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Credentialing the Clinical Ethics Consultant: An Academic Medical Center Affirms Professionalism and Practice

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ABSTRACT

In response to national trends calling for increasing accountability and an emerging dialogue within bioethics, we describe an effort to credential clinical ethicists at a major academic medical center. This effort is placed within the historical context of prior calls for credentialing and certification and efforts currently underway within organized bioethics to engage this issue. The specific details, and conceptual rationale, behind the New York-Presbyterian Hospital's graduated credentialing plan are shared as is their evolution and ratification within the context of institutional policy. While other programs will design their credentialing schema consistent with their local context and demographics, the description of one such effort is offered to be instructive to others who want to bring additional standardization to the assessment of the readiness and credentials of those who will engage in the practice of clinical ethics case consultation.

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INTRODUCTION

In the past several years the clinical ethics community has begun to address the issue of credentialing and certification of hospital ethics consultants as well as the accreditation of clinical ethics programs. Although the pace of this movement is slow, and resistance remains to credentialing and certification in some quarters, it appears that these trends are inevitable. In an era calling out for more standards, qual-

ity, and accountability, it no longer seems tenable to allow clinical ethicists to be one of the very few *practice* disciplines for whom qualification standards fail to exist. It is our considered view that it is only a matter of time before clinical ethics consultation is recognized as a professional activity requiring a delineation of qualifications, training, and experience that is commensurate with the significance of the activity. Both trends in medical liability and the patient safety movement would tend to point to the establishment of standards that, at a minimum, promote patient safety and establish a community standard of practice.

Although outside forces have yet to make a call for such standardization of practice and credentialing, we believe that drawing attention to this need *from within the field* is part of the self-regulation that is the mark of professionalism. We believe that our local efforts and those contemplated by organized bioethics[1] will draw the attention of stakeholders like patients, payers, and regulators. While this move towards standardization of practice, via a credentialing or a certification process, might be viewed as self-serving and a means to exclude others from this task, we assert that the performance of ethics consultation is morally weighty and clinically significant and should be viewed as a privilege reserved for those who are qualified to perform the task with consistency and integrity.

In this article we do not address these broader questions in depth, but confine ourselves to our part of this evolutionary process. We describe how one institution, New York-Presbyterian Hospital (NYPH), at its Weill Cornell and Columbia Presbyterian campuses, initiated a credentialing process for clinical ethicists that was approved by its medical board. We delineate the credentialing criteria upon which we reached a consensus, and the process by which these standards were ratified by the hospital's medical board.

We believe these local efforts can help inform the national debate on credentialing and certification, and that this intermediate step towards a more formal board certification process has the virtue that it can be modified and replicated elsewhere, in the short term, by hospitals interested in bringing a degree of standardization and accountability to this clinical practice.

BACKGROUND

Lest we confuse the discussion, it is important to clarify the distinction between credentialing and certification. A *credential* is some evidence of qualification, for example, a diploma, certificate of course completion, professional license, or an official letter attesting to completion of a course of study or training program. In the hospital setting, credentialing refers to a local, institutionally based review process to determine if an individual has the required qualifications and experience to undertake a particular role or engage in specific activities.[2] If the requirements are met, the institution grants permission, or the privilege, to perform those duties within that institution. This credential is not transferable and only pertains to the individual's home institution, which documents, and at the same time delimits, through a "delineation of privileges," one's scope of practice.

In the context of healthcare, *certification* is formal recognition that an individual satisfies established competency standards, and this is most often taken to mean medical specialty certification, a *national* review process to assess if an individual has the required knowledge, skills, and experience to undertake a particular role and engage in specific activities.[3] This process usually involves a psychometrically validated written examination offered by a specialty board recognized by the National Board of Medical Specialties. Unlike the credentialing process that occurs within an institution, certification is recognized across institutions as a uniform indicator of a minimal degree of competency within a specified domain. Institutions needing to credential an individual for service can utilize this validated and standardized assessment.

HISTORICAL ANTECEDENTS

In the past two decades, there have been a number of preliminary efforts to advance the credentialing and certification of clinical ethi-

cists in the wake of the 1991 standards published by the Joint Commission for Accreditation of Health Care Organizations (JCAHO, now the Joint Commission), requiring that hospitals provide a mechanism for resolving moral dilemmas that arise in the care of patients. Among early proponents were John La Puma and David Schiedermayer, who, in the early 1990s, described the consultant as one who should have years of broad clinical experience and education in the humanities, healthcare law, and moral reasoning.[4] Adapting a medical model, they called for the certification of ethics consultants as an outgrowth of medical licensure for what they described as a "field of expertise in healthcare rather than a separate field, discipline or profession."[5] Also in response to the then-new JCAHO standards, La Puma and Priest presciently suggested standardized criteria for privileging consultants to perform consults as one strategy to promote patient safety.[6]

