Special Section: Coming of Age in Clinical Ethics Consultation: Time for Assessment and Evaluation

Why Quality Is Addressed So Rarely in Clinical Ethics Consultation

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Introduction

In a practice like ethics consultation, quality and accountability are intertwined. Critics of ethics consultation have complained that clinical ethics consultants exercise power or influence in patient care without sufficient external oversight.[1] Without oversight or external accountability, ethics consultation is seen as more sophistical than philosophical. Although there has been more discussion of accountability, concern for quality in ethics consultation is arguably more important, because it represents a central challenge for the field, namely, how to structure a responsible practice of ethics consultation.

Despite the seriousness of these concerns about accountability, there is no compelling evidence that clinical ethics consultation is fraught with abuse of power or conducted irresponsibly. Nevertheless, this concern lingers, but its "solution" is seriously misplaced if located outside the practice of ethics consultation itself. Focusing on external accountability, moreover, may divert attention from what is internally prerequisite for a responsible practice. In this paper, I argue that addressing the question of quality in ethics consultation can only be done from a perspective within the practice and primarily as a matter of the practice. External accountability is a much weaker form of accountability that should be connected with a robust internal commitment to quality. Both are essential for a fully responsible practice of clinical ethics.

Responsible Practice

Without denying that full accountability for clinical ethics consultation would involve external oversight, it is reasonable to ask how clinical ethics consultants can practice responsibly and what mechanisms of accountability might be most readily available within the practice itself.

In a personal e-mail sent a few months before he died, the eminent University of Virginia Professor of Biomedical Ethics, John Fletcher, wrote the following: "Our basic loyalty as consultants is to the role that our institutions define for

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consultation. The responsibility is on the institution to offer ethics consultation and to have a policy and practice that will stand up to criticism and evaluation'' (personal communication, April 4, 2003).[2] We both agreed that the credentialing requirements for ethics consultation should be met by *all* consultants. Even though it might be reasonable to presume that medical, nursing, or allied health professional staff members have prerequisite ''clinical knowledge and patient care skills'' or that bioethicists with academic credentials possess appropriate ''ethics knowledge,'' neither is sufficient. Because ethics consultation is a unique kind of doing in the context of patient care,[3] regular review of these activities is essential. Such review should include an assessment of consultants' full capacity to perform competently the expected functions making up ethics consultation as well as an assessment of the actual performance of these functions. That means that regular assessment of the skills, experience, and continuing education for each function should occur for every type of professional who offers ethics consultation services.

Credentialing by the healthcare organization within which the ethics consultation occurs, of course, is only one component of accountability, but it is important because it is anchored within the institutional setting where the services are provided. Even if other loci are needed,[4] ethics consultants should be accountable to the institutions within which they function as a first line of accountability. As such, credentialing focuses on assuring minimal entry or continuing competence but does not address the more important question about how to develop the best practices. In this paper, I assume that meeting minimal standards is a prerequisite for a responsible ethics consultation practice and follow John Fletcher's suggestion that healthcare organization-based credentialing should be the primary mechanism for assuring that this occurs. That said, the question of how to assure that more than minimal standards obtain forces me to consider why attention to quality is so relatively rare in treatments of ethics consultation, especially given the concern about the accountability of clinical ethics consultants.

Quality

The term *quality* involves a complex family or range of meanings that complicates discussions of quality improvement in ethics consultation just as it does in healthcare generally. Claiming that something has quality involves choosing among features that reflect complex judgments of value, which implies that quality is inevitably multifaceted. A consequent of this point is that the pursuit of quality is inevitably a multifaceted and complex commitment that has to be made part of everyday operations to be fully effective within the practice. Episodic commitments and endeavors, of course, can yield salutary results, but celebrating isolated results should not displace the active and continuous search for even marginal improvement in the practice.

