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The Chiaroscuro of Accountability in the Second Edition of the *Core Competencies for Healthcare Ethics Consultation*

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ABSTRACT

"Chiaroscuro" is a art technique that makes use of light and shade to suggest depth and solidity on a flat surface. I argue that the standards regarding accountability in the second edition of the *Core Competencies for Healthcare Ethics Consultation* (*CC2*),[1] are chiaroscuro, because, despite the offered lists of competencies, it is very difficult to imagine how consultants might be held accountable to such standards. It is not clear to which of the many suggested standards a consultant should be held accountable, and even if one stipulates that only the tabulated competencies are meant as standards, the vague wording makes it hard to know how a consultant might fail to meet the standards or perform excellently. In addition, because terms such as "ethics" and "ethical" are not defined in the document, we are left with no way to determine whether consultants have made appropriate recommendations. The document is useful as a point of discussion, but not yet ready to serve as a tool for holding practitioners accountable.

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INTRODUCTION: MOUNTING PRESSURE FOR STANDARDS

In the early days of clinical ethics consultation, academics whose work focused on ethics were invited to reflect on clinical dilemmas. This was usually undertaken by individuals (such as philosophers or theologians) whose employment and research focus lay elsewhere. Over time, and for a variety of reasons, clinical ethics consultation has grown, and for many individuals it now constitutes a significant and increasing proportion of their professional responsibilities. This has contributed to the movement to establish clinical ethics consultation as a distinct profession, with its own code of ethics, training standards, certification, et cetera. This is a significant step, for it implies that clinical ethics consultants have a set of skills to offer, one distinct from sets available in existing professions or academic disciplines.

While a significant step, however, it is also problematic. In the past, those contributing their expertise to cases in clinical medicine were almost invariably employed in distinct disciplin-

ary or professional homes (for example, theology, law, philosophy, and medicine) with established standards of evaluation for competence—for example, through peer assessment of research, teaching success, and service contributions. But the more that an individual's work time was spent on the new task of clinical ethics consultation, the greater the need to construct and make transparent the new standards by which she or he should be evaluated for work in that area.[2] In addition, as the practice of clinical ethics consultation expands, its reception (especially by those who pay for it, but also by those who make use of it) will depend in part on whether others understand what to expect of a competent clinical ethics consultant.

As a result of these factors, clinical ethics consultants began to discuss the establishment of practice standards. These discussions have focused on several fronts—for example, a proposed code of ethics,[3] a working group considering credentialing in the field,[4] and the formation of a task force by the Society for Health and Human Values and the Society for Bioethics Consultation devoted to articulating a set of skills for the field of clinical ethics consultation. The first edition of the *Core Competencies for Health Care Ethics Consultation*,[5] the result of the task force's work, was initially published in 1998 (hereafter, *CC1*) and was revised in 2011 (hereafter, *CC2*). A body within the American Society for Bioethics and Humanities (ASBH), the Clinical Ethics Consultation Affairs (CECA) Committee, was recently appointed "to develop standards for ethics consultants working in clinical settings and to ensure clinical ethics consultants' competency and integrity."[6]

Some of these trends have been motivated by the desire to transform the practice of clinical ethics consultation into a profession. However, it is both possible and important to separate two distinct aspirations for the field. On the one hand is the desire to create a profession; on the other is the desire to clarify standards of accountability in the practice. Although professionalism requires accountability, the reverse is not true: it is clearly possible to establish standards of accountability without establishing a profession.[7] Therefore, establishing accountability standards seems like the appropriate first step in clarifying the role of the clinical ethics consultant, independent of whether or not it is considered to be a profession. Insofar as practitioners of clinical ethics consultation think there are ways in which the activity can be conducted poorly or objectionably, it is necessary to articulate what poor or objectionable practice consists of, and how to avoid it.

