

# Health Care Ethics Consultation: Nature, Goals, and Competencies

## A Position Paper from the Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation

Mark P. Aulisio, PhD; Robert M. Arnold, MD; and Stuart J. Youngner, MD, for the Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation\*

Patients, families, and health care providers have a right to expect that ethics consultants can deal competently with the complex issues that they are asked to address. The Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation explored core competencies and related issues in ethics consultation. This position paper summarizes the content of the resulting Task Force Report, which included nine general conclusions: 1) U.S. societal context makes “ethics facilitation” an appropriate approach to ethics consultation; 2) ethics facilitation requires certain core competencies; 3) core competencies can be acquired in various ways; 4) individual consultants, teams, or committees should have the core competencies for ethics consultation; 5) consult services should have

policies that address access, patient notification, documentation, and case review; 6) abuse of power and conflicts of interest must be avoided; 7) ethics consultation must have institutional support; 8) evaluation of process, outcomes, and competencies is needed; and 9) certification of individuals and accreditation of programs are rejected.

*Ann Intern Med.* 2000;133:59-69.

For author affiliations and current addresses, see end of text.

\* For members of the Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation, see Appendix 1. See editorial comment on pp 55-57.

Faced with complex moral questions, health care providers, patients, and families are increasingly turning to ethics consultants for assistance (1, 2). Cases involve such issues as patient autonomy, informed consent, competence, rights of conscience, medical futility, resource allocation, confidentiality, and surrogate decision making. In addition, consultants must help the health care team deal with the complex interpersonal and affective issues that often accompany these cases, such as guilt over a loved one’s sickness or impending death, disagreement among health care providers, possible conflicts of interest, or distrust of the medical system.

Ethics consultation has been encouraged by the courts (3), endorsed by a major President’s Commission (4), and supported by Joint Commission on Accreditation of Healthcare Organization requirements (5). Calls for accountability and quality assurance (6–9) have accompanied the growing prevalence of ethics consultation and its power to influence clinical practice (10–14). This concern has been underscored by recent legal cases in which ethics committees or consultants were named or negatively implicated (15, 16). Unlike for health care specialists, there is neither an agreed-on set of competencies nor any standard education or training for those who provide ethics consultation.

The rapid growth of consultation and concerns about accountability and quality assurance led two major bioeth-

ics organizations, the Society for Health and Human Values and the Society for Bioethics Consultation, to convene a national task force to explore core competencies and related issues in ethics consultation (Appendix 1). The sponsoring organizations of the Task Force selected the codirectors, who then selected 19 scholars representing diverse fields and a wide variety of organizations and institutions. A comprehensive bibliography of the empirical and conceptual literature on ethics consultation was compiled. Information was also solicited from bioethics education programs through a national mailing. The Task Force held six meetings in the course of 2 years. Subcommittees developed drafts on specific content areas. The drafts were discussed at the meetings and revised throughout the project. Feedback on an initial draft report was obtained from the bioethics community. Revisions were made and a final draft was unanimously approved by the Task Force. The Task Force Report was later adopted by the American Society for Bioethics and Humanities. This article summarizes the conclusions of the Task Force Report (17).

### Conclusion 1: Our Societal Context Makes “Ethics Facilitation” an Appropriate Approach to Ethics Consultation

Two salient features of the U.S. societal context shape an appropriate approach to ethics consultation (18–22).

4First, U.S. society is pluralistic, comprising persons of diverse racial, ethnic, religious, and nonreligious backgrounds who hold diverse values. This diversity is mirrored in the clinical setting and is further complicated there by the presence of various professional, institutional, and systemic values. Second, individual persons and communities in our society have the right to pursue different conceptions of the “good life” and to live by their own values. This right does not disappear merely because one becomes a health professional or because one falls ill and becomes a patient. An appropriate approach to ethics consultation must be sensitive to the pluralistic health care setting in which consultation is provided and consistent with the societal value of autonomy.

Societal values are often reflected in law and institutional policy, which are also part of the context that frames ethical issues in contemporary health care settings. Therefore, law and institutional policy also inform a proper understanding of ethics consultation and are widely discussed in the bioethics literature. Many states, for example, have legislation that governs the application of advance directives and outlines procedures for surrogate decision making in the absence of such directives. Similarly, institutions have policies that are applicable in certain types of cases, such as guidelines on life-sustaining treatment or requests for organ or tissue donation. Helping to identify the implications of law and institutional policy for particular cases is another role of ethics consultation in contemporary health care settings.

The bioethics literature covers several possible approaches to ethics consultation (23–25). Most approaches fall between one extreme that might be termed the *authoritarian approach* and another that might be termed the *pure facilitation approach*. For illustrative purposes, we will briefly characterize these two extremes; point out their inadequacies; and outline an alternate approach, *ethics facilitation*, that we believe is appropriate for ethics consultation in our society.