In this regard, it is important to stress that even though change is inevitable in any practice, the ethical challenge is to channel change in the direction that improves the services provided. Hence, we need to think of ethics consultation as a dynamic and adaptive practice rather than a static set of services provided routinely without reflective engagement. Saying this does not mean that ethics consultation is adaptive to rather than transformative of the clinical situation, but that the setting establishes a boundary or horizon within which the consultative

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practice has to be situated.[5] As a result, the central concern should be one of channeling change in the direction that improves one or another parameter of ethics consultation services. Using any variant of the well-known formula of Plan-Do-Study-Act (PDSA) quality improvement methods allows planned change to occur, a change that is intentional in nature and designed to achieve benchmark measures that document improvement in specific aspects of the practice of ethics consultation.[6]

Although the question of quality was raised early in the development of the field of ethics consultation, surprisingly, it has not received much attention since. As early as 1992, an issue of the *QRB Quality Review Bulletin* (Vol. 18, No. 1) was devoted to the theme of ''Defining Quality in Ethics Consultation: First Steps.'' A special section, ''Evaluation of Case Consultation in Clinical Ethics,'' was published in the *Journal of Clinical Ethics* in 1996 (Vol. 7, No. 2). These first engagements with the question of quality in ethics consultation are remarkable mostly because they are signposts on a road that has been seldom traveled since. Because this road has been so infrequently traveled, it is important to ask what reasons make attending to quality so infrequent in ethics consultation.

Diversity of Goals and Techniques

Two main reasons might explain why quality improvement has been a much ignored topic in ethics consultation. First, the lack of agreement or clarity about the goals of ethics consultation seems to obstruct efforts to conceptualize how to improve quality. The variety of consultation models—individual consultants, teams, and committees—also seems to make improving quality a topic without much interest to the field at large. Second, the diversity of opinion regarding the procedures or techniques, such as arbitration, conflict resolution, or mediation, that are appropriate, useful, or, indeed, essential in ethics consultation seems to point to different underlying measures of quality, which impedes a broad commitment to quality improvement in the field. Discussing these impediments can help us clarify why attention to quality in ethics consultation should be a priority for the field and how quality improvement might be pursued.

Goals

Although it might seem that ethics consultation as a practice should have a single goal or a unified set of goals, disagreement about how to articulate the goals of ethics consultation persists. Even if we assume that the primary purpose of ethics consultation is to give sound advice about ethical questions or conflicts arising in the care of patients, this goal does not specify to whom the advice is primarily owed—physician, healthcare team, or patient/family surrogate. For example, should the ethics consultant offer advice that serves primarily to protect the patient or family rights over and against the physician, healthcare team, healthcare institution, or insurer? Or, as a representative of the institution and, perhaps, a member of the nursing or medical staffs, should the ethics consultant stress accommodation to professional norms or institutional priorities? These points suggest that even if the goal of ethics consultation is to render ethically sound advice, considerable complexity remains about the type of advice, the primary audience for the advice, and the purpose of the advice.

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Patient rights advocates might object to this point by insisting that patients should always be primary in healthcare. This insistence, however, overlooks the fact that there is no reliable way to avoid situations of genuine ethical conflict among and between the rights of patients, families, and physicians/health professionals. Prioritizing patient rights over all other rights might work in theory, but in practice there needs to be a way to address the kinds of ethical quandaries created for health professionals that result when, for example, a patient demands an unnecessary and risky procedure. In a similar way, practical ethical problems are not avoided by insisting that ethics consultation should be primarily an advisory service (whether to the physician, healthcare team, or patient/family) as opposed to a service charged to resolve ethical conflicts over patient care. Were the goal of ethics consultation limited to resolving ethical conflicts, then consultations would not seem appropriate unless there was a clear conflict between relevant parties. However, situations that are ethically difficult or ambiguous also prompt many requests for ethics consultation. Thus, limiting ethics consultation to addressing ethical conflicts would seem to prevent consultants from becoming legitimately involved in cases of ethical confusion or situations in which ethical reassurance was being sought. Furthermore, whenever questions, confusions, or uncertainty arise about what is an ethically appropriate or justified course of treatment or decision in a case, an ethics consultation service designed to deal only with conflicts would hardly seem appropriate. The goal of resolving conflicts over patient care also seems to presume capacities that are different from those essential for offering ethical analysis or rendering ethical advice. To further complicate matters, some ethics consultation cases involve questions or issues that are covered by institutional policies, and many ethics consultation services function under the aegis of the institutional ethics committee; therefore, should informing parties about, or enforcing, existing ethics policies be the primary function of ethics consultants? How would such a function square with any of the other asserted goals for ethics consultation such as rendering ethical advice or resolving conflicts?