Fletcher and Hoffman, writing about the widespread establishment of ethics committees, proposed the development of standards for education, training, and consultation in 1994.[7] They noted that ethics committees and consultants were directly influencing decisions regarding the care of patients, including futility disputes and rationing debates, often without having established consultation goals, procedures, or educational requirements. Many other ethicists at the time weighed in on these and related issues, notably Giles Scofield, who argued against the professionalization of clinical ethics, and recommended that clinical ethicists assume the role of educators rather than consultants or mediators.[8] This produced a number of responses challenging his assumptions and proposing alternate views.[9]

The *Core Competencies for Health Care Ethics Consultation,* published by the American Society for Bioethics and the Humanities (ASBH), a product of many years' effort originating with the Standards for Bioethics Consultation Task Force of the Society for Health and Human Values and the Society for Bioethics Consultation, was an important step forward in identifying the ethical issues involved and the skills necessary to conduct ethics consultation—an essential step toward standardization. According to the *Competencies*, a knowledge base should include: moral reasoning and ethical theory, common bioethical issues and concepts, healthcare systems, the local healthcare institution and its policies, the beliefs and perspectives of the local patient and staff population, relevant codes of ethics and guidelines of accrediting organizations, and relevant health law.

According to the *Competencies,* a skill set should include: ethical assessment, process, and interpersonal skills. However, in response to the widely divided perspectives among experts on qualifications and training, the report itself strongly cautioned against certification and accreditation, and stressed that such competencies were "voluntary guidelines."[10]

The critique against credentialing and certification has been quite robust in some circles. Until recently, calls for credentialing have been met with suspicion and concern. Some feared that formalizing qualifications would undermine the diversity of disciplines and limit the perspectives that are now valued in ethics consultation. Others feared that some consultants might not meet new standards; some worried that formalization of standards would mark a drift from ethics into regulation and the law, with consultants fulfilling the role of healthcare lawyers, administrators, and risk managers, with little "ethics" involved.[11]

Among the critics was Nancy King, who responded in 1999 to the *Core Competencies* by asserting that they were the "First step towards a now-inevitable certification scheme," noting, "I fear reduction in the diverse pathways to skill and knowledge that have been the hallmark of bioethics and the medical humanities. I also fear our institutionalization, 'capture,' and homogenization."[12] Jeffrey Spike and Jane Greenlaw pointed to the difficulty of determining training requirements in an interdisciplinary field, and recommended that consultation teams at tertiary care hospitals include a physician, an attorney, and a PhD philosopher or ethicist.[13]

As clinical ethics evolved, some began studying the related questions of credentialing and certification with an eye towards the development of standardization of practice and

establishment of workable norms. An important contribution by the Veterans Health Administration National Center for Ethics in Health Care was a survey of ethics consultation programs by Ellen Fox and colleagues. Published in 2007 in the *American Journal of Bioethics,* this survey of more than 500 hospitals depicted clinical ethics consultation (CEC) as a discipline in need of standards and as wholly unregulated.[14] The data were alarming; the authors noted, "When extrapolated to all general hospitals in the United States, these data suggest that in a one-year period approximately 29,000 individuals devoted more than 314,000 hours to performing more than 36,000 ethics consultations." Consultants came from a range of disciplines (34 percent physicians, 31 percent nurses, 11 percent social workers, 11 percent chaplains, 9 percent administrators) and had little or no training. The authors reported, "Only 5 percent had completed a fellowship or degree program in bioethics; 41 percent had been trained by direct supervision of an experienced ethics consultant, and 45 percent had learned independently, without supervision."

The implication, to many, was that certification and accreditation, although potentially flawed, were preferable to permitting tens of thousands of consultants to perform a massive number of consultations without the training and expertise expected in any other discipline that was so central to the welfare of patients and families, and so important to the ethos of clinical relationships.[15] In a commentary in the same issue of *American Journal of Bioethics,* Nancy Dubler and Jeffrey Blustein voiced such concerns; they emphasized the urgency of professionalizing the training and practice of CEC and presented recommendations for credentialing standards in hospitals. Among them was participation in a formal bioethics training program and an apprenticeship that included the observation of skilled consultants, the conduct of consultations under direct supervision, and attendance at ethics committee and/or consultation debriefing meetings.[16]