### The Authoritarian Approach

The defining characteristic of the authoritarian approach to ethics consultation is its emphasis on consultants as the primary moral decision makers. Ethics consultation can be authoritarian with respect to *outcome* or *process*.

Consider the case of a competent, well-informed, adult patient who refuses treatment on religious grounds. Imagine that the ethics consultants are sensitive to the pro-

cess of consultation and talk to all involved parties, addressing the factual, conceptual, and normative issues raised by the case. The consultants then recommend that the patient be given treatment against his wishes, despite the fact that the patient is competent and well informed, because their substantive values differ from those of the patient. The case, of course, begs for more detail, but it suffices to illustrate an authoritarian approach to the *outcome* of consultation; ethics consultants, as the primary moral decision makers, displace the appropriate moral decision maker, in this case the patient. By misplacing moral decision-making authority, this approach fails to recognize the appropriate boundaries of ethics consultation, as fundamentally established by the rights of individuals in U.S. society.

To illustrate the inadequacies of an authoritarian approach to the process of consultation, consider a case in which a family and health care team disagree over continued treatment of a critically ill adolescent. Suppose the health care team believes that continued treatment is futile, whereas the family hopes for a miraculous recovery. After speaking only to the attending physician, the ethics consultant sides with the health care team and recommends that treatment be discontinued. The consultant reaches his decision on the basis of his interpretation of the controversial concept of “futility” as discussed in the bioethics literature (15, 16). This approach is authoritarian in its *process* because it excludes relevant parties from moral decision making. It fails to open lines of communication between the family and the health care team in order to work toward a consensus that falls within the boundaries set by societal values, law, and institutional policy.

### The Pure Facilitation Approach

The sole goal of the pure facilitation approach is to forge consensus among involved parties. Imagine that consultants facilitate consensus between a patient’s family and the health care team to override the wishes of the patient as expressed in a valid advance directive. The patient has become unconscious, and no other relevant new information has become available. Although the consultants are inclusive and achieve consensus, they do so without clarifying the implications of societal, legal, and institutional values for the case. By placing too much emphasis on facilitating consensus, consultants risk forging a consensus that falls outside acceptable boundaries. In this case, the consensus violates the patient’s right to self-determination.

### The Ethics Facilitation Approach

We believe that an ethics facilitation approach is most appropriate for health care ethics consultation in contemporary society. The ethics facilitation approach is informed by the context in which ethics consultation is provided and involves two core features: identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus. By “consensus,” we mean agreement by all involved parties, whether that agreement concerns the substantively morally optimal solution or, more typically, who should be allowed to make the decision.

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

1. Gather relevant data (for example, through discussions with involved parties and examination of medical records or other relevant documents).
2. Clarify relevant concepts (such as confidentiality, privacy, informed consent, and best interest).
3. Clarify related normative issues (such as the implications of societal values, law, ethics, and institutional policy for the case).
4. Help to identify a range of morally acceptable options within the context.

Health care ethics consultants should also help to address the value uncertainty or conflict by facilitating consensus among involved parties (which may include patients, families, surrogates, and health care providers). To do so, they must ensure that the voices of all involved parties are heard, assist the involved individuals in clarifying their own values, and facilitate the building of morally acceptable shared commitments or understandings within the context.

The ethics facilitation approach recognizes the societal boundaries for morally acceptable solutions. In contrast to the authoritarian approach, ethics facilitation emphasizes an inclusive consensus-building process. It respects individuals’ rights to live by their values by not misplacing moral decision-making authority or representing the personal moral views of the consultant only. In contrast to the pure facilitation approach, ethics facilitation recognizes that societal values, law, and institutional policy have implications for a morally acceptable consensus. The ethics facilitation approach is consistent with both the pluralistic context in which ethics consultation is done and the rights of individuals to live by their values, recognizing that there are definite boundaries within which decisions must be made and

helping to ensure that these boundaries are not transgressed.

### Conclusion 2: Ethics Facilitation Requires Certain Core Competencies

Given the approach to ethics consultation described above, the Task Force believes that consultants should possess certain skills, knowledge, and character traits to perform competently.

#### Skills

Ethics consultation requires three types of skills. *Ethical assessment skills* are needed to identify and analyze the ethical issues that emerge in particular clinical cases. Examples of ethical assessment skills are the ability to distinguish the ethical dimensions of the case from other, often overlapping, dimensions (such as legal, medical, and psychiatric aspects) and the ability to identify and justify a range of morally acceptable options and their consequences. *Process skills* focus on resolving value uncertainty or conflict as it emerges in health care settings. Facilitation is an example of a process skill. *Interpersonal skills* are critical to nearly every aspect of ethics consultation. Two examples of interpersonal skills are the ability to listen well and communicate interest, respect, support, and empathy to involved parties and the ability to represent the views of involved parties to others (26).