This short review of some of the tensions and conflicts among and between the goals asserted for ethics consultation might seem to confirm why attention to quality is so rare in ethics consultation when, in fact, the persistence of these tensions and conflicts leads to a different conclusion. As a practical matter, the individual circumstances of the clinical cases into which ethics consultants are invited challenge ethics consultants to choose among a wide range of alternative goals and approaches depending upon the specific requirements of the particular cases. Arguing about what is the best or primary goal for ethics consultation is too often situated at the level of theory far removed from the exigencies of the actual practice of ethics consultation. Such regression to the level of theory tends to obscure the fact that ethics consultation is not an academic field of inquiry, but a practice that evolved to assist patients, families, and health professionals who were confronting ethical questions and concerns in the course of patient care. Because uncertainty about the goals of ethics consultation occurs at a level of generality well above the practical engagement with actual clinical ethics cases, it *need not* inhibit the practical commitment to quality improvement in the practice itself. If it has, it is because the literature on ethics consultation tends to focus on concerns that are far more theoretical than practical.

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Techniques

Similar to the theoretical disagreements about the goals of ethics consultation, diversity of opinion regarding the procedures or techniques, such as arbitration, conflict resolution, or mediation, that are appropriate, useful, or, indeed, essential for ethics consultation may point more to variation in conceptions of ethics consultation than to fundamental disagreements that would practically impede the pursuit of quality improvement in actual practice. In fact, it is more likely that a balanced appreciation of the usefulness and relevance of any one of the competing approaches to or definitions of ethics consultation would be attained if quality were taken seriously.

Consider, for example, the difference between the view that ethics consultation consists of clarifying ethical concepts or the theoretical justification of clinical ethics positions, a stock analytical approach of some philosophers, and the view that ethics consultation consists of techniques for arbitrating or negotiating conflicts over patient care. Either one of these approaches might fare well or poorly depending on the circumstances of the particular clinical ethics case. Successfully mounting theoretical arguments is simply beside the point when one is faced with situations that demand the communication skills that the other approach features and vice versa. Just as the skills of the surgeon or the psychiatrist are not appropriate or inappropriate for patient care universally but depend on the specific needs of the individual patient, arguing about whether surgical, medical, or psychiatric skills should define medical practice is a pursuit that is fundamentally worthless for improving the quality of patient care.

Within any practice setting, however, one can ask whether one or another intervention or approach is more appropriate or adequate for a particular problem, such as whether drug x or drug y is a better treatment for a particular patient with a particular medical history or whether a medical or surgical treatment is better for a particular presentation of a disease. In a similar fashion, questions of appropriateness of approach in ethics consultation arise at the level of the case. Historically, advocacy for the use of arbitration or conflict resolution approaches arose from the experiences of ethics consultants confronted with disagreements over patient care decisions. Ethics consultation has remained a viable and advocated approach not for theoretical reasons alone, but for *practical* reasons, because conflicts are common in ethics consultation cases. In practice, the best approach is one that is both flexible and collaborative and whose goals are appropriate for the demands of actual ethics consultation cases.