The *CC2* continues to be the most comprehensive set of standards yet devised for the field of clinical ethics consultation.[8] Proponents of a certain conception of clinical ethics consultation that was omitted from the document could complain about that omission; alternatively, skeptics of the entire field could complain that the document fails to justify robustly the field's very existence. Such arguments may or may not have merit, but at any rate are not my concern. Instead, I approach the *CC2* as a supporter of the field of clinical ethics consultation, with genuine puzzles in mind about the parameters of appropriate practice. Most immediately, appropriate practice is codified in standards of accountability—what practitioners will be held responsible for doing or failing to do. The *CC2* is presented as including standards of accountability, but several problems compromise the document's usefulness in holding consultants accountable, as I will argue.

THE PURPOSE OF THE *CORE COMPETENCIES*

In order to critique the *CC2* for problems with holding consultants accountable to its standards, it must first be shown that this is a central purpose of the document. The task force for the initial report (*CC1*) was assigned the purpose of exploring standards for healthcare ethics consultation. Specifically, "the work of the Task Force was motivated by the belief that when patients, health care providers, or others seek the assistance of health care ethics consultants, ethics consultants should be *competent to offer that assistance*" (*CC1,* 1, emphasis added). That focus seems to continue in *CC2*:

"The ultimate concern of this Task Force is quality assurance and improvement in ethics consultation. Patients, families, surrogates, and health care providers should be able to trust that when they seek help sorting through the ethical dimensions of health care, ethics consultants are *competent to offer that assistance*" (*CC2*, 19, emphasis added). The problem indirectly identified is that clinical ethics consultation is regularly conducted by individuals and teams with strikingly different training and ability, and the task force recognized a need to address the question of competence.

The report focuses on four main areas that: "(1) define the nature and goals of HCEC; (2) identify the types of skills, knowledge, attributes and emerging process standards that are important for conducting HCEC; (3) discuss the evaluation of HCEC; and (4) examine HCEC as an emerging profession" (*CC2*, 1).[9] ("HCEC" is an acronym for healthcare ethics consultation.) In the end, despite the motivating concern regarding ensuring competence in consultation, the initial report made no binding or even strongly suggested recommendations in that direction.

> The Task Force unanimously recommends that the content of this report be used as voluntary guidelines. . . . The Task Force:
> - does not wish certifying or accrediting bodies to mandate any portion of its report
> - believes that certification of individuals or groups to do ethics consultation is, at best, premature
> - does not intend for its report [to be] used to establish a legal national standard for competence to do ethics consultation . . . [*CC1*, 31].

It is likely that, in part due to this retreat at the end of the report, there has not been much in the way of professional adoption of its recommendations.[10] The stance has changed somewhat in *CC2*, from rejection to "endorsement" of using the proposed standards to hold consultants accountable. The task force recognizes "a growing demand to ensure that individuals performing HCEC are qualified to do so," "supports the ideal of having at least one individual who possesses advanced HCEC competencies among the individuals who perform ethics consultation at each facility," and "endorses holding individuals performing HCEC accountable to the standards outlined in this report" (*CC2,* 51).

I take this last phrase ("endorses holding individuals performing HCEC accountable to the standards outlined in this report") as the basis for my critique of the *CC2* document, for several reasons. First, as the task force's own declaration of its aims, it provides the means for assessing the success of the report on its own terms.[11] Second, the basis of some critiques of clinical ethics consultation is that the field is utterly without standards and a means to hold anyone accountable to them, so an articulation of such standards would provide a strong response to critics of the field. Third, I think it accurately represents what *is* part of the goal of the accountability and professionalizing movements, to establish standards for clinical ethics consultation and hold consultants accountable to them as a matter of integrity and responsibility. Finally, I think it is a reasonable statement of what *ought* to be a goal of the accountability and professionalization movements.

