The Clinical Ethics Consultant: Verifying the Qualifications of a New Type of Practitioner in a Community Hospital

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EXECUTIVE SUMMARY
Ethics consultation has been occurring in various forms within hospitals for more than 30 years. These consultations constitute a clinical act, and as such, the qualifications of those who provide them must be verified by the hospitals at which the ethics consultants practice. The clinical nature of the practice exposes the participants to malpractice liability. The field of medical ethics has struggled to provide a clear set of knowledge and skills that characterize its practitioners. Hospitals are faced with the immediate task of assessing the qualifications of and ensuring malpractice coverage for individuals providing clinical ethics consultation. We offer one example of how a community hospital has addressed this challenge.

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INTRODUCTION
The practice of examining and resolving ethical dilemmas that arise in particular cases of medical care is now common in American hospitals. This practice began in the 1970s, usually in association with the establishment of hospital ethics committees. Initially, committee members engaged in deliberation about ethical problems as a whole or in small groups. Individuals, some with training in bioethics, have also appeared in clinical settings to review cases and offer advice about the resolution of ethical problems that arise in specific patients’ care (Andereck 1992; Jonsen 1998). We argue that the recommendations resulting from an ethics consultation may have direct effects on the course of a patient’s care and, as such, constitute a clinical act.

It follows that ethics consultations fall under the responsibility of the hospital, or its medical staff, to ensure that all such actions are performed according to acceptable standards of care. We propose that, as a clinical act, ethics consultation incurs malpractice liability.

Initially, physicians already on the hospital staff conducted ethics consultations. Thus, credentialing was not considered an issue, because such consultation was assumed to be a natural part of a credentialed physician’s practice. As the discipline of medical ethics has developed, those conducting consultations have included persons other than physicians. These persons bear many titles: clinical ethicist, bioethicist, ethics consultant, ethics committee member, and so on. For the purposes of this article, we label them “clinical ethics consultants.”

According to one report, 29,000 individuals participated in clinical ethics consultations in 2006 (Fox, Myers, and Pearlman 2007). The role of ethics committees functioning in hospitals has been discussed (Swetz et al. 2007). The goals of this article are to explore the role of specific people serving as clinical ethics consultants, either individually or as a member of an ethics committee, and to address the challenges facing a hospital, or its medical staff, in assessing the qualifications of these individuals and ensuring their liability coverage.

A Slowly Emerging Field
One of the present authors (ARI), with other colleagues, organized a National Institutes of Health conference in 1985 to explore ethics as a clinical field (Jonsen, Fletcher, and Quist 1989). Participants at that conference agreed that consultation about ethical issues could be useful, but they reached no agreement about standards that could govern the practice. Attempts were continued by the Hastings Center in 1993 to define the practice of clinical ethics and consider certification—the process by which a training institution or specialty board determines that an individual possesses sufficient knowledge and skill to be recognized as proficient in a particular field (Thornton, Callahan, and Nelson 1993). That conference reached the conclusion that the field was too new, and the participants too diversified in background and training, to narrow the multiplicity of perspectives by formalizing a specific path to certification in the field. In 1998, the American Society of Bioethics and Humanities (ASBH), the primary professional body for ethicists
in the United States, proposed the most comprehensive effort to establish core competencies, which were significantly revised in 2010. They call for proficiency in three domains: a set of defined core skills; mastery of a core body of knowledge; and appropriate attributes, attitudes, and behaviors (called “character” in 1998). An important reason for describing a set of core competencies was the empirical evidence indicating that the training and skill set of many of those providing clinical ethics consultations were insufficient in one or more of these categories, even though many providers perceived themselves as fairly skilled (Hoffman, Tarzian, and O’Neil 2000). To date, no process has been formally accepted to certify individuals claiming competence in clinical ethics consultation in the United States, the United Kingdom, or other European states. (A preliminary version of this article was presented at the International Bioethics Conference in Lausanne, Switzerland, in 2009. None of the attendees were aware of any form of certification or process for credentialing clinical ethics consultants in their countries.)

