

Training to Increase Rater Reliability When Assessing the Quality of Ethics Consultation Records with the Ethics Consultation Quality Assessment Tool (ECQAT)

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ABSTRACT

The Ethics Consultation Quality Assessment Tool (ECQAT) establishes standards by which the quality of ethics consultation records (ECRs) can be assessed. These standards relate to the ethics question, consultation-specific information, ethical analysis, and recommendations and/or conclusions, and result in a score associated with one of four levels of ethics consultation quality. For the ECQAT to be useful in assessing and improving the quality of healthcare ethics consultations, individuals who rate the quality of ECRs need to be able to reliably use the tool.

We developed a short course to train ethics consultants in using the ECQAT, and evaluated whether the participants (1) achieved an acceptable level of calibration in matching expert-established quality scores for a set of ethics consultations, and (2) were satisfied with the course. We recruited 28 ethics consultants to participate in a virtual, six-session course. At each session participants and faculty reviewed, rated, and discussed one to two ECRs. The participants' calibration in matching expert-established quality scores improved with repeated exposure at all levels of ethics consultation quality. Participants were generally more accurate when assessing consultation quality at the dichotomous level of "acceptable"

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(scores of three or four) versus “unacceptable” (scores of one or two) than they were with a more specific score. Participants had higher rates of accuracy with the extreme ratings of “strong” (level four) or “poor” (level one). Although participants were highly satisfied with the course, only a minority of participants achieved the prespecified acceptable level of calibration (that is, 80 percent or greater accuracy between their score and expert-established scores). These results suggest that ECQAT training may require more sessions or need modification in the protocol to achieve higher reliability in scoring. Such trainings are an important next step in ensuring that the ECQAT is a tool that can be used to promote improvement in ethics consultation quality.

INTRODUCTION

Ethics consultation, sometimes referred to as healthcare ethics consultation, is a service provided by an individual or group in response to questions from patients, families, healthcare professionals, or other involved parties who seek to resolve uncertainty or conflict about value-laden concerns that emerge in healthcare.¹ Even though ethics consultations occur in most hospitals in the United States, there are few valid, reliable, and practical tools to evaluate, ensure, and improve the quality of ethics consultation.² The quality of ethics consultation is important because poor quality ethics consultation can cause harm or result in ethically inappropriate outcomes for patients and other stakeholders.³

The Ethics Consultation Quality Assessment Tool (ECQAT) establishes standards by which the quality of written healthcare ethics consultation records (ECRs) can be assessed.⁴ Depending on the approach to charting ethics consultations in a healthcare institution, ECRs may include the patient’s medical record alone or in combination with the ethics consultation service record. These standards pertain to the ethics question, consultation-specific information, ethical analysis, and recommendations and/or conclusions. Unlike other attempts at measuring quality, such as focusing on process steps (for example, elapsed time between a request and the response) or participants’ satisfaction,⁵ ECQAT assesses the quality of the written ethics consultation record. Further explication of the standards for judging quality and the rationale for relying on documentation through ethics consultation records have been discussed elsewhere.⁶

For the ECQAT to be useful in assessing the quality of the written records of the ethics con-

sultations and informing quality improvement in ethics consultation, ratings of quality need to be reliable. Thus, raters need to be proficient in assigning rating scores such that they achieve a high degree of calibration. Calibration is the measure of raters’ reliability in matching established quality scores as determined by experts for a set of ethics consultations, that is, the accuracy in scoring by raters. Achieving a high degree of calibration requires training and practice. Consequently, we developed a short course for training raters modeled after the U.S. Department of Agriculture (USDA) approach to training lawyers in holistically rating the quality of legal briefs.⁷ The primary purpose of this article is to assess whether a short virtual training course is sufficient to achieve an acceptable level of calibration using the ECQAT. The secondary goal is to characterize the participants’ experiences and perceived value of such a training course to inform future ECQAT training activities.

METHODS

Overview of the Ethics Consultation Quality Assessment Tool (ECQAT)

The ECQAT employs a holistic rubric assessment approach to the evaluation of the quality of ethics consultation that is based on the documentation in the consultation record. With holistic assessment, raters consider key elements and other factors that work together and score the narrative account on the “total impression” it makes upon the rater.⁸ Because of the subjective aspects of a holistic approach to assessing quality, two raters are expected to rate each consultation record independently. If there are significant disagreements, these are discussed among the raters with the goal of achieving agreement.⁹

The ECQAT considers four key elements of ethics consultation records. (1) The first is the ethics question, which focuses the consultation process and response. After clarifying the ethical concern(s) that gave rise to the consultation request, the ethics question identifies whose values are uncertain or in conflict, and identifies the decision(s) or action(s) in question. (2) The second key element is the consultation-specific information that informs the ethical analysis. Consultation-specific information conveys (a) the most important information about the

medical and social facts, (b) the patient's and other involved parties' preferences, values, and interests, and (c) appropriate sources and processes that can be used to obtain relevant information. (3) The third key element, the ethical analysis, articulates and weighs valid and compelling arguments and counterarguments based on the consultation-specific information and ethics knowledge to provide justification for the conclusions and/or recommendations. Informing the analysis using ethics knowledge reflects the ethics consultants' expertise, that is, their familiarity with ethics "best thinking" and the application of it to the current case.¹⁰ (4) The fourth key element is the conclusions and recommendations that promote ethical practices. This element should identify and explain the range of ethically justifiable options and clearly communicate practical recommendations that are ethically justifiable and responsive to the ethics question(s).

