question of agency will have to be defined—perhaps even defined differently in different settings, or defined in terms of the CEC model adopted in a given case—before the code of ethics can be sufficiently elaborated to serve as a real-world guide.

I expect that the “integrity” portion of this code (except for the bits that seem really to deal with conflicting interests), like the “justice” portion, will see little use. Whether the other portions of the code become useful will depend in part on whether a practical means for their elaboration and application can be set up. Perhaps, following the lead of many professional associations, the American Society for Bioethics and Humanities (ASBH) could formally establish an ethics committee to apply the provisions of the code to particular cases, and to elaborate a “common law” of code interpretation.

Whether the code obtains community sanction may also depend upon whether CEC becomes central enough in health care decision making to become the target of litigation, as institutional review boards (IRBs) have begun to be. And finally, it may depend upon whether the models of CEC can become sufficiently standardized that the duties of consultants (whether as agents or as neutrals) can be seen to flow from them in a consistent, predictable fashion. One day, perhaps, fat, annotated versions of this code may sit on the shelves of medical malpractice attorneys and human resources officers and hospital compliance officers everywhere. If that day arrives, CEC will have professionalized.

Becoming a Competent Ethics Consultant: Up to Code?

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Tarzian and colleagues (2015) offer important insights into the process of developing the new Code of Ethics and Professional Responsibilities, as well as reflections on implications for current and future health care ethics (HCE) consultants. The authors state in the first directive of the Code that the obligation to “be competent” “does not address how HCE consultants are to achieve the required competencies” (44). Along with the centrality of the Core Competencies for Healthcare Ethics Consultation, 2nd ed. (Core Competency Task Force 2011), to our current understanding of the duties of HCE consultants, positioning this provision first gives it the status of a mandate. One should note that the admonition to be competent extends to all persons involved in the process, regardless of whether the consultation services are provided by an entire committee, by a subcommittee or panel, or by those practicing under the single (solo) consultant model. For those who purport to train others to be competent single or lead HCE consultants with advanced knowledge and skills, the stipulation carries additional significance.

Movement toward “quality attestation” in HCE consultation has gained traction recently (Kodish et al. 2013). This process, which is in pilot stages at this point, notably directs participants to submit evidence of competency, including educational background and cases in which the consultant acted as lead or co-lead and authored or co-authored documentation (personal communication, K. Weise). It is important to recognize that formal accreditation or informal peer acknowledgment systems have not yet been established to recognize training programs designed to train single or lead HCE consultants (nor for that matter in any other consultation model). Current thought leaders in the field, an educationally diverse and largely self-trained group, have discussed competencies, but have not yet defined minimal or even suggested national educational standards for reaching them. If the field is to continue to grow and gain credibility parallel to other clinical practices, both standardization of training program essentials and the means of assessing the competence of HCE consultants will be needed.

White has described available educational approaches in clinical ethics in detail in an article responding to the 2010 New York Family Health Care Decisions Act (White 2013). Types of programs include, but are not limited to:

- Intensive immersion programs, usually limited to one training site.
- A series of coordinated seminars, including lectures, group discussions, standardized patient encounters, and rounds, usually on-site.
Individual graduate courses addressing clinical ethics theory and practice, on-site or online.
Certificate programs in clinical ethics (typically carrying graduate course credit), on-site or online.
Graduate degrees in bioethics, on-site or online, with or without clinical exposure or mentoring.
Fellowship training programs with extensive HCE consultation experience, overseen and mentored by practicing single HCE consultants.

What elements of training and assessment are desirable or requisite to promote and achieve competencies to deliver HCE consultation services within the single or lead-consultant model? We propose that—at a minimum—training programs that purport to train toward this type of consultant (e.g., fellowship programs) should have:

- Coordinated, structured, and systematic educational opportunities that focus on practical application of theoretical concepts and principles.
- Extensive opportunity to participate in clinical ethics consultations as a trainee, that is, a sufficient number and mix of cases to engender a thorough appreciation for the ASBH skills competencies.
- Intensive ongoing mentorship and oversight by those who are experienced teaching and delivering HCE consultation services using a single or lead-consultant model.
- A faculty and staff sufficiently schooled in all of the disciplines and fields represented in the ASBH educational and skills core competencies.
- Valid, continuous and summative assessment of competencies as the trainee progresses from unskilled apprentice to skilled independent practitioner.

An HCE consultant working in an organization that uses a single or lead-consultant model will need to have mastered the highest breadth and depth of core knowledge and skills. In addition, one who is mentoring HCE consultants in the classroom and at the bedside must have expertise in all realms of theory and practice relevant to HCE consultation, as well as the ability to foster knowledge and professional skills in others. Because of the unique, special relationship educators have with trainees as they strive to achieve competency as HCE consultants, it is important to create educational and practical opportunities that would unhesitatingly merit peer acceptance within the profession.