The Task Force distinguishes between basic and advanced skills. A *basic skill* is defined as the ability to use the skill in question in common and straightforward cases. An *advanced skill* is defined as the ability to use the skill effectively in more complex cases. The distinction between basic and advanced skill is necessarily vague and somewhat arbitrary. In patient interviewing, for example, being able to take a history is considered a basic skill, whereas attending to an anxious patient’s affect while taking a history and negotiating treatment options with patients who use illicit drugs are considered more advanced skills. The purpose of the distinction is to provide general guidance on the type and level of skills required for ethics consultation; the task of more detailed operational definitions belongs to those who provide education and training (Table 1).

#### Knowledge

In addition to skills, the Task Force believes that ethics consultants must have knowledge in nine areas: moral rea-

soning and ethical theory, bioethical issues and concepts, health care systems, clinical context, knowledge of the local health care institution in which consultation is done, the local health care institution’s relevant policies, beliefs and perspectives of patient and staff population, relevant codes of ethics and professional conduct and guidelines of accrediting organizations, and relevant health law (Table 2). These general knowledge areas overlap, and their specific content will vary over time because of technological development and changes in the health care environment. Specific issues (for example, organ transplantation) may arise frequently in some institutions and infrequently in others.

The Task Force distinguishes between basic and advanced competencies in this area as well. *Basic knowledge* is a general, or introductory, familiarity with the specified

area. *Advanced knowledge* is a detailed grasp of the specified area. We also distinguish between knowledge that could be brought to the process as opposed to knowledge that is merely available to the process. *Brought to the process* means that the individuals identified must have the knowledge to the level specified. *Available to the process* means that the individual consultant or at least one member of the group must know how to access advanced knowledge in the specified area.

**Character Traits**

In addition to the core competencies considered above, good character is important for optimal ethics consultation. The rationale for this belief, and opinions about

**Table 1. Skills for Ethics Consultation**

Skill Area	Level of Skill That Individual/At Least One Member of the Team or Committee Needs	Level of Skill That Every Team Member Needs	Level of Skill That Every Committee Member Needs
1. Ability to identify the nature of the value uncertainty or conflict underlying the need for ethics consultation (such as the ability to discern and gather relevant data, distinguish the ethical dimensions of the case from other dimensions, and identify relevant values of involved parties)	Advanced	Basic	Basic
2. Ability to analyze the value uncertainty or conflict (such as the ability to access relevant knowledge, clarify relevant concepts, or critically evaluate and use relevant knowledge)	Advanced	Basic	Basic
3. Ability to facilitate formal and informal meetings	Advanced	Basic	Basic
4. Ability to build moral consensus	Advanced	Basic	Basic
5. Ability to use institutional structures and resources to facilitate implementation of the chosen option	Basic	Not required	Not required
6. Ability to document consults and elicit feedback on the process of consultation so that the process can be evaluated	Basic	Not required	Not required
7. Ability to listen well and to communicate interest, respect, support, and empathy to involved parties	Advanced	Basic	Basic
8. Ability to educate involved parties about the ethical dimensions of the case	Basic	Not required	Not required
9. Ability to elicit the moral views of involved parties	Advanced	Basic	Basic
10. Ability to represent the views of involved parties to others	Advanced	Basic	Basic
11. Ability to enable the involved parties to communicate effectively and be heard by other parties	Advanced	Basic	Basic
12. Ability to recognize and attend to various relational barriers to communication	Basic	Basic	Basic

