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Credentialing and Certification in Ethics Consultation: Lessons from Palliative Care

David Schiedermayer and John La Puma

ABSTRACT

In response to an article by Acres and colleagues, "Credentialing the Clinical Ethics Consultant: An Academic Medical Center Affirms Professionalism and Practice,"[1] the authors urge continued action for the credentialing and certification of clinical ethics consultants. They also promote a vigorous and engaged model for ethics consultation.

Acres and her colleagues deserve kudos for their thoughtful and measured ethics consultation credentialing program. They have established reasonable standards and forged exemplary relationships. We hope others expand their work, but we are afraid that the entire field is still waiting for a "spine transplant." We need stronger action in both credentialing and certification. As a rule, ethics consultants still aren't properly recognized, regulated or reimbursed. Our continued lack of self-policing and quality control is embarrassing.

The arguments against credentialing and certification (C and C) seemed noble at first: we do need intellectual diversity. Ethics consultation should be widely available. Anyone with a keen mind and a kind heart should be able to volunteer to be on an ethics committee.

While kindness and intellect are necessary components for ethics consultation, they are not sufficient. They do not substitute for training, experience, and expertise. Ethics committees are not suited for doing consultation as a large group; an individual member or several members must make the initial evaluation at the bedside. The committee best serves as an interdisciplinary think tank and a community sounding board.

Some have argued that C and C are irrelevant or even harmful because ethics committees and consultants ought to be merely advisory. Since they make no actual recommendations, they don't need regulation. They need not be held accountable.

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This reasoning is flawed, because it leads to a dangerous hands-off approach. In this model of consultation, since we are merely educating the patient/family/clinicians about an ethical issue, we don't need to see the patient, and since we are not seeing the patient, we are not doing clinical care, and since we are not doing clinical care, we are not accountable.

In medical care, accountability includes detailed documentation. Many committees do not document consults properly in a complete fashion in the chart (instead making a notation such as "ethics committee meeting held" or even no note at all). Even if recommendations are made in the meeting, they may not be recorded on the chart, and the clinical information and ethical reasoning used to arrive at these recommendations are not documented. Most committees also do not write daily notes. Therefore, it is difficult for them to know if they are responsible for positive outcomes (less pain and suffering, more ethically desirable decision making, better communication, and so on). More importantly, such an approach fosters errors in data gathering, and misses crucial day-to-day changes in the patient's situation. It is also poor "public relations" in the hospital—clinical consultation services that do not follow up on patients daily are viewed with disdain by nurses, physicians, patients, and their families.

Another element of the usual accountability process holds clinical consultants individually responsible for proper training and professional behavior—a necessary vetting process. Ethics committees and consultants are now mainly outside of this normal accountability process. Some members of the committee may belong to the hospital staff or may be employed by other groups and organizations that do proper screening. But there is no formal process in most institutions. Can we really be certain, without the usual safeguards, that ethics consultants are up to date, are not currently drug or alcohol impaired, and, for that matter, are not guilty of recent criminal activity?

The role we have always promoted for ethics consultation is a most active one. We argue that passivity is dangerous here, because clinical care should involve human contact and emotion, as well as thought. We use palliative care consultation as a model for ethics consultation, since it is very vigorous and engaged, and one of us (DS) is currently a palliative care consultant. Our argument is that ethics consultation should be even more vigorous and engaged, since ethics cases are often more vexing. For example, a palliative care consultant is usually asked to help clarify goals at the end of life, and to facilitate the transition to comfort care. Most of the time, this work can proceed without difficulty. But in situations of extreme conflict, such as when physicians or patients or families pursue futile care, the ethics consultant and committee are better equipped than the palliative care consultant. Or should be. One could argue (and wish) that they are in fact better trained for exactly this type of work, that they are certified and credentialed and can roll up their sleeves.

Risk managers with whom we have worked have consistently been impressed with ethics consultation's willingness to take on the most troubling dilemmas in the hospital. Such involvement can lead to risk reduction for clinicians and institutions and higher quality patient care and higher patient satisfaction scores. Nurses and physicians see the ethics consultant being active, and they encourage patients, families, and other clinicians to seek consultation.

We have been advocates for this active approach for many years. We want more action. We wonder why, 20 years after one of us (JL) first co-created and described medical staff privileges for ethics consultants, we still lack national standards. We have suggested timidity and role confusion as possible reasons. There are others: hospitals and clinicians do not seem to require proof of our credentials. Also, we do not actively seek proper compensation.

We do think ethics consultants should bill extensively for all the time it takes to do these difficult consults properly. Such billing requires documentation of the time spent personally counseling families or patients—that's the way we do it in palliative care. (A radiologist also documents a personal service, just a non-talking service.)

In ethics consultation, a level five initial consult should be the norm. This is a consult of an hour and a half or so in length. More than half of this time should be documented as being spent in counseling with the patient and family at a family meeting. Level three follow-up visits (35 minutes, 50 percent counseling) might also be common.

In hindsight, perhaps there is so little pressure for C and C from hospitals and healthcare systems because we are basically seen as volunteers. But the work we do has become integral to the medical system itself, and reimbursement should now reflect this level of importance.

Will it take another 20 years to establish C and C? We hope not. We believe the need to move forward is more pressing than ever.

There are, of course, many obstacles. We are uncertain, despite Acres and colleague's description, of the proper length and content of a clinical ethics fellowship. Unstated in their work is the importance of getting paid for the value and volume of one's work, and the relationship of C and C to money (and power). The future of ethics consultation, as a broadly adopted hospital/ACO service,[2] and a billable service with a diagnostic code, hangs in the balance. We doubt, however, that ethics consultation will be reimbursed by third-party payers without the level of documentation we discuss above.

We have also made parallels to palliative care consultation because one of us (DS) has had recent relevant experience in C and C for hospice and palliative care. Although a young field, palliative care has had a certifying exam since 2008. When DS applied for hospital staff privileges in palliative care and hospice, he was asked for proof of certification. On a yearly basis, he needs to be re-appointed, and every year he answers questions about ongoing medical education, possible drug and alcohol impairment, experience with lawsuits, criminal activity, and so forth. Our point is that it took only a few years for palliative care to "get it done." Like ethics consultation, palliative care is a complex field, with different groups of clinicians involved. Like ethics consultation, the certifying test cannot be strictly technical, but must contain moral, legal, cultural, and humanities content. Like ethics consultation, various organizations had to cooperate and agree on the concepts of C and C.

Meanwhile, it has taken decades for ethics consultation to even approach one C, and we are still waiting for any meaningful action on the other C.

So congrats to Acres and colleagues. It's time to get out of the chair, read the chart, see the patient, listen to the story, hold a family meeting, document the consult, and be properly reimbursed. It's time for C *and* C.

NOTES

1. C.A. Acres, K. Prager, G.E. Hardart, and J.J. Fins, "Credentialing the Clinical Ethics Consultant: An Academic Medical Center Affirms Professionalism and Practice," in this issue of *JCE.*

2. "ACO" is an acronym for "accountable care organization," a healthcare reform model that attempts to tie the reimbursement of healthcare providers by third-party payers to improvements in the quality of services provided to patients and to reductions in costs. The model was first proposed by E.S. Fisher, D.O. Staiger, J.P.W. Bynum, and D.J. Gottlieb, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs* 26, no. 1 (January 2007): w44-w57.