What is accountability? Obviously it means the ability to be called to account for one's actions or decisions, which can be interpreted internally or externally. Internal accountability would be holding oneself accountable to one's own standards (for example, a sense of personal responsibility or integrity), and external accountability means being subject to review by others. The more common understanding of accountability is the external sense rather than the internal sense, because an external standard (such as a code of ethics) provides some transparency for the practice and an important check on power without requiring us to leave standards up to individuals' views of their personal responsibility (although this does not prevent internal standards being employed in addition).[12] Therefore, the kind of accountability needed for clinical ethics consultation is one that could be enforced or monitored externally (by a professional or other organizing body).[13]

One is accountable for X if one is responsible for making X the case. So, because one cannot be responsible without being *able*, establishing accountability requires answering a question of ability. Put more philosophically, "ought implies can": it makes no sense to say that clinical ethics consultants *ought* to do something if they are not *able*. There are at least two senses of ability: ability in the sense of something being within one's capacity, and ability in the sense of empowerment. Someone needs both the competence to do something and the power of permission to do it, for us justifiably to hold her or him accountable. For example, a lawyer who is board-certified in state A may have the legal skill to try a case in state B, but is not empowered to try a case in state B in the absence of bar admission there. The reverse can also be imagined: the head of a federal agency may be empowered to act in an emergency, but lack the competence to do so effectively.

The result of this conceptual parsing is that to be held externally accountable, clinical ethics consultants must possess the competence (ability) and be granted the power to do the things for which they are to be responsible. It is worth first considering the "power" aspect of accountability to the *CC2*—that is, to be held accountable, one must be empowered to perform one's responsibilities. This is a helpful facet of the *CC2* because, to the extent that something like the report is formally adopted, this point would enable consultants to explain to their employers the range of power or permission required to perform the job effectively. That is, consultants can argue that if they are to be held accountable for offering reasonable recommendations in clinical ethics situations, it is vital to understand the facts of the case. Consultants must therefore have access to patients, their charts, and their healthcare providers to "discern and gather relevant data" and "assess the social and interpersonal dynamics of the consultation" (*CC2,* 22). The interference (active or passive) by an institution or employee with this process results in a situation where consultants cannot be held accountable because their pursuit of their task is being obstructed. Several professional work conditions follow—for example, as part of their professional role, consultants should have a reasonable purview to ask relevant questions without censure, or to request meetings even with busy providers in the reasonable expectation that the request will be honored.

The importance of this should not be minimized; consultants simply cannot perform effectively in an environment in which the administration does not make it possible for such steps to be taken. Consultants frequently observe that the initial reason stated for an ethics consult (for example, "refusal to withdraw care") is not what turns out to be the actual issue; consultants must be granted the latitude to probe for further information to ascertain what the problem actually *is*.

On the other hand, for consultants to be able to be held accountable entails that it is actually possible to be held accountable to the standards. The problem with some of the standards articulated in the *CC2* is that consultants may literally not be able to comply with them, because they are vaguely stated or ill-defined, as I argue below.

PROBLEMS WITH ACCOUNTABILITY

To reiterate, the *CC2* "endorses holding individuals performing HCEC accountable to the standards outlined in this report" (*CC2,* 51). The task force thus identifies accountability as an important aim, and endorses holding consultants accountable, but offers no conception of what an accountability process or official body for monitoring this would be. This is a trivial problem, because one document is not necessarily meant to serve every purpose. Whatever body is set up to help govern the profession, the task force might endorse, as one aim of the governing body, taking the competencies articulated in the *CC2* to be the basis of a formal process or structure of accountability. The document need not itself specify how this is to be done. However, other problems render it difficult to envision holding consultants accountable to this set of standards.

Practical Problems

An initial puzzle is, which among the many suggestions in the *CC2* are held to be the accountability standards? For example, one standard of accountability might be whether or not consultants achieve the *CC2's* stated goals for consultation: to "identify and analyze the nature of the value uncertainty or conflict that underlies the consultation" and "facilitate resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of all involved" (*CC2,* 3). Other duties are also outlined: "the consultant should notify the involved parties that . . . they may be obligated to report egregious violations" (*CC2,* 4-5), although what constitutes an "egregious violation" is not defined; consultants should not use either the "authoritarian" (authoritatively telling patients what to do) or "pure consensus" (seeking mere agreement) approaches to consultation (*CC2,* 6-7); consultation services should formulate a "thorough and systematic process" for consultation (*CC2,* 12); et cetera. A more likely (but not certain) conclusion is that the accountability standards the task force had in mind are only the competencies themselves, which are summarized in the three categories of skills, knowledge, and attributes (*CC2,* 19). A further ambiguity there, however, is whether only the competencies listed in tables 2 and 3 (*CC2,* 25, 27) should be used for accountability purposes, or instead the more comprehensive (and very long) lists in section 2.2-2.4 (*CC2,* 22-33)? My intention is not to analyze any of these particular suggestions, merely to illustrate that there are many potential accountability standards, depending on which are taken to be most important. This is not a trivial point, because a minimum condition of holding individuals accountable to a set of standards is that one is able to articulate exactly what those standards *are*. As a result of these ambiguities, I will take a relatively narrow interpretation of "standards" as referring only to the tables 2 and 3 in *CC2*, so that I do not attribute more to the report than was intended.[14]