Practical Commitment to Quality

The challenge for ethics consultation services is less a matter of the diversity of approaches or disagreements at the level of theory than it is the availability of ethics consultants with a broad range of developed skills able to respond in a timely fashion within any given healthcare organization. Hence, ethics consultants will more likely need to be generalists who need to have the time and ability to respond appropriately to the particular issues, problems, or conflicts arising in their practice. An essential requirement is that they have the capacity to deal with the most common ethical problems or questions arising within the institution.

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Like generalist physicians, whose primary challenge involves identifying problems and treating or referring, the ethics consultant may primarily need a general range of skills or competences suited to the typical ethical problems arising in the particular healthcare organization. In addition, they need to be skilled in collaborating with others and communicating effectively in addressing both the ethical complexities of the case and the emotions that arise when ethical conflicts or uncertainties arise. In addition, ethics consultants obviously need the time to respond to consultation requests. Because many consultation services are staffed by individuals with full-time professional responsibilities elsewhere, identifying the time to meet with patients, families, and healthcare professionals involved in an ethics consultation case and for completing the variety of tasks that make up an ethical consultation are critical needs.

Quality in the practice of ethics consultation has less to do with the very things that are primary concerns in the bioethics literature such as certification, professionalization, or the prerequisite disciplinary training for doing ethics consultation than may be apparent on first look. The proliferation of ethics consultation shows that resolving these questions theoretically is not requisite for the development of ethics consultation as a practice. Because improving the quality of ethics consultation is fundamentally a practical task, a key to understanding its place in ethics consultation is to recognize that debate over credentialing may continue without precluding the actual commitment to and pursuit of quality. That is not to deny that differences in disciplinary orientation and conception of the goals of ethics consultation could play a role in influencing the pursuit of quality in practice. But quality in ethics consultation, like quality in the practice of medicine, may depend more on local conditions. It is a mistake to assume that attention to quality in ethics consultation requires resolution of theoretical disagreements before progress in the field is possible. Rather, it might be the case that theoretical disagreement reflects the inadequacy or incompleteness of the current theoretical formulations of ethics consultation to capture the complexity of the practice.

As the quality improvement literature[7] strongly shows, the issue of quality is amenable to multiple definitions, and quality inevitably must be pursued within the context of specific practice settings, where the relevant agreement or disagreement is not in the stratosphere of theory but in the details of the world of practice. Thus, the striving for quality is a task for ethics consultation in the same way that it is a task for clinical medicine and healthcare. It can be addressed meaningfully within the particular institution, program, and/or case setting without fully closing off discussion of the wider questions about the nature of the field and, most importantly, without needing to wait for these questions to be resolved.

Quality Processes in Ethics Consultation

What conclusions can be drawn from these observations about goals and techniques? The lack of consensus about the goals and techniques of ethics consultation reflects skepticism about the legitimacy of ethics consultation and differences among theoretical accounts. Despite the importance of these disagreements within bioethics as a field, they have not prevented ethics consultation from becoming a well-established practice internationally. The actual historical

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development of ethics consultation has thus occurred despite controversy over its nature and legitimacy. This fact needs to be stressed, because ethics consultation is a pervasive and, arguably, an important feature of contemporary medical care; thus, it is not only reasonable but essential to consider why a commitment to quality in ethics consultation is necessary *at the level of practice* and to suggest what this commitment might involve.

Viewing clinical ethics and ethics consultation as a field of discord and disagreement is a direct result of giving priority to the perspectives dominated by theoretical, professional, or political concerns within the field. These concerns operate at a level of generality well above the actual challenges of doing ethics consultation. Whenever ethics consultation is examined up close as a practical activity, a set of themes and concerns emerges about which it is much easier for ethics consultants and consultation services to reach agreement. These practical concerns reflect the kinds of questions, issues, and circumstances under which requests for ethics consultation typically arise as well as the typical expectations for the consultative process in the institution. Obviously, the kinds of questions or cases that are brought to ethics consultation services within certain institutions are structured by the nature of those institutions, the interests and concerns of those who request ethics consultations, as well as the overall clinical culture within which the service functions. Identifying the processes whereby cases and questions are brought to the ethics consultation service and the processes or procedures by which ethics consultants respond within each setting is a natural target for improving the quality of the services provided. This is true even if there are other differences among services such as who, in fact, is permitted to provide ethics consultation services or the dominant consultation format. Questions of process would need attention even if consensus about the nature and goals of ethics consultation were achieved, and the lack of consensus does not prevent attention to these matters.

