appreciation of the candidate's typical experiences in regard to ethics consultation and the processes and expectations of the consultation service at the candidate's institution.

Second, the examiners will select two additional vignettes from a stock of cases that ASBH will draft and vet. (A sample vignette and descriptions of questions that examiners might ask are available in the online version of *HCR* and on the ASBH website.[44]) Having reviewed the cases that the candidate provided, the examiners will select hypothetical cases that enable them to probe the range of cases and issues with which the candidate is familiar and comfortable. These case discussions will enable the examiners to witness how the candidate initially frames, or conceptualizes, a case. The candidate will then be asked to articulate in some detail the process he or she would use to conduct the consultation. Such a process provides a window into the cognitive and interpersonal performance of the candidate, either confirming the evidence provided in the portfolio or generating reason to doubt that the candidate's performance matches the cases provided.

> The oral examination can demonstrate candidates' intellectual and discursive agility, their ability to "think on their feet."

We also believe that the oral examination can demonstrate candidates' intellectual and discursive agility, their ability to "think on their feet." In other words, candidates will hear a case for the first time and narrate the thought process they undertake to assess a situation. They can explain what facts and circumstances seem relevant and how they initially analyze the ethical issues. They can also lay out the processes they would follow to further develop their understanding of the situation and to move the case toward resolution and closure. As the exam proceeds, the examiners will be able to alter facts and introduce additional information, furthering their insight into the candidate's abilities to integrate information during the consultation process and develop appropriate strategies. In addition, the examiners can challenge the candidate's interpretations and analyses. This will yield an opportunity to observe the candidate's ability to integrate alternative perspectives and hypotheses.

Throughout the exam, the candidate will need to demonstrate ability to reason using a basic knowledge base and ability to acquire the information necessary for judgment. This includes the ability to utilize the medical fact pattern and know when to seek more expert consultation for additional clarification of the medical facts. The potential knowledge base for the oral exam is daunting, and each candidate will come to the assessment with varying degrees of experience. Despite this variance, candidates must demonstrate a basic level of ethics knowledge and clinical literacy relevant to the assessment of CECs encountered in routine clinical practice. Examiners may present less common cases to assess the candidate's reasoning ability in novel situations. Our intent is that the oral examination will accommodate candidates of varying degrees of clinical sophistication.

Evaluative Model

Evaluation will occur in two stages: first for the portfolio and again for the oral examination. Each component will be necessary to obtain the designation that the consultant's quality has been attested by ASBH. Each assessment will be conducted by two examiners from differing disciplines. Evaluation criteria are being developed to assess both the portfolio and the oral examination. These instruments will be scored by the examiners and assessed for inter-rater

reliability. It is the expectation that candidates will need to achieve a minimum score on both examiners' assessments.

It is worth stressing here that bioethics comprises a number of methods and schools of thought applicable to the conduct of CEC. This diversity is to be valued and respected and is reflective of the respect for pluralism that has long been a hallmark of ASBH's culture. The assessment process takes this into account, and Candidates will be evaluated with a recognition of the diversity of well-developed approaches that can be used to achieve the goals of ethics consultation. Each of these methods shares common elements necessary for analysis: identification of the problem; collection of relevant data; inclusion of stakeholders; and knowledge of applicable ethical standards as well as of institutional policies, procedures, and the law. This analysis will lead to the elucidation of the relevant ethical concerns, norms, and values and to an approach to respond to the issue that prompted the consultation. The consultation and subsequent write-up will be assessed based on the quality of the analysis; applicability of the recommendations; their ethical justification; and ultimately, the quality of communication with involved parties.

> Candidates will be evaluated with a recognition of the diversity of well-developed approaches that can be used to achieve the goals of ethics consultation.

For the portfolio case summaries, priority will be placed on clear writing, logic, the quality of the argument, and the sophistication of the overall approach. Analogous standards will be applied to cases discussed during the oral examination, in which examiners will have flexibility to alter the narrative so as to dynamically engage the candidate and assess his or her ability to apply a coherent methodology to an ongoing case discussion. We expect to provide substantive feedback to candidates who engage in the quality attestation process so as to promote continuous quality improvement.

Anticipated Concerns

The current plan for quality attestation of clinical ethics consultants leaves some unresolved pedagogical, evaluative, and logistical issues that require additional reflection and study. Fundamentally, there are questions about quality, measurement, and inclusiveness. The premise of the quality attestation process is that the field of CEC needs standards that are robust and valid. However, as Anita Tarzian and colleagues have cautioned, measurement could "lead to detrimental reductionism."[45] She argues that this can be avoided if consultants approach their task with "integrity and a commitment to serve those who ask for their help."