Even then, there are practical problems. The task force acknowledges that consultations can be performed by individual consultants, teams, or committees, and points out that "This Report thus identifies the competencies of a clinical ethics consultant who may function alone . . . as well as the minimum competencies of the *ethics consultation service* (if being provided by a group of individuals who do not each possess all the minimum required competencies outlined in this Report)." (*CC2,* 19, fn 46). In the individual model, who will be held accountable is straightforward, but if the *service* fails to meet the minimum competencies, who will be held accountable? The chair? The institution? Each member? Presumably something like this can be worked out in the details, but it bespeaks a failure to consider just how accountability to the *CC2* might actually work.

Problem of Definition

One main problem with the *CC2* is that it is difficult to establish standards of accountability when a key term, "ethical," (this also includes the variants "moral" or "value") is both undefined and subject to radical disagreement. The problem is compounded, as I articulate below, because it is not clear which standards we should take as the appropriate accountability standards.

The idea that consensus exists regarding what constitutes an "ethically acceptable" choice in a clinical ethics consultation is patently absurd, and, if it were true, it might mean much less work for clinical ethics consultants than is presently enjoyed.[15] Such a consensus does not exist, and *CC1* directly addressed the worry that credentialing standards in consultation might enforce a single moral view: ". . . certification could lead to the institutionalization of a particular substantive view of morality, a certain view of the relation between ethical theory and practice, or one conception of the relative importance of skills that are important for ethics consultation" (*CC1,* 31). Yet in the *CC2*, the recapitulation of that point reads as follows: "Accrediting graduate programs to train ethics consultants to conform to established standards, it was thought, could promote a myopic view of the theory and practice of ethics consultation" (*CC2,* 51). It is the conclusion of the task force that these barriers are no longer

problematic, yet the point about the danger that certification "could lead to the institutionalization of a particular substantive view of morality" is simply dropped without acknowledgment. There are reasonable arguments that consensus exists on *some* issues in clinical ethics consultation, such as the need to obtain consent to treatment for a competent adult patient, which could form the basis for such a claim. Those arguments have not been offered in the *CC2*, which means it would be very difficult to hold consultants accountable for recommending or sanctioning an "ethically unacceptable" choice that wasn't also (like consent) a legal requirement (in which case, the accountability derives from existing laws, not necessarily from the *CC2* or existing moral consensus). Overall, the *CC2* relies on an implicit notion of what constitutes an ethical solution to a clinical ethics problem, which means that although consultants are held accountable to the standard of offering ethical recommendations, what that means—and therefore how to identify when it has been achieved—is radically open to interpretation.