**Table 2. Knowledge for Ethics Consultation\***

Knowledge Area	Level of Knowledge That Individual/At Least One Team or Committee Member Needs	Level of Knowledge That Every Team Member Needs	Level of Knowledge That Every Committee Member Needs	Level of Knowledge That Individual/At Least One Member Can Access
1. Moral reasoning and ethical theory (such as consequentialist vs. nonconsequentialist or principle-based vs. casuistic)	Advanced	Basic	Basic	Not required†
2. Bioethical issues and concepts that typically emerge in ethics consultation (such as autonomy, informed consent, confidentiality, surrogate decision making, and provider rights of conscience)	Advanced	Basic	Basic	Not required†
3. Health care systems (such as managed care or governmental systems)	Basic	Basic	Basic	Advanced
4. Clinical context (value-laden nature of “health” and “disease”; knowledge of roles of various health care providers and how care is provided on various services; terms for basic human anatomy, diagnosis, treatment, and prognosis)	Basic	Basic	Basic	Advanced
5. Health care institution in which the consultants work (such as mission statement, basic structure, range of services, and ethics consultation resources)	Basic	Basic	Basic	Advanced
6. Local health care institution’s policies that are relevant for ethics consultation (such as informed consent, withholding or withdrawing of life-sustaining treatment, and confidentiality or privacy policies)	Advanced	Basic	Basic	Not required†
7. Beliefs and perspectives of patient and staff population where one does ethics consultation (such as important beliefs that bear on the health care of racial, ethnic, cultural, and religious groups served by the facility and resource persons for cultural and faith communities)	Basic	Basic	Basic	Advanced
8. Relevant codes of ethics, professional conduct, and guidelines of accrediting organizations (such as JCAHO standards and AMA or ANA guidelines)	Basic	Not required	Not required	Advanced
9. Health law (such as end-of-life care issues, surrogate decision making, informed consent, confidentiality)	Basic	Basic	Basic	Advanced

\* AMA = American Medical Association; ANA = American Nurses Association; JCAHO = Joint Commission on Accreditation of Healthcare Organizations.  
 † All team or committee members should have basic knowledge in the indicated area, and the individual consultant or at least one member of the team or committee should have advanced knowledge.

the specific relation between character and ethics consultation, depend on several issues that raised controversy among Task Force members. Controversy stemmed, at least in part, from the close connection between character

and conceptions of “the good.” When people disagree about conceptions of the good, they are likely to hold divergent views of character.

Nonetheless, the Task Force affirms that such virtues

as tolerance, patience, compassion, honesty, courage, prudence, humility, and integrity are important for consultants. Consultants should strive to embody and exhibit these traits in consultation. Some of the skills that are central to consultation may be closely related to certain virtues. For example, tolerance, patience, and compassion should enable consultants to “listen well and communicate interest, respect, support and empathy” (Table 1); other examples are listed in Appendix 2.

### **Conclusion 3: Core Competencies Can Be Acquired in Various Ways**

Many ways exist to acquire the core competencies that we have identified as important for ethics consultation. These range from traditional degree programs in relevant areas, certificate programs, and continuing education programs to fellowships, practicums, intensive courses, and self-study. Different educational techniques may work better for specific knowledge or skill areas. For example, traditional classroom-based approaches may work well for learning about moral reasoning and ethical theory. More “hands-on” approaches, such as simulated consultations or clinical practicums in ethics consultation, may be effective for teaching interpersonal or process skills.

The supplemental education or training that any person may need to acquire a particular competency will be contingent on at least two factors: 1) their professional background, experience, and personal qualities and 2) the capacity in which they do ethics consultation, whether as an individual consultant, as part of a consultation team, or as part of a full ethics committee. Ultimately, our foremost concern is that consultants have the required competencies, not how they acquire them.

### **Conclusion 4: Individual Consultants, Teams, or Committees Should Have the Core Competencies for Ethics Consultation**

The Task Force does not take a position on whether ethics consultation is best done by individual consultants, consult teams (typically consisting of 3 or 4 persons), or full ethics committees (typically consisting of 12 to 15 persons). Each method has strengths and weaknesses. The individual method is well suited to bedside consultation but is limited by offering the perspective of only one person. A committee brings diverse perspectives but is some-

times impractical. A consult team carries both of these strengths and weaknesses to a lesser degree.

The method used does, however, have implications for how the core competencies are distributed. When ethics consultation is offered by an individual consultant, the consultant should have all of the core competencies required for ethics consultation. Individual consultants normally will need additional training to obtain these competencies.

In a consultation team, the full range of core competencies required for ethics consultation is distributed among the team so that less demand is placed on any individual team member. Depending on the team’s composition, individual members may still need training so that the team has the full range of competencies. Suppose a consultation team included a philosopher, a lawyer, and a clinician. Team members may need to acquire additional group process and interpersonal skills or advanced knowledge of the health care organization’s relevant policies. The strengths of the team method of consultation depend on all members being able to fully participate in case discussions. Thus, each team member should take steps to acquire the basic competencies outlined in Tables 1 and 2.

Like consultation teams, ethics committees that perform case consultation should collectively have the full range of core competencies. Because core competencies in ethics committees will be distributed over a larger number of people, the demand placed on any particular person is less than that placed on members of consultation teams and far less than that on an individual consultant. Again, it is important that each member have basic skills and knowledge sufficient to address the types of issues that come before the committee so that different viewpoints can be heard. Thus, every ethics committee member should have the basic competencies indicated in Tables 1 and 2.