In 2009, an issue of *HEC Forum* was devoted to the subject of ethics consultant credentialing and/or certification. Most of the commentators supported the need for some type of standards and quality measures, noting that too many hospitals relied on unskilled consultants. Anita Tarzian observed that momentum was building to professionalize CEC, and methods for demonstrating competency were needed.[17] Kenneth Kipnis proposed an agenda for the newly established Clinical Ethics Consultation Affinity Group (CECAG) of ASBH to work towards developing practice standards.[18]

Taking a different tack and looking at the institutional context, Jeffrey Spike proposed the accreditation of training programs, rather than the certification (through examination) of individuals. He spoke to the necessity of a broad education and experience that goes beyond the individual's degree field or primary specialty, in order to address the interdisciplinarity of clinical ethics.[19] However, Jeffrey Bishop and colleagues provided a "dissensus report," arguing that efforts of standardization, akin to an evidence-based model, prize process and consensus over content, thereby diminishing differences and dissent.[20] Brian Childs, in an editorial, agreed that there should be standards, but also expressed concern that the heterogeneity of ASBH members and clinical ethics consultants would be lost through certification efforts.[21] Like Spike, he believed the best healthcare ethics consultants (HECs) "have an awesome multiplicity of skills from legal scholar, psychologist, healer, philosopher/theologian, case manager to friend and confidant."[22] H. Tristram Engelhardt, Jr., however, viewed credentialing as a self-serving request by healthcare employees who do not actually engage in ethical decision making, seeking job security.[23]

In contrast to such objections, Nancy Dubler and colleagues continued to champion the need to professionalize the consultative process with the establishment of the National Working Group for the Clinical Ethics Credentialing Project in 2008.[24] These leaders in the field produced a consensus statement on CEC standards, evaluation, and credentialing measures, published in 2009 in the *Hastings Center Report.* They recommended that the JCAHO requirement that "professionals who intervene in patient care have their required qualifications and

competency defined and periodically evaluated" apply to ethics consultants and suggested that institutions should address a myriad of questions, including:

- How often, and by what means, will qualifications be assessed?
- Might consultants be able to write in medical records and be insured without formal credentialing?
- Would credentialing affect the institution's bylaws?
- Should the CEC program be a separate clinical department?
- How will previous informal experience and ongoing learning be supported and monitored?

They also stressed the importance of a quality improvement process, and developed a tool to be used for retrospective analysis of medical record documentation as well as education. In addition to recommendations for specific processes for consultation, medical record documentation, and institutional oversight, the group proposed that institutions require particular qualifications for clinical ethics consultants (CECs) that expanded on their earlier recommendations of formalized training programs and apprenticeship.

The ASBH Clinical Ethics Consultation Affairs Committee (CECA), established in 2009, set curricular standards for clinical ethics educational programs as a first step in delineating an acceptable fund of knowledge for CECs. Work in progress includes vetting a code of ethics for CECs as a necessary step toward professionalization, and the exploration of funding to support certification.[25]

Perhaps the most evolved of these efforts were from Martin Smith and colleagues at the Cleveland Clinic, who proposed a detailed process for the certification of CECs in a 2010 article in *JCE*.[26] They suggested a four-step process to assess an individual's skills and knowledge based on the ASBH *Core Competencies,* led by experienced and accomplished CECs: (1) written examination to assess knowledge, (2) evaluation of a case portfolio to determine consultative experience, (3) case simulations with standardized patients to assess interpersonal and communication skills, and (4) an oral examination to assess integration of skills and knowledge, and role identity.

The authors pointed out that an advantage of their proposal is that certification would not be dependent on a particular educational program or type of training, thereby recognizing the diversity of backgrounds, academic pathways, and experiences available to the would-be CEC.

THE NYPH CREDENTIALING PLAN

One of the authors of this manuscript (JJF) was a member of Nancy Dubler's National Working Group for the Clinical Ethics Credentialing Project, and his involvement in those deliberations motivated this effort to formalize a credentialing process at NYPH, a multi-site hospital with two medical schools: Cornell University's Weill Cornell Medical College (WCMC), and Columbia University's College of Physicians and Surgeons (CUMC). Formerly two distinct hospitals and medical centers, the New York Hospital-Cornell Medical Center, located on the upper east side of Manhattan, and the Columbia Presbyterian Medical Center at the northwest tip of Manhattan, the institution was formed by a merger in 1998 to become the largest not-for-profit, nonsectarian hospital in the country, with 2,353 beds.[27]

Within NYPH there are two directors of medical ethics (DMEs), JJF and KP, and three chairs of ethics committees, JJF, KP, and GEH (see statements of the authors' affiliations). The total number of formal consults in 2011 was 420 (WCMC: 235, CUMC: 185).