A further problem involves the point made above regarding which standards—the tables or the longer lists in the report—are meant to be the standards of accountability. Relying solely on the tables is somewhat less problematic, because most of the skills listed there direct consultants to act on relatively straightforward tasks such as "identify the nature of the value uncertainty" (*CC2,* core skill A-1, 25), which may only require establishing what is at issue. On the other hand, if the longer lists are meant to give concrete help in applying the competencies listed in the tables—if they are amplifications and clarifications of the more succinct, tabulated skills—there are more significant problems. For example, in the longer lists, *CC2* recommends that among the appropriate tasks of the ethics consultation service is "apply relevant ethical considerations," and "identify and justify a range of ethically acceptable options" (*CC2,* 23). The glaring question is, what constitutes a "relevant ethical consideration" or an "ethically justifiable option?" According to which standards is something rendered "ethical"? Is the fact that a patient belongs to a religion that requires submission to a recognized authority (husband, minister, church elder) a "relevant ethical consideration" requiring a solution, for example, or is it instead an exercise of autonomy? Must a consultant who opposes abortion consider it to be and present it as an "ethically justifiable option"? The reliance on an unspecified notion of "ethical" means that although consultants might be held accountable for offering only "ethically justifiable" solutions, what counts as "ethically justifiable" is at the discretion of the consultant, a particularly problematic notion if the field is trying to establish practice standards for external accountability. Or, if it is not at the discretion of the consultant, the unstated premise here is that there is enough consensus over what lies within the range of "ethically acceptable" that no more needs to be said. Because the standards of what counts as "ethical" or "moral" are not possible to interpret from the *CC2*, both because the terms are undefined and because of uncertainty regarding what should be taken to be the proper accountability standards, consultants would be responsible for something they cannot identify. We should not endorse holding consultants accountable to such nebulous standards.

OTHER PROBLEMS

I have been arguing that the *CC2* fails to offer tenable standards of accountability, which is one of its stated goals and ought to be the goal of a document such as this. However, it is also worth considering what has been omitted from the *CC2* that perhaps should have been addressed.

One omission is that it does not address impermissible practice or behavior. There are sections on conflicts of interest and obligation, as well as confidentiality (*CC2,* 48-49), but no accountability standards for refraining from such practices.[16] It might have been worthwhile to establish some boundaries of permissible behavior, both because that would provide transparency regarding how others should evaluate consultants' practice, and because it would be relatively straightforward to assess adherence

to a proscription. For consultants concerned with the integrity of their practice, as much as for critics, it is important to be able to articulate standards of inappropriate behavior or action in the conduct of clinical ethics consultation.

Another problem is that the *CC2* verges on equivocating on the notion of "standards." The *CC2*, much like the initial *CC1*, seems to describe current practice in an effort to standardize it. Yet obviously standardizing (making things uniform) isn't the same as setting standards (establishing limits of acceptable behavior). For example, Core Skill I-2 states, "Educate involved parties regarding the ethical dimensions of the consultation" (*CC2,* 25). If all consultants were to follow this standard, then we might see that consultants *uniformly educate involved parties* (the practice of education has therefore become standardized). Yet one consultant may educate an involved party that abortion is impermissible, and another that it is permissible. I think that what critics of the field worry about is the latter point (the lack of consistency of ethical advice in consultations—that is, what ethical standards ought to be met), not whether or not all consultants are educating involved parties. The very general categories of the competencies (for example, "effectively run an HCEC service," "elicit the moral views of the involved parties," and "utilize institutional structures and resources to facilitate the implementation of the chosen option") (*CC2,* 25, table 2), may ensure that all consultants know about and attend to the same general categories of their practice. However, absent a metric of success, these and other *Core Competencies* do not establish a practice *standard*.

This is problematic for two reasons: first, as I have been arguing, it is difficult to hold consultants accountable to vague standards. Second, critics might observe that what the field needs to engender trust is a way to identify when practitioners have not lived up to the standards that should be expected, and a mere description of general categories of practice does not satisfy this need. *Standards* are much more normatively forceful than are standardized categories. For standards of practice to succeed in establishing the field's integrity, it is important both that non-practitioners be able to ascertain whether consultants have acted inappropriately, and that practitioners be able to point to standards to defend an appropriate but unpopular action or recommendation. This will be difficult with the standards recommended in the *CC2*.

CONCLUSION

What becomes clear with an evaluation of the *CC2* is that it is a chiaroscuro: it attempts, through the use of light and shade, to suggest depth and solidity where none obtains. The standards of accountability it proffers are too vague and ill-defined to be of help in ensuring the competence of clinical ethics consultants. This does not mean that the field has no integrity, or that the *CC2* does not move forward the discussion of holding consultants accountable. The *CC2* accommodates a great deal of diversity under one umbrella, and with 14 authors (six less than the *CC1*), there is more than a whiff of compromise. This is understandable at the beginning of a profession, but we should not pretend the results are more robust than they are.