### **Conclusion 5: Consult Services Should Have Policies That Address Access, Patient Notification, Documentation, and Case Review**

The process of ethics consultation starts with a request for consultation and concludes with an evaluation. We address the following normative questions about the process of ethics consultation: 1) Who should have access to ethics consultation services? 2) Should patients be notified if a consult is called? 3) Should ethics consultations be docu-

mented? 4) Must a consultation service have a mechanism for case review?

### Access

Patients, families, surrogates, health care providers, and other involved parties should have access to ethics consultation services. A general policy of open access is important to ensure that the rights and values of all involved parties are respected. Requests for ethics consultation by patients, families, or surrogates should be honored as a matter of policy. Although consultations requested by health care providers or others should be provided, the Task Force recognizes that reasonable people may disagree about whether these consultations may be limited (for example, whether it is appropriate for an attending physician to limit direct involvement of consultants with patients or surrogates). Exceptions to a general policy of open access to consultations, or specific limitations in carrying them out, should be carefully considered and clearly delineated in the institution's ethics consultation policy.

### Notification of Consultation

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

Certain types of consults do not demand patient involvement, such as those called to resolve a dispute between two health care providers or to provide information about hospital policy. Exceptions to the guideline that pa-

tients be notified when a consultation is called should be clearly spelled out in consultation service policies.

### Documentation of Consults

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

### Case Review

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

Finally, it is important that each consult service clearly specify its procedures, justify them, and periodically reevaluate how well they are meeting overall service and institutional objectives and values. An appropriate balance must be struck between a formal, legalistic approach that tries to fashion rigid rules to capture every case and an approach that appeals only to abstract principles that are too general to provide genuine guidance.

### Conclusion 6: Abuse of Power and Conflicts of Interest Must Be Avoided

Ethics consultants have the power to influence clinical care. This power can be abused. For example, ethics consultants have access to privileged information, including highly personal medical, psychological, financial, and legal information. The requirements of confidentiality must be respected. In addition, conflicts of interest can bias consultants' recommendations. If ethics consultants have important personal or professional relationships with one or more parties that could lead to bias, these relationships should be disclosed, and the consultants should perhaps remove themselves from the case. Individuals should never serve as ethics consultants on cases in which they have

clinical or administrative responsibility. In addition, a conflict of interest may arise when ethics consultants are employed by the health care institution. In that situation, the personal interests of the consultant may be harmed by giving advice or otherwise acting against the institution's perceived financial or public relations interest, for example. This issue should be addressed proactively with the health care institution. If the conflict of interest in an individual case puts ethics consultants in the position of shading an opinion to avoid personal risk, they should either take that risk or withdraw from the case.

### **Conclusion 7: Ethics Consultation Must Have Institutional Support**

When patients, families, surrogates, or health care providers seek assistance in sorting through the ethical dimensions of health care, they deserve assurance that those who offer that assistance are competent to do so. Nonetheless, the burden of satisfying these obligations should not fall solely on the shoulders of ethics consultants (many of whom are health care professionals with primary responsibilities in other areas). Health care institutions must be responsible to those who use ethics consultation services by providing support for ethics consultants in their institution. For example, institutions should have a clear process by which ethics consultants are educated, trained, and appointed and should provide such resources as support for continuing education and access to core bioethics reference texts and journals. In addition, institutions should ensure that those who provide ethics consultation are given adequate time, compensation, and resources to perform ethics consultation properly. Finally, institutions should foster a climate in which ethics consultants can carry out their work with integrity. For example, ethics consultation should be separated from personnel oversight so that health care providers see ethics consultation as a resource for addressing ethical uncertainties or conflicts rather than as a disciplinary action.

### **Conclusion 8: Evaluation of Process, Outcomes, and Competencies Is Needed**

A full discussion of the purposes and techniques of evaluation is beyond the scope of this Task Force. The Task Force attaches great importance to evaluation, however, and sees it as an area that should be actively pursued through research and practice (1, 27–30).

It is important to assess the degree to which individual consultants have the core competencies described above. This is especially critical for programs that offer training in ethics consultation. To the extent that educators are persuaded that these competencies are important for ethics consultation, they should take steps to ensure that their educational objectives cover these competencies and that they have reliable measures for identifying whether those objectives are achieved.

Evaluation of the process of consultation is also needed. This is important for determining whether the procedures of a consult service are being followed. Chart review, for example, could indicate whether consults are properly documented, or patient or family surveys could help to confirm that notification procedures are being followed.

Finally, the outcomes of ethics consultation must be evaluated. Evaluating outcomes is an important way to justify and correct recommended competencies for consultants and process procedures. Currently, no evidence is available that consultants who possess certain competencies provide “better” consultations. Similarly, no data are available on what methods of ethics consultation best achieve its goals. Research in these areas is much needed (31, 32).