Bioethics literature has again turned its attention to the issue of training and certification in clinical ethics, with strong arguments both for and against it (Kipnis 2009; Tarzian 2009; Bishop, Fanning, and Bliton 2009; Engelhardt 2009), but the practical reality of how a clinical ethics consultant fits into the hierarchy of a modern hospital is in a formative state regardless of what observers think. Despite a lack of consensus within the field of bioethics itself, The Joint Commission, in 1993, required all accredited hospitals to demonstrate the ability to deal with ethical problems that arise in medical care (Joint Commission 1993). Most hospitals have chosen to establish an ethics committee and/or an ethics consultation service to fulfill this requirement. Nearly fifteen years after the initial Joint Commission requirement, a survey of US hospitals revealed that 81 percent of them have an ethics consultation service available to respond to conflicts and dilemmas, 68 percent used a system of small teams, 23 percent used a full ethics committee, and 9 percent relied on an individual consultant (Fox, Myers, and Pearlman 2007). While the existence of an independent ethics consultant is still a rarity in most hospitals, an increasing number of individuals are claiming proficiency in clinical ethics consultation based on “certificates” issued by a variety of organizations upon completion of a course of study, either in person (Union Graduate College, Mount Sinai School of Medicine) or online (Center for Practical Bioethics). These programs are often targeted at the working professional, not just the physician, seeking to improve his or her effectiveness at the current position. The curriculum of some of these courses is similar to that proposed by ASBH, but as yet no standard has been recognized beyond the individual certifying institution. Certificate holders often become active ethics consultants in their local hospitals and are likely to provide ethics consultations as individuals. With an increasing number of people claiming competence in clinical ethics consultations, hospitals, faced with the serious obligation to ensure the competence of those involved in the care of their
patients, may begin to ask how they can verify the qualifications of this new type of practitioner in the absence of any recognized licensing or certifying body for this professional group.

WHO IS A CLINICAL ETHICIST?

In the United States, 34 percent of the individuals who perform ethics consultations have medical degrees (MD, DO) (Fox, Myers, and Pearlman 2007). Most of the other providers have various degrees in the fields of nursing, social work, theology, law, and philosophy. Only 5 percent of those providing ethics consultations in the United States have completed a bioethics fellowship program or received a graduate degree in bioethics (Fox, Myers, and Pearlman 2007).

Among the skills of a medical practitioner are the abilities to perform a medical examination, make a diagnosis, and conduct medical interventions, which are considered clinical acts. The practice of clinical ethics consultation requires some knowledge of clinical medicine and a particular set of additional skills (La Puma and Schneiderman 1991). Although distinct from the practice of a physician, the practice of a clinical ethicist requires the ability to recognize the ethical issues involved in a particular case and assist the medical team in designing a care plan to accommodate these issues. It is not uncommon for the ethicist to review the medical chart; interview the patient and his or her family or surrogate; discuss the case with the medical team; perform a literature search; and offer a series of specific recommendations (defining ethically appropriate and ethically inappropriate options), which are documented in the medical record 72 percent of the time (Fox, Myers, and Pearlman 2007). Although recommendations from the ethics consultation are not binding, they often have a direct and concurrent effect on the medical treatment offered to a patient in a clinical setting. As such, the consultation can be considered a clinical act, if not strictly a medical one. Clinical ethicists work independently and formulate a recommendation for the medical team. They do not work directly under the supervision of the physician, however. In this regard they may be aligned with allied health practitioners such as physician assistants, advanced practice nurses, or psychologists. Each of the latter professions has defined roles and responsibilities within the institution. The role of the clinical ethicist is less clear.

INSTITUTIONAL OBLIGATIONS

The Joint Commission requires hospitals to verify the qualifications of all members of the medical staff (Joint Commission 2009, HR.01.02.05). This requirement applies to physicians and all allied health practitioners. The process for credentialing and privileging involves verifying the licensure, credentials, educational background, and experience of the applicant. The integrity of these hospital activities depends on a system of professional education in each field, with standard curriculum and accreditation. Physician accreditation is governed by an organized system of board certification, in which individuals document their educational activities and their personal accomplishments.
to skilled examiners in the specialty (ABMS 2010). The field of bioethics has none of this infrastructure. ASBH argued in 1998 that healthcare institutions "should support a clear process by which ethics consultants are educated, trained and appointed, and provide the resources to ensure that they have the competencies to perform consultation" (ASBH 1998, 30), but the recommendations offered were proposed only as "voluntary guidelines" (ASBH 2010, 51). The organization's 2010 report describes an ambitious level of proficiency, especially compared to current levels. Nevertheless, the task force working on the recommendations concluded that the proficiencies set forth in its report should serve as the standards to which those performing healthcare ethics consultation should be held accountable (ASBH 2010, 51).

Despite ASBH's efforts to describe the ideal clinical ethicist, verifying the qualifications of someone performing clinical ethics consultations still presents a problem. The academic backgrounds and practice experiences of ethics consultants currently have no formal standards or methods to attest to the quality of education or the adequacy of training needed for the work of consultation. Clinical ethics consultants come either from the health professional specialties, which do not automatically qualify for ethics consultation, or come from philosophy, religious studies, or social sciences backgrounds, which also do not have standards or techniques to ensure the appropriate skills. Even the relatively new programs that focus on bioethics have not formulated common standards beyond general adherence to the core competencies. Without agreement on an essential curriculum for bioethics, the prerequisites for credentialing and privileging that hospitals rely on simply does not exist (Smith et al. 2010). How, then, are hospitals to fulfill their duty to obtain, assess, and verify the qualifications of these healthcare practitioners who provide patient care services?