Conclusion

The perception of an impasse in addressing quality in ethics consultation based on the lack of consensus regarding the goal of ethics consultation or the models, methods, or concepts that guide its practice is misleading. Impasse at the level of theory or at a level of generality above the actual practice is not an impediment to quality improvement, because improving quality is a matter of practice, not theory. Quality in ethics consultation can and should be meaningfully addressed within the particular institution, service, or case setting by focusing on the actual processes by which ethics consultants respond to consultation requests.

Notes

1. For a set of references on the issue of the questionable exercise of ethical expertise by ethics consultants, see Agich, GJ. The question of method in ethics consultation. *American Journal of Bioethic*s 2001;1(4):31. Some critics of ethics consultation see the bogeyman of professional status for clinical ethicists lurking beneath the surface of almost any serious treatment of clinical ethics. For example, Wesley J. Smith (The question of method in ethics consultation: Transforming a career into a profession. *American Journal of Bioethic*s 2001;1(4):42–3) commented on my paper "The Question of Method in Ethics Consultation" and complained that even raising the question of method was a step toward advocating professional status, a point he attributed without

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warrant and something he assumed to be seriously objectionable without offering supportive argumentation.

2. John Fletcher will be most likely remembered for his unflinching willingness to raise and address difficult ethical questions and to defend positions without regard to their acceptance by others. He specifically challenged the field of clinical bioethics to think critically not only about ethical issues arising in the care of patients but also about the very processes whereby bioethicists become involved in hospitals and healthcare institutions. John not only offered thoughtful reflections, but he addressed questions that many in the field sought to avoid. He was one of the first, and perhaps the leading, proponent of the need to develop standards, and he advocated, at various times, the creation of credentialing or licensing of clinical ethics consultants as a way to press the point about the importance of accountability and the need for quality assessment and improvement in this new field of practice. He minimized concerns about the professionalization of bioethics and related issues such as whether ethics consultants can or do profess ethical expertise and, instead, insisted that accountability is a primary responsibility for an eminently practical field like clinical ethics and consultation. In this spirit, I address the question of why quality is so rarely a theme in the literature on ethics consultation.
3. Agich GJ. What kind of doing is clinical ethics? *Theoretical Medicine Bioethics* 2005;26(1):7–24.
4. Spielman B. Has faith in health care ethics consultants gone too far? Risks of an unregulated practice and a model act to contain them. *Marquette Law Review* 2001;85(1):161–221.
5. This is a descriptive and not a normative point. Of course, clinical ethics should aim to transform the institutional setting of practice, but such change is, in my view, more a by-product of ethics consultation than a direct result, which is why ethics consultation is ideally a component of a clinical ethics program that includes policy formulation and education as well.
6. For a fuller treatment of the complex question of the ethics of quality improvement, see Baily MA, Bottrell M, Lynn J, Jennings B. The ethics of using QI methods to improve health care quality and safety. *Hastings Center Report* 2006;36:S1–40; Lynn J, Baily MA, Bottrell M, Jennings B, Levine RJ, Davidoff F, et al. The ethics of using quality improvement methods in health care. *Annals of Internal Medicine* 2007;146(9):666–73; Jennings B, Baily MA, Bottrell M, Lynn J, eds. *Health Care Quality Improvement: Ethical and Regulatory Issue*s. Garrison, New York: The Hastings Center; 2007.
7. Donabedian, A. *The Definition of Quality and Approaches to Its Assessment.* Ann Arbor, MI: Health Administration Press; 1980.

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