### **Conclusion 9: Certification of Individuals and Accreditation of Programs Are Rejected**

The Task Force rejects both certification of individuals or groups to provide ethics consultation and accreditation of educational programs that would train individuals or groups to provide ethics consultation. First, certification increases the risk for displacing providers and patients as the primary moral decision makers at the bedside because it gives the impression that certified individuals have special standing in ethical decision making. Certification, then, could encourage the type of authoritarian approach to ethics consultation rejected by the Task Force.

Second, both certification and accreditation could undermine disciplinary diversity if they were controlled by a particular discipline and widely adopted. The Task Force believes that such control would be undesirable because the different disciplines involved in ethics consultation each bring identifiable strengths to the process. It is important that consultants have the relevant competencies, not that they come from a particular professional or academic field.

Third, certification and accreditation could lead to the institutionalization of a particular substantive view of mo-

rality, a certain view of the relation between ethical theory and practice, or one conception of the relative importance of skills for ethics consultation.

Fourth, although the knowledge and skills identified by the Task Force might be measurable in principle, there is little experience in evaluating consultants' competencies (in conclusion 8, we encourage these efforts). Thus, even if certification were warranted—and it is not—it is unlikely that a sufficiently reliable standardized test could be developed for that purpose.

Finally, both certification and accreditation would also require the development of a new management bureaucracy, with all the attendant costs and difficulties. This raises serious political and practical difficulties and is not warranted at this time.

The Task Force believes that its report should be used as a guide. After informed consideration of the report's merits, health care organizations, educational and training programs, and individuals involved in consultation should decide how best to make use of it.

### Conclusion

The Task Force Report constitutes the first multidisciplinary and multi-institutional attempt in the United States to articulate what ethics consultation is and what competencies it requires. The issues involved in ethics consultation are complex, and it is imperative that those who provide ethics consultation have a proper understanding of their role and be competent to address these issues. It is hoped that the work of the Task Force will stimulate continued debate over, among other things, the proper role of ethics consultation in contemporary health care settings and the kinds of competencies it requires. In addition to continued debate, we hope that the work of the Task Force will spur development of new educational and training programs for consultants, along with revision of existing ones. We hope that serious efforts will be made to evaluate and improve existing consult services and that, where new services are developed, every effort will be made to ensure that the staff are well qualified. We also hope that institutions will provide adequate support for consult services so that they can be of high quality. Ultimately, all of these hopes are based on the belief that ethics consultation provided by well-qualified consultants can be valuable to patients, providers, and others as they try to sort through the multifaceted, important, and increasingly complex ethical decisions they face in today's health care environment.

### Appendix 1: Members of the Society for Health and Human Values—Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation

Robert M. Arnold, MD (*Co-Director*), University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania; Mark Aulisio, MD (*Executive Director*), University of Pittsburgh, Pittsburgh, Pennsylvania; Françoise Baylis, PhD, Dalhousie University, Halifax, Nova Scotia, Canada; Charles Bosk, PhD, University of Pennsylvania, Philadelphia, Pennsylvania; Dan Brock, PhD, Brown University, Providence, Rhode Island; Howard Brody, MD, PhD, Michigan State University, East Lansing, Michigan; Linda Emanuel, MD, PhD, American Medical Association, Chicago, Illinois; Arlene Fink, PhD, University of California, Los Angeles, Los Angeles, California; John Fletcher, PhD, University of Virginia, Charlottesville, Virginia; Jacqueline J. Glover, PhD, West Virginia University, Morgantown, West Virginia; George Kanoti, STD, Cleveland Clinic Foundation, Cleveland, Ohio; Steven Miles, MD, University of Minnesota, Minneapolis, Minnesota; Kathryn Moseley, MD, Henry Ford Health System, Detroit, Michigan; William Nelson, PhD, Veterans Affairs National Center for Clinical Ethics, White River Junction, Vermont; Ruth Purtilo, PhD, Creighton University, Omaha, Nebraska; Cindy Rushton, DNSc, MSN, The Johns Hopkins University, Baltimore, Maryland; Paul Schyve, MD, Joint Commission on Accreditation of Healthcare Organizations, Chicago, Illinois; Melanie H. Wilson Silver, MA, Society for Healthcare Consumer Advocacy of the American Hospital Association, Chicago, Illinois; Joy Skeel, BSN, MDiv, Medical College of Ohio, Toledo, Ohio; William Winslade, PhD, JD, University of Texas Medical Branch, University of Houston, Galveston, Texas; Stuart J. Youngner, MD (*Co-Director*), Case Western Reserve University, Cleveland, Ohio.