After reviewing this literature, we set out to define key qualifications relating to the level of responsibility assumed by CECs. We used a graded approach to consultative work that reflected the current attending model structure of the hospital, in which there is a progression from an assistant attending physician, to associate, to full attending status (table 1). We also decided, despite the use of a medical model in structuring a tiered level of responsibility, to be fully ecumenical in broadening access to the consultative role to professionals within and

outside medicine. We felt strongly that CECs could—and should—hail from a range of disciplines and that such interdisciplinarity reflected the richness of bioethics and strengthened the deliberative process that is essential to reaching an ethically sound consensus.

In our plan, CECs would receive a hospital appointment upon (1) the recommendation of their DME and (2) endorsement by the chair of the clinical or academic department where they had a pre-existing appointment. The recommendation by a DME for a hospital appointment would be approved by the medical board of the hospital. All CECs would have a minimal set of core qualifications, including a clinical license or the completion of a clinical ethics fellowship if they were not a clinical practitioner. (The question of standards for bioethics training programs is currently being considered by the Association of Bioethics Program Directors.)[28]

We required this degree of *clinical* training for consultants who were not coming out of one of the clinical disciplines because the nature of a CEC's interactions with team members, patients, and families is informed by clinical knowledge. A strong clinical background is essential, not only to understanding the clinical nuances upon which ethical judgments often rest in the hospital setting, but to be credible with clinicians who ask for assistance. As a result, consultants who are not trained as clinicians are required to have significant clinical experience and knowledge, criteria most likely satisfied by a fellowship in clinical ethics.

Assistant Clinical Ethicist

Entry level criteria for an assistant ethics consultant include a master's degree, more than 25 hours of bioethics education, and more than 25 supervised ethics consultations. A candidate's graduate degree can be in any discipline, including a range that spans the humanities, sciences, and social sciences. The more specific bioethics educational requirements can be met through exposure to an array of relevant disciplines including law, philosophy, religion, conflict resolution, et cetera, and could be met by formal course work, continuing education courses, or regular attendance at ethics committee meetings, and so on. Whatever the mix, the experiences, must be documented (table 1).

The required supervised consultative experience could be met by active participation in CEC as a training program student, apprentice, or member of a consultation team. Verification—for example, a letter from a program director or supervising consultant—is required.

Once credentialed, an assistant clinical ethicist may participate in or conduct case consultation under supervision. The level of supervision is at the discretion of the supervisor, and may entail ongoing and in-person participation for all telephone calls, medical record review, and team or family meetings; discussion of the case at critical periods; or any combination of in-person and periodic review. All assistant consultant documentation in the medical record must be co-signed by a supervising consultant. In addition, the assistant consultant will participate in the teaching of medical ethics to medical students, clinicians, and staff.

Associate Clinical Ethicist

An associate ethics consultant must have a terminal degree or more than five years of clinical experience doing consults, more than 50 hours of bioethics education, and more than 50 supervised or independent ethics consultations. He/she must have bioethics teaching experience at the medical or graduate level (table 1). Once credentialed, he or she may conduct *independent* consults, supervise an assistant clinical ethicist, and engage in educational activities.

Senior Clinical Ethicist

Senior clinical ethicists must have a terminal degree as well as 10 years of experience doing independent consultation and must have engaged in independent scholarship. They must have performed more than 250 independent adult or more than 100 pediatric consults for this designation, in either the adult or pediatric sphere. Individuals who desire a joint senior appointment would need to document the aforementioned number of consults in their home area of competence and one-half as many consults in their secondary area. For example, a senior adult clinical ethicist desiring to gain

joint senior status would need to perform more than an additional 50 pediatric cases (table 1).

This degree of stringency at the senior level is to establish a position commensurate with a high academic rank, comparable to an associate or full professor in a university setting, positions obtained within seven to 10 years.

Director of Medical Ethics

Senior clinical ethicists are entitled to conduct and/or supervise all consults and are alone eligible to serve as DME. DMEs are appointed by the medical board to chair the hospital ethics committee and oversee and review the credentials of all CECs (table 1).

Comments on Criteria

The required numbers of educational hours and consultations is based on our own experiences and discussions with our NYPH consultant colleagues. We determined the number of consults by speaking among ourselves and our trainees and reviewing their experiences developing progressive competence with consultative work. For example, we considered the experience of a former member of the WCMC division of medical ethics. An internist, she had completed the Montefiore/Einstein Certificate Program in Bioethics and Humanities before coming to our institution, and had chaired the ethics committee and conducted ethics consultations at a smaller community hospital. She said she felt a level of proficiency and independence at our institution after about 200 consultations.[29] At that point she was confident that if she felt the need to consult with a more senior ethics consultant on a particularly difficult case, the senior consultant would also be challenged by the dilemma at hand. Other respondents described reaching a similar point in their skillset at that range of consults.