NOTES

1. R.M. Arnold et al., *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, Ill.: American Society for Bioethics and Humanities, 2011). Hereafter, *CC2*.

2. Another significant aspect of this change is the economic pressure that attends the inception of a new, salaried occupation: is it worth the money? Or, if it to be a financially losing proposition, do its corollary benefits make that a worthwhile exchange? Since that evaluation will be made by the employer, and will be based on multiple considerations, investigating this aspect is beyond the scope of this article. However, it is intriguing to think about how this might intersect with the criteria of evaluation. Consider one scenario: a healthcare institution has assessed the usefulness of clinical ethics consultation at its facility, and has established that it is a net cost-saving mechanism. It might willingly employ

clinical ethics consultants regardless of whether there are established standards of behavior, certification, training, et cetera. On the other hand, consultants could be trained and certified appropriately, yet find no one willing to hire them because the economic calculation doesn't recommend hiring consultants. In such a case, what might incline the institution to hire consultants is when it faces external pressure (for example, the Joint Commission requirement to have a mechanism in place for addressing ethical issues; a legal precedent in which the presence of an ethics consultation service mitigates risk; or public pressure of a more amorphous sort), which the presence of a clinical ethics consultation service relieves. Because these kinds of pressure surely exist, the field must consider how to guard against their inappropriate effects. I have considered the implications of data suggesting clinical ethics consultants are net cost saving in L. Rasmussen, "Sinister Innovations: Beward the Cooptation of Clinical Ethics Consultation," *Journal of Values Inquiry* 40 (2006): 235-42.

3. R. Baker, "A Draft Model Aggregated Code of Ethics for Bioethicists," *American Journal of Bioethics* 5, no. 5 (2005): 33-41.

4. N.N. Dubler, M.P. Webber, D.M. Swiderski, and the Faculty and National Working Group for the Clinical Ethics Credentialing Project, "Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation," *Hastings Center Report* 36, no. 6 (2009): 23-33.

5. R.M. Arnold et al., *Core Competencies for Healthcare Ethics Consultation* (Glenview, Ill.: American Society for Bioethics and Humanities, 1998). Hereafter, *CC1*.

6. ASBH, "Committee Charter," *http://www.asbh.org/about/content/committees.html*, accessed 16 April 2012.

7. Standards of accountability could serve as the basis for further steps towards professionalization, but need not; a separate argument must be offered for why the field should pursue professionalization.

8. Hereafter, references will be to *CC2*, unless otherwise specified.

9. The relevant text of the *CC1* is nearly identical:

> (1) define the nature and goals of ethics consultation (that is, what ethics consultation ought to be and aim to achieve); (2) identify the types of skills, knowledge, and character traits (core competencies) that are important for conducting ethics consultations; (3) address the emerging area of organizational ethics consultation; (4) discuss the importance of evaluating ethics consultations; and (5) underscore some of the special obligations of consultants and institutions.

(*CC1*, 1). Apart from the terminological change from "ethics consultation" to "healthcare ethics consultation," there are four features of the revised text worth noting:

(a) In point #2, "attributes" has replaced "character traits." A cover letter issued with the initial draft of the *CC2* notes that this was merely a terminological change, better to reflect standard language in the health professions.
(b) Also in point #2, the phrase "emerging process standards" has been added. Section 1.2 (*CC2*, 10) focuses on these, stating that "certain process standards have become widely accepted as necessary for high-quality ethics consultations." (No support for the claim of wide acceptance is offered.)
(c) The former #3 (regarding organizational ethics) has been dropped. The cover letter notes that the report's treatment of clinical ethics and organizational ethics has been merged: "The 2nd edition no longer recognizes 'clinical ethics' and 'organizational ethics' as distinct entities. The decision was made to eliminate this distinction because of both the wide divergence of opinion regarding the meaning of these terms, and recognition of the increasing trend to integrate ethics throughout an organization."
(d) The final point on the list (#5 in *CC1* and #4 in *CC2*) has changed from "underscore some of the special obligations of consultants and institutions" to "examine HCEC as an emerging profession."