Equally challenging questions concern the threshold for sufficient quality and whether it will be adequately inclusive. CEC is an eclectic task, involving a wide diversity of practitioners with variable training and case volume. We have sought to articulate standards commensurate with routine practice, not esoterica and not the complicated cases that become the object of academic dispute. The quality attestation process seeks to affirm the capabilities of daily practice. This is in the spirit of continuous quality improvement and an enduring commitment to a multidisciplinary approach to those engaged in this practice.

Other unresolved issues include the reapplication eligibility of candidates who do not pass either component of the evaluation and the duration of successful candidates' quality attestation. These are areas of ongoing development for ASBH, and the goal is to move to psychometrically sound instruments as this process evolves.

Governance

We appreciate the inherent conflict of interest borne by a professional society that administers a test to its own members. We have debated the propriety of this and believe that there is no group better situated to initiate this process than ASBH because of the organization's expertise, history, and diversity of membership. Moreover, a review of the history of the establishment of venerable examining boards shows that they often originated in a professional society before they were handed off to a new independent organization.[46] Our intent and plan is to follow that course.

We also believe that we need to act now to establish a quality attestation process because other organizations with less expertise, potentially motivated by commercial interests, are very likely to design one if we do not fill the need ourselves. ASBH is a not-for-profit organization, and none of its officers or members is paid.

Another governance concern is the standing of the initial group of examiners. We plan to use the QA-PTF to evaluate all individual ASBH members who would seek to become examiners, at least initially. We hope to develop a process to include others to further represent the field. In addition, once the process of administrating the quality attestation process has been transferred to a new independent entity, we expect the influence of the QAPTF founding generation to be further mitigated and managed.

Next Steps

We will invite a small number of ASBH members to submit a portfolio to the examiners from the QAPTF to test the feasibility of the quality attestation process outlined here. We believe that demonstration of proof of principle should precede widespread dissemination and a general call to the bioethics community for the submission of portfolios. We appreciate that the quality attestation process will be time consuming, and we want to defer that call until we are convinced that this is a productive method of assessment and that the process is sustainable.

Our initial proof of principle will be to solicit twenty to forty portfolios for review by the QAPTF. All twelve members of the QAPTF will review all portfolios and convene to establish assessment metrics based on this sample. Appreciating the value of a structured assessment tool, we will review the literature for model instruments, which could be used or modified to address the specific needs of quality attestation for CEC.

Once these instruments are developed, we will pilot them with the first round of submitted portfolios. We envision that pairs of QAPTF members will be assigned portfolios to review and score. These teams of two will present their scores to the entire group for critique in order to refine the scoring instrument. In this way, we hope to move beyond face validity,

providing evidence of construct validity (the ability of the test to measure what is intended) and enhancing inter-rater reliability (the degree of agreement between two evaluators).

Developing a system to conduct oral examinations will require the cultivation of case vignettes, which could be generated by the QAPTF or through the modification of cases submitted as part of the portfolio process. The latter option would provide cases more representative of routine practice. Moreover, the scoring of the case summaries for the portfolio evaluation could form the basis of assessing other candidates' performance on the oral examination, which will be introduced once the methodology of the portfolio and the vignettes are deemed appropriate.

We share these additional details to demonstrate that this is a multiyear process and that we have envisioned the future development of the assessment process and are sequentially taking steps to work toward it.

The Maturation of CEC

We believe that the quality attestation process outlined here is a first, long overdue step in bringing greater accountability and transparency to one of the most critical and intense activities that occur in modern health care. We fully appreciate that this is a work in progress and that we are seeking to both evaluate clinical ethics consultants and assess the value of our proposed assessment method. We expect refinement over time as we collect data, gain experience, and benefit from the counsel of the clinical ethics community.

Although the implementation of this process could have been delayed until all of the details had been worked out and all of the concerns had been resolved, we believe that we will best be able to improve on our current proposal by cautious and reflective implementation. Patients deserve nothing less and should expect forward progress. In time, we hope that governing organizations that oversee hospitals, like The Joint Commission, incorporate these emerging standards into their accreditation of institutions. The standards will improve the status quo and promote patient quality and safety.

In this paper, we have articulated the need for quality attestation as the logical next step in the maturation of CEC and shared our collective best judgment about a way to proceed. The importance of being proactive cannot be overstated. After decades of debate, the field of bioethics has come together with a broad consensus that this is the right thing to do and that this is the right time to do it. Confluences like this come around rarely, and it is our generation's task to take this convergence of attitude and translate it into improved CEC practice for the benefit of the patients that we seek to serve.

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