The overall ECQAT scoring of an ethics consultation ranges from one to four. Scores of one and two indicate less than acceptable quality. A score of one indicates "poor" quality because the ECR is significantly flawed, such that the conclusions/recommendations are not supportable. A score of two indicates "less than adequate" quality because the ECR is flawed in some ways that raise significant questions about whether the conclusions/recommendations are supportable. Scores of three and four indicate acceptable quality. A score of three indicates "adequate quality." The ECR may be flawed in some ways, but the flaws do not raise significant questions about whether the conclusions/recommendations are supportable. A score of four indicates "strong" ECR quality: minor flaws may exist, but the conclusions/recommendations are easily supportable, are based on appropriate information and ethics knowledge, and are responsive to the ethics question(s).¹¹ Examples of ECRs that were rated at each level of quality are available at <https://www.ethics.va.gov/activities/ecq.asp>.

Training

The training protocol was modeled after the USDA's approach to training lawyers in evaluating legal briefs.¹² Our protocol included a review of the principles of holistic rubric assessment, the key elements, and the scoring rubric, and an iterative review of the participants' group

scores for each ECR with comparison to the expert rating, followed by group discussion about the rationale for the experts' rating. The expert ratings of an ECR's quality were determined through a deliberative and iterative process involving the ECQAT developers and feedback from Veterans Affairs (VA) and non-VA ethics consultants in the U.S. who were involved in the development of the ECQAT.¹³ The ECRs used in the training course came from VA and non-VA sources and did not include information that identified institutions or patients. These established expert ratings included a narrative assessment that explained and justified the expert rating of each ECR.

The USDA experience also informed the number of sessions and the length of the course (six sessions over six days) and the virtual delivery of the training. In the first session (0.75 hours), the primary trainer (RAP) provided an overview of the ECQAT, instructions on the use of the tool, and an explanation of how an expert rating was established for a sample ECR by a consensus group of trained expert reviewers. Before all subsequent sessions, participants independently reviewed and rated two ECRs using the ECQAT and submitted their ratings to (RAP). During the second session (1.25 hours), the trainer led a discussion during which the participants explained the reasoning for their individual ratings. During the discussion, the trainer used the participants' explanations to reinforce the established scoring criteria. This second session was considered a practice session for gaining familiarity with the process and was not included in outcome measures for calibration (see below). In the third and following sessions, the trainer used the expert ratings and feedback developed for each ECR to reinforce the strengths and weaknesses of the ECR as well as the basis for the holistic score. Prior to third through sixth sessions, participants reviewed and rated two ECRs with narrative comments to support their rating. Prior to the discussions during these sessions, the participants were given the distribution of all of the participants' scores. In the third through sixth sessions (one hour per session), one or more of the co-authors joined the primary trainer and participants in their discussions about the reasoning for the established quality scores of the ECRs and the participants' ratings.

The virtual training occurred in July 2016. Initially the participants were divided into two

training groups. However, due to scheduling problems, some of the participants changed between groups to continue to participate in the training. After the initial review of the ECQAT and the rating of a sample ECR, the first discussion of consultation records (the practice session) involved ECRs with established quality a score of four (strong) and a score of two (less than adequate). The purpose of discussing an

ECR scored at level four was to demonstrate a high quality ECR, and that high quality did not require perfection. The choice to discuss an ECR score at level two was to demonstrate an ECR assessed with less than acceptable quality. The sequencing of ECRs for the subsequent four training sessions used records with established quality scores of three and four, one and two, two and three, and one and four, assuring each level of quality was presented twice for participants' ratings. This sequence was determined by consensus amongst some of the authors (RAP, DA, BLC, KAB).

TABLE 1. Participants' characteristics (*N* = 28)

Characteristic	<i>n</i>	%
Work environment		
VA	22	79
Non-VA	6	21
Gender		
Female	19	68
Male	9	32
Leadership role in ethics consultation ¹	14	50
Primary profession ²		
Social worker	5	23
Nurse	4	8
Physician	2	9
Administrator	2	9
Other (e.g., psychologist)	5	23
Ethics-related (e.g., clinical ethicist, director of ethics)	4	18
Education and training in clinical ethics ³		
Formal, direct supervision by an experienced consultant	11	50
Educational resources and programs, such as seminars and workshops	10	45
Independent learning without formal, direct supervision	7	32
Completed a fellowship or graduate degree program in bioethics that included explicit training in ethics consultation	6	27
Completed a fellowship or graduate degree program in bioethics that did not include explicit training in ethics consultation	2	9
Characteristic	Yrs	Range
Median time conducting consultations (years) ⁴	8	0-15

NOTES

1. Self-reported leadership role, such as chief, lead, chair, and Integrated Ethics® ethics consultation coordinator (VA).
2. Based on follow-up survey data from participants (*n* = 22).
3. Ibid. Respondents could select all that applied; thus, the percentages total more than 100%.
4. Based on follow-up survey data from participants (*n* = 22).

Recruitment

The request to participate in training sessions in the use of ECQAT was communicated to VA and non-VA audiences in May 2016 through the IntegratedEthics® listserv, a VA national listserv for ethics consultation coordinators at VA facilities, and the Medical College of Wisconsin (MCW) ethics listserv. The announcement for this convenience sample communicated that this training was