The literature contains an early model for clinical ethicist credentialing that focused on extending ethics consultation privileges to those already on a hospital's medical staff (physicians with an MD or a DO and current in-state licensure to practice medicine) (La Puma and Priest 1992). However, this model fails to meet the crucial test of competency to provide ethics advice. In addition, it does not apply to many of those practicing clinical ethics consultation in the United States (nonphysicians). La Puma and Priest admit their model is designed exclusively for the physician but also foresaw the ability for it to be applied to other "doctoral professionals" who could otherwise satisfy the remainder of the credentialing and privileging criteria (e.g., one year of full-time postgraduate fellowship training in clinical ethics, documentation of having performed 25 supervised consultations). Again, this advice misses the mark, because no commonly accepted criteria are available against which to judge the adequacy of fellowship training or the quality of consultations.

More recently, the National Working Group for the Clinical Ethics Credentialing Project has begun to view the whole process of clinical ethics consultation and credentialing its practitioners as a quality improvement program (Dubler,
Webber, and Swiderski 2009). It recognizes the lack of clear standards for assessing competence, and it framed that absence as one of the first improvement measures to be addressed.

STRUCTURING AN ETHICS CONSULTATION SERVICE IN A COMMUNITY HOSPITAL

In light of these practical and theoretical difficulties, we turn to the experience of one large community hospital. California Pacific Medical Center, San Francisco, has offered an active ethics consultation service since 1985 and performed formal consultations on more than 650 cases. The consultation service reports to the Medical Ethics Committee, a committee of the medical staff. In 2002 the medical center established the Program in Medicine & Human Values (PMHV) to provide institutional support to the existing Medical Ethics Committee. A physician on the medical staff, who is one of this article’s authors (WSA), serves as the codirector of the PMHV and the chair of the Medical Ethics Committee. Two PhD bioethicists have been employed by the hospital as clinical ethicists and serve as ex officio members of the Medical Ethics Committee, along with 17 other members from various disciplines, including pastoral care, social work, nursing, medicine, psychiatry, and law. With the introduction of a formal ethics program within the institution, the number of requests for ethics consultation has risen dramatically, from about 24 annually to almost 100 a year (Exhibit 1). This volume has

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EXHIBIT 1
Annual Ethics Consultations at California Pacific Medical Center by Category, 1985–2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Problem focused</th>
<th>Comprehensive</th>
<th>Complex</th>
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<tr>
<td>2005</td>
<td>120</td>
<td>100</td>
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<tr>
<td>2019</td>
<td>120</td>
<td>100</td>
<td>80</td>
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269
far outstripped the ability of a volunteer medical staff committee and forced the medical center to develop new mechanisms to structure the consultation service and verify the qualifications of its participants.

The hospital’s Medical Ethics Committee now provides consultation in three formats. A subcommittee of the committee is appointed to provide consultation in about 18 to 20 difficult cases a year. This form of consultation is called a comprehensive consultation. The committee has also continued to conduct a few full committee hearings in cases that are less time sensitive and involve delicate legal or political issues. This second consultation process is called a complex consultation. Finally, the bulk of the increased consultation load has been met with a new consultation model, called a problem-focused consultation, and is conducted by a single individual identified as the clinical ethicist (Exhibit 2). The distribution of the medical center’s consultations within these categories since employing a professional ethicist in 2007 has also changed dramatically (Exhibit 1).

The use of a single individual to provide ethics consultation has brought the issues of hospital privileges and malpractice coverage to the forefront at California Pacific Medical Center. As mentioned, agreement among the bioethics community on a process for certifying proficiency in the field has been a subject of robust debate for years. Nevertheless, the Program in Medicine & Human Values has been instructed by the medical staff to develop a workable

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**Exhibit 2**
Consultation Categories

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<tr>
<th>Category of Consultation Type</th>
<th>Example</th>
<th>Provider Involved in the Consultation</th>
</tr>
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<tbody>
<tr>
<td>Problem-Focused</td>
<td>Straightforward or routine ethics consultation that does not involve significant conflict</td>
<td>Clinical ethicist</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Cases involving greater intricacy or specific matters such as withdrawal of support in patients lacking decision-making capacity and without surrogates</td>
<td>Hospital ethics committee subcommittee* and clinical ethicist (The chair of the subcommittee is the ethics liaison; the clinical ethicist provides background and support)</td>
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<tr>
<td>Complex</td>
<td>Cases with particularly difficult legal or political implications that are not time sensitive</td>
<td>Full ethics committee</td>
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*A subcommittee generally consists of the liaison and two general members of the ethics committee.
solution to verify the qualifications of individuals involved in ethics consultation while recognizing the lack of a clearly accepted model.