The main differences here seem to be that a longer list of concerns is offered in *CC2*, and the special section on "Institutional Obligations to Patients, Providers, and Consultants" seems to have been incorporated into this section.

10. However, at least two graduate programs advertise their use of the *CC2* as part of the curriculum. The Alden March Bioethics Institute, located at the University of Albany, offers this description of its "Master of Science in Bioethics, Concentration in Clinical Ethics Consultation" curriculum: "[this program] is designed to provide advance training and supervision in the American Society for Bioethics and Humanities (ASBH) educational core competencies and skills." *http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/degrees_certificates/master_science_bioethics.html,* accessed 7 March 2012.

The Bioethics Program at Union Graduate College at the Mt. Sinai School of Medicine describes its degrees similarly: "Two Master of Science programs—an MS in Bioethics and an MS in Bioethics: Specialization in Research Ethics—are designed to meet the needs of working professionals, comply with the requirements of national accrediting and funding agencies, and impart the skills and knowledge recommended by the American Society of Bioethics and Humanities." *http://www.bioethics.union.edu/p-online_Bioethics_MS_Masters_Program.htm*, accessed 7 March 2012. Of course, the use of the *CC2* by these two graduate programs has no necessary bearing on the field, since no degree is required to practice clinical ethics consultation in the first place.

11. E. Bedford, "The Core Competencies: A roman catholic Critique," *HEC Forum* 23, no. 3 (2011): 147-69

12. Reliance solely on an internal standard would also pose two particular problems for clinical ethics consultation. First, internal standards of accountability border on paternalism (an early bête noir of the field), if by that means a consultant could justify acting on her or his own moral views rather than those of the patient. The momentum in bioethics has resolutely been towards providing stakeholders with information relevant to making their own moral choices. What would be made of clinical ethics consultation if it determined that consultants should rely on their own private notions of accountability when bioethics regularly admonishes physicians and others who might forward such a version of accountability in their own field? Second, precisely because what clinical ethics consultants do is value-laden, and because in most places where it is practiced, moral pluralism is the norm, the field must make the values on which it operates transparent. Internal accountability provides no such transparency, so while individuals should always hold themselves internally accountable, this alone does not suffice for purposes of publicity and transparency.

13. What is true in other fields is also true of clinical ethics consultation: there is always the potential for tension between one's personal moral system ("internal accountability" in this discussion) and one's professional moral obligations ("external accountability"). This is but one species of the genus "moral dilemma," and I do not have a solution for it. But it is worth noting the potential tension between these two systems, and I thank an anonymous reviewer for *JCE* for prompting me to do so.

14. Obviously, then, if "standards" are meant to apply to recommendations besides the competencies in table 2, there may well be other problems with accountability to the *CC2* than those articulated here. In addition, the relationship between the competencies listed in the tables and the longer lists of skills in sections 2.2-2.4 is unclear: when interpreting the competencies in the tables, are we to rely on the longer explanations as mere suggestions, or as amplifications of how the competencies should actually be understood?

15. That is, if one of the main reasons for a clinical ethics consultation is to help resolve ethical disagreement, then presumably the more that people tend to agree on moral values, the less cause there might be for an ethics consultation. (Obviously, there are other reasons for consultations that would remain salient.) As an example of the claim that there is not a universally accepted set of moral values, consider Elliot Bedford's article on the *Core Competencies*: Bedford sets out a robust example of a set of ethical standards—the Roman Catholic faith and its *Ethical and Religious Directives for Catholic Health Care Services*—that are in tension with the claim that there is consensus on ethically acceptable options. Bedford, see note 11 above. And of course, we need not limit the source of dissensus to religious beliefs.

16. I have argued elsewhere for this "side-constraint" or proscriptive approach to standards in clinical ethics consultation. L. Rasmussen, "An Ethics Expertise for Clinical Ethics Consultation," *Journal of Law, Medicine and Ethics* 39, no. 4 (2011): 649-61.