It is important to note that these numbers are not scientifically determined but based on our consensus views; supervision is essential in knowing when consultants are ready for the next level of independent work. Individuals must demonstrate proficiency with problem solving, collaboration with faculty and staff at all levels, and conflict resolution involving a broad range of value-laden issues before being

TABLE 1. CEC credentialing at NYPH

Core qualifications:
- Clinical license and/or clinical ethics fellowship training
- Eligible for faculty appointment in clinical department

Additional qualifications for:

Assistant clinical ethicist
- Masters degree or higher
- Bioethics education >25 hours
- >25 supervised consults
- Credentialed activities:
  - — Supervised consultations
  - — Ethics education

Associate clinical ethicist
- MD, PhD, JD, or other terminal degree (or >5 years CEC experience)
- Bioethics education >50 hours
- >50 supervised or independent consultations
- Bioethics teaching experience at medical or graduate level
- Credentialed activities:
  - — Independent consultations
  - — May supervise assistant clinical ethicist
  - — Ethics education

Senior clinical ethicist
- MD, PhD, JD, or other terminal degree
- 10 years independent consultations
- Independent scholarship
- Credentialed activities:
  - — Independent consultations
  - — Supervise all levels
  - — Ethics education

Senior (adult)
- >250 independent adult consultations

Senior (pediatrics)
- >100 independent pediatric consultations

Senior (adult & pediatrics)
- >250 adult and >50 pediatric or >125 adult and >100 pediatric

Director of medical ethics
- Physician
- Must be senior clinical ethicist
- Appointed by medical board
- Credentialed activities:
  - — Chair of ethics committee
  - — Reviews credentials; makes recommendations for appointments to medical board

considered for privileges.

Consensus and Approval Process

Once the three campus DMEs agreed on the proposal, it was shared with the NYPH's senior vice president for patient services, who approved the presentation of the proposal to the credentialing committee of the NYPH medical board. The proposal was well received by the committee, but one member noted the disparity of requirements between adult and pediatric consultants.

The relative difference between the numbers of consults required for pediatric versus adult senior status had already posed a challenge for the three DMEs. Initial suggestions for numerical parity neither cohered with the far fewer cases seen in pediatrics as compared to adult medicine, nor with case variation. Although our combined campuses performed 22 pediatric consults in 2011, a survey of children's hospitals reported by Jennifer Kesselheim and colleagues in 2010 found that 70 percent of the largest freestanding children's hospitals did 10 or less consults per year.[30] In addition to the small absolute number of cases performed, there was less variation in the types of cases for which consultation is requested. These factors suggested the need for fewer required cases for senior ethicist to be qualified in pediatrics.

But questions remained: How were we to determine the threshold for pediatric proficiency when there were fewer consultations? Would a lesser requirement for pediatrics erroneously suggest consultative work there was devalued, compared to work done in the adult context? While we appreciated that other institutions might reach different conclusions, we sought a local answer drawing on historical data. Depending on their degree of engagement, adult consultants might do 125 to 500 cases in five to 10 years, while a pediatric consultant might do 50 to 100. We were also influenced by the need to have a requisite overall amount of experience, no matter the pediatric prevalence to approximate the experience of adult consultants. For this reason, we do not distinguish the types of cases (adult/pediatric) that make up the first 50 cases for associate status. Incrementally, then, the first "generic" 50 cases may serve as a base on which pediatric expertise can be built.

In this way, a compromise was reached for 100 pediatric cases required for a senior pediatrics consultant. This was agreed upon by the two chairs of pediatrics at Weill Cornell and Columbia Physicians and Surgeons at the request of the credentialing subcommittee of the NYPH medical board. With this agreement, the subcommittee approved the recommendations and the proposal went to the full medical board, where it received final approval in 2010.

CONCLUSION

In response to calls for practice standards, training, and certification, we addressed the credentialing of CECs at our institution. It served our purpose to be able to provide expert consultation with what we deemed to be appropriately educated and trained clinicians and helped us define a program for training future consultants. This is not a certification process, but a framework for identifying and evaluating credentials in this emerging field. It recognizes the diversity of backgrounds and educational paths for CEC, but also relies on the expertise, mentoring abilities, and leadership of the senior consultants at our institution. We believe this is an early but necessary step in professionalizing the practice of clinical ethics consultation. Others who embark on this process will need to evaluate their program strengths and needs in order to develop credentialing plans of their own. We expect to revise this model in years to come as we learn from our experience, and as the profession continues to address standards, accreditation and certification.

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