In order to develop and maintain a program that can train single or lead-consultant model practitioners, adequate financing is essential. Traditional academic and some HCE training programs charge tuition to help offset most, but not all, of those financial needs. Programs that pay trainees a stipend, such as purely clinically based fellowships or those with mixed clinical and scholarly expectations, may struggle with funding if strong institutional or research support is not available. Without sufficient funding from the host institution or from philanthropic sources, such programs may not be sustainable in the long term. Trainees may also face financial challenges. Those who have recently graduated from an HCE degree program generally want or need to enter the professional employment pool as quickly as possible. However, purely academic programs do not offer sufficient (if any) clinical experience to prepare graduates to develop skills competency as single or lead HCE consultants without additional training or mentoring. Unlike clinical medicine, in which residency training is expected—and required—for one to practice independently, HCE consultation as a profession has yet to reach that plane. Trainees may need to accept wages lower than working peers in order to achieve competence as envisioned by the Code.

Given the array of programs designed to train HCE consultants, many of which have potential value in moving students toward peer-accepted competence, trainers and mentors should be transparent about the extent to which they can provide key elements of critical training. Different programs may fill varying core knowledge and skills voids for aspiring HCE consultants. Demonstrated advanced theoretical knowledge, extensive clinical experience, and intensive professional mentorship are essential to achieve the level of competence needed to provide HCE consultation in a single or lead-consultant model at the level to which our new professional Code aspires, and that patients and other HCE consultation stakeholders demand.

It is noteworthy that the ASBH Core Competencies document itself purposefully distinguishes between two levels of competence required of those engaged in ethics consultation: basic and advanced. This distinction is a contingent one, accepting the different existing models of consultation and the extent to which the single HCE consultant bears sole or varying degrees of joint responsibility for the conduct of the consult. In the end, it remains for HCE consultants-in-training to identify gaps in their knowledge and experience, and to strive to overcome them in order to become competent in the roles they will play in their own organizations. It is also striking, as noted earlier, that there is a wide spectrum of educational and training programs, which, given their very different content and duration, necessarily differ in the level of education and skills trainers can reasonably claim to offer. Until standard elements of educational programs are developed, as we have proposed here, and until accepted systems of evaluating the competencies of HCE consultants are crafted and adopted, it is particularly important for the programs that purport to train single or lead HCE consultants to recognize what they have to offer. Thus, we strongly believe that it is incumbent on those organizations and mentors who offer training programs to state clearly the nature, scope, and limits of the training they provide. Specifically, and consistent with the new Code provision to “be competent,” we feel that all training programs have a professional obligation (i.e., an obligation owed to our profession) to state clearly the level of competency their program is designed to offer and the expected level of competency that a trainee may reasonably claim upon
The Duty of Competence and the Role of Simulated Ethics Case Consultation

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The Code of Ethics for Health Care Ethics Consultation (HCEC) is a pivotal step in the process of identifying and clarifying standards in our field. It draws on the Core Competencies articulated by the American Society for Bioethics and Humanities (ASBH) and focuses on HCECs and those who conduct them. Understandably, the first responsibility noted is to “be competent,” which includes education and experiential training to acquire the knowledge, skills, and attributes needed to conduct HCECs effectively. Over the past few years, the field of HCEC has been wrestling with how to set and assess such standards. For instance, as is well known in the U.S. bioethics community, the ASBH is piloting a quality attestation (QA) process to evaluate the competence of ethics consultants, which involves reviewing portfolios of ethics consultants’ work as the first stage of such competency evaluation. These portfolios include case narratives, a statement of HCEC ideology, and letters of support (Fins et al. 2013).

The ASBH Code of Ethics reflects the work of the ASBH Core Competencies for Healthcare Ethics Consultation document in recognizing the importance of professional and personal characteristics, including interpersonal skills in doing ethics consultation (American Society for Bioethics and Humanities). Assessment of the domain of interpersonal skills often presents logistical difficulties. For instance, when one wishes to hire a clinical ethics consultant, one usually has to settle for indirect evidence of such interpersonal skills. The best evidence would seem to be direct observation of these skills being employed in a clinical ethics case consultation. As a result of the difficulty of obtaining that gold standard, one generally must settle for the testimony of others who have done such observation or make an inference based on observing similar skills in some analogous setting. According to the model outlined by the Quality Attestation Presidential Task Force, evidence for such skills may come from live case discussions as part of an oral examination. In addition, letters provided by those who have observed the consultant’s work may also give some insight to these skills. These seem to be reasonable approaches to increasing confidence in the skills of the consultant. Of course, more evidence is better than less. If the candidate can be directly observed exercising these interpersonal skills in a clinical ethics consultation, that would further enhance confidence in a consultant’s abilities, whether that evidence were used as part of an evaluation process or a hiring decision (Smith et al. 2010).

HOW SIMULATION CAN HELP

We believe that simulated ethics consultations are one key way to both train ethics consultants and assess their interpersonal skills in “real time.” This approach should be developed and widely used within our field. Ethics case simulations allow educators and evaluators to construct cases to test a variety of interpersonal skills and observe how the ethics consultant reacts and performs as the case unfolds. Different case scenarios can be written based on real-life experience of ethics consultants and health...