### Appendix 2: Character Traits for Health Care Ethics Consultation

Below are examples of character traits or personal qualities that are believed to be related to success in ethics consultation. Unlike skills, character traits cannot be divided into basic and advanced levels. Acquisition and nurturing of character are goals that persons should strive for over a lifetime. Most Task Force members agree that character can be nurtured and that its importance for ethics consultation should be taught and modeled. All ethics consultants should strive to possess and exhibit these traits.

*Tolerance, patience, and compassion* enable the consultant to “listen well and communicate interest, respect, support and empathy” (skill 7, **Table 1**). Tolerance and patience help consultants welcome people with difficult problems, those who may be emotionally distraught, or those who have minority views, so that

these people can be fully and respectfully heard. Compassion helps the consultant to work constructively with feelings in sometimes tragic situations.

*Honesty, forthrightness, and self-knowledge* help prevent the manipulative use of information and help “create an atmosphere of trust” necessary to facilitate formal and informal meetings (skill 3, **Table 1**). Consultants must be honest about their own limitations, their need for more knowledge, how their agendas and values are shaping the consultation, and their uncertainty about proposed solutions.

*Courage* is needed to enable various parties, especially those who are less powerful politically, to communicate effectively and be heard by other parties (skill 11, **Table 1**). It is also required to take positions that are unpopular or contrary to the interests of one’s employer or other powerful persons.

*Prudence and humility* can inform behavior when rash or novel courses of action are being considered and can enable consultants not to overstep the bounds of their role in consultation. These character traits can help consultants acknowledge possible areas of conflict between their personal moral views and their role in providing consultation (skill 4, **Table 1**).

*Integrity* enables consultants to pursue the option or range of options ethically required in the case even when it might be convenient to do otherwise (skill 5, **Table 1**). Integrity should inform all behavior of consultants as they strive to fulfill the trust placed in them by health care providers, patients, and families who seek help in resolving ethical issues.

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

From University of Pittsburgh, Pittsburgh, Pennsylvania; and Case Western Reserve University, Cleveland, Ohio.

**Grant Support:** The Society of Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation is supported by a grant from the Greenwall Foundation and contributions from numerous other organizations, centers, and networks. The Soros Foundation supported the participation of Robert M. Arnold and Steven Miles as Faculty Scholars for the Open Society, Project on Death in America.

**Requests for Single Reprints:** Mark P. Aulisio, PhD, Consortium Ethics Program, University of Pittsburgh, Center for Bioethics and Health

Law, Medical Arts Building, 3708 Fifth Avenue, Suite 300, Pittsburgh, PA 15213; e-mail, maa13@pitt.edu.

**Requests To Purchase Bulk Reprints (minimum, 100 copies):** Barbara Hudson, Reprints Coordinator; phone, 215-351-2657; e-mail, bhudson@mail.acponline.org.

**Current Author Addresses:** Dr. Aulisio: Consortium Ethics Program, University of Pittsburgh, Center for Medical Ethics, Medical Arts Building, 3708 Fifth Avenue, Suite 300, Pittsburgh, PA 15213.

Dr. Arnold: University of Pittsburgh, Montefiore Hospital, 200 Lothrop Street, Suite W-919, Pittsburgh, PA 15213.

Dr. Youngner: Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106.

## References

1. Youngner SJ, Jackson DL, Coulton C, Juknialis BW, Smith EM. A national survey of hospital ethics committees. *Crit Care Med.* 1983;11:902-5.
2. Tulskey JA, Fox E. Evaluating ethics consultation: framing the questions. *J Clin Ethics.* 1996;7:109-15.
3. Cranford RE, Doudera AE. The emergence of institutional ethics committees. In: Cranford RE, Doudera AE, eds. *Institutional Ethics Committees and Health Care Decision Making.* Ann Arbor, MI: Health Administration Pr; 1984:5-21.
4. Decisions to Forgo Life-Sustaining Treatment. A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions. Washington, DC: President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; 1983:153-60.
5. Patients’ rights and organizational ethics. In: *Comprehensive Accreditation Manual for Hospitals.* Chicago: Joint Commission on Accreditation of Healthcare Organizations; 1995:66.
6. Fry-Revere S. *The Accountability of Bioethics Committees and Consultants.* Frederick, MD: Univ Publishing Group; 1992:141.
7. Fry-Revere S. Some suggestions for holding bioethics committees and consultants accountable. *Camb Q Healthc Ethics.* 1993;2:449-55.
8. Fry-Revere S. Ethics consultation: an update on accountability issues. *Pediatr Nurs.* 1994;20:95-8.
9. Wolf SM. Quality assessment of ethics in health care: the accountability revolution. *Am J Law Med.* 1994;20:105-28.
10. Fletcher JC, Hoffmann DE. Ethics committees: time to experiment with standards. *Ann Intern Med.* 1994;120:335-8.
11. La Puma J, Schiedermayer DL. Ethics consultation: skills, roles, and training. *Ann Intern Med.* 1991;114:155-60.
12. La Puma J, Schiedermayer D. *Ethics Consultation: A Practical Guide.* Boston: Jones and Bartlett; 1994:234.
13. Pellegrino ED, Siegler M, Singer PA. Future directions in clinical ethics. *J Clin Ethics.* 1991;2:5-9.
14. Singer PA, Pellegrino ED, Siegler M. Ethics committees and consultants. *J Clin Ethics.* 1990;1:263-7.
15. Capron AM. Abandoning a waning life. *Hastings Cent Rep.* 1995;25:24-6.
16. Fletcher JC, Spencer EM. Ethics services in health care organizations. In: Fletcher JC, Lombardo PA, Marshall MF, Miller FG, eds. *Introduction to Clinical Ethics.* 2d ed. Frederick, MD: Univ Publishing Group; 1997:270-5.