The first step was to divide the members of the hospital ethics committee into three categories reflecting their different levels of experience: ethics committee member, ethics committee liaison, and clinical ethics consultant.

All newly appointed members of the hospital ethics committee are assigned to the ethics committee member category. The criteria for this category reflect the qualifications of most ethics committee members around the country: They are, for the most part, health professionals with a personal interest in medical ethics. The ethics committee member must be willing to serve as a subcommittee member in comprehensive consultations provided by the ethics consultation service, be familiar with the general literature in his or her field as it pertains to clinical medical ethics, and be aware of the core competencies as described by ASBH. The committee member must also complete four hours of ethics continuing medical education (CME) per year.

The ethics committee liaison should be a member of the hospital ethics committee who has demonstrated a basic body of knowledge and clinical competence in the area of ethics consultation, at least within the scope of his or her field, and have participated in at least seven previous ethics consultations as a subcommittee member. The liaison rotates on a weekly call schedule to be available to the committee for consultation if requested by the chair. This individual is expected to serve as the subcommittee chair in comprehensive consultations and take responsibility for documenting the subcommittee’s actions. The subcommittee’s activities and recommendations are reported by the liaison at the monthly meeting of the entire committee. The liaison is expected to complete at least eight hours of ethics CME yearly.

The role of the clinical ethics consultant, which offers problem-focused consultations without the participation of additional contemporaneous committee input, requires a higher level of expertise. To reflect this elevated proficiency, the clinical ethics consultant for California Pacific Medical Center defined the clinical ethicist as an individual who has demonstrated advanced abilities in the field of clinical ethics. This individual is expected to have had some graduate training in bioethics or demonstrate equivalent knowledge and experience in the field. The clinical ethicist should possess a broad knowledge of medical ethics, as well as particular expertise in the area of clinical ethics, and is encouraged to be an active contributor to the literature. In addition to an advanced knowledge of medical ethics, the clinical ethicist is expected to possess the ethical assessment skills, process skills, and interpersonal skills necessary for effective ethics consultation. The clinical ethicist should not only continue his or her professional education but also serve as mentor and teacher to other healthcare professionals in CME and other activities. The clinical ethicist can perform problem-focused ethics consultations independently and assist the members of the subcommittee performing comprehensive consultations.
It is the clinical ethicist, the individual working independently with the medical team, to whom the medical staff has chosen to grant privileges, as it does to other allied health practitioners. Qualifications are verified based on the criteria set forth in the earlier description of the clinical ethicist.

LIABILITY CONCERNS
Malpractice coverage presents a unique challenge. Very little information is available on the malpractice coverage carried by these individuals. At California Pacific Medical Center, both the ethics committee members and the ethics liaison are duly appointed members of the Medical Ethics Committee, and, while serving in that role, their liability coverage is provided by the medical malpractice policy of the hospital’s medical staff, as it applies to individuals engaged in peer review or other medical staff functions. The authors have found no other model for ethics committees (ASBH 2004).

We were unable to identify any medical malpractice company in California that issues an individual policy specifically for clinical ethics consultation. Some individuals have obtained personal liability coverage as a rider to their own professional (legal or medical) coverage (various personal communications, documentation of which may be obtained from the corresponding author upon request). To address the issue of liability coverage, California Pacific Medical Center decided that all clinical ethicists would either be employees of the hospital as allied health practitioners or, in the case of physicians, employees of the medical foundation affiliated with the hospital. (California law does not allow hospitals to employ physicians directly.) In this manner, malpractice liability coverage is provided either by the hospital or by the medical foundation. The hospital and medical staff realize that, as currently written, the medical center’s liability policy excludes private individuals who wish to serve as ethics consultants for hospitalized patients at the facility.

CONCLUSION
Individuals with varying degrees of training and qualifications are beginning to appear in the role of clinical ethics consultant. In the absence of a generally recognized formal certification or licensure process, the mechanisms by which hospitals typically verify clinical qualifications are undefined for individuals providing ethics consultation. Historically, institutions have found ways to incorporate new methods of practice prior to their establishment as board-certified specialties, as they did in the fields of family medicine, geriatrics, and palliative care. Clinical ethics consultation appears to be in a particularly slow process of development. As institutions seek ways to improve the overall quality of care delivered to the patients they serve, a structured way to ensure the competence of individuals providing ethics consultation presents a progressive approach to quality improvement. In this spirit, we present a model adopted by one institution for dealing with the difficulty of verifying the qualifications of individuals providing clinical ethics consultation.
ACKNOWLEDGMENTS
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REFERENCES