17. Society for Health and Human Values—Society for Bioethics Consultation. Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities. Glenview, IL: American Society for Bioethics Consultation; 1998.
18. **Scofield GR.** Here come the ethicists! *Trends Health Care Law Ethics.* 1993;8:19-22.
19. **Scofield GR.** Ethics consultation: the least dangerous profession? *Camb Q Healthc Ethics.* 1993;2:417-26.
20. **Scofield GR.** Ethics consultation: the most dangerous profession: a reply to critics. *Camb Q Healthc Ethics.* 1995;4:225-8.
21. **Ross JW.** Why clinical ethics consultants might not want to be educators. *Camb Q Healthc Ethics.* 1993;2:445-8.
22. **Ross JW.** Response to Jonathan Moreno [on ethics consultation]. *Hospital Ethics Committee Forum.* 1996;8:22-8.
23. **Aulisio MP, Arnold RM, Youngner SJ.** Can there be educational and training standards for those conducting health care ethics consultation? In: Monagle JF, Thomasma DC, eds. *Health Care Ethics: Critical Issues for the 21st Century.* Gaithersburg, MD: Aspen; 1998:484-96.
24. **Crigger BJ.** Negotiating the moral order: paradoxes of ethics consultation. *Kennedy Inst Ethics J.* 1995;5:89-112.
25. **Zaner RM.** Voices and time: the venture of clinical ethics. *J Med Philos.* 1993;18:9-31.
26. **Lipkin M, Putnam SM, Lazare A.** *The Medical Interview: Clinical Care, Education, and Research.* New York: Springer-Verlag; 1995.
27. **Fox E.** Concepts in evaluation applied to ethics consultation research. *J Clin Ethics.* 1996;7:116-21.
28. **Fox E, Arnold RM.** Evaluating outcomes in ethics consultation research. *J Clin Ethics.* 1996;7:127-38.
29. **Fox E, Tulsy JA.** Evaluation research and the future of ethics consultation. *J Clin Ethics.* 1996;7:146-9.
30. **Tulsy JA, Stocking CB.** Obstacles and opportunities in the design of ethics consultation evaluation. *J Clin Ethics.* 1996;7:139-45.
31. **Fink A.** *Evaluation Fundamentals: Guiding Health Programs, Research, and Policy.* Newbury Park, CA: Sage; 1993.
32. **Patton MQ.** *How to Use Qualitative Methods in Evaluation.* Newbury Park, CA: Sage; 1987.

So Semmelweis went patiently about his work, serene in the confidence that anything so true as his *Lehre*, his doctrine, must be known merely by its own lifesaving properties.

And there he made a serious mistake, for no great discovery has ever been immediately accepted. Rather, in medicine, it seems that the reverse is true, and every one must go through a period of trial and even censure before what seems the obvious truth is recognized generally. Perhaps this is best in the final analysis, because such opposition has throttled many a false doctrine before it could be widely accepted by the credulous and exploited by the charlatan. But slow acceptance prevents the real discoveries from being known and widely accepted earlier, and many lives are thus sacrificed needlessly.

Frank G. Slaughter  
*Immortal Magyar: Semmelweis, Conqueror of Childbed Fever*  
New York: Henry Schuman; 1950:74

Submitted by:  
Giora Netzer, MD  
Temple University School of Medicine  
Philadelphia, PA 19103

Submissions from readers are welcomed. If the quotation is published, the sender's name will be acknowledged. Please include a complete citation (along with page number on which the quotation was found), as done for any reference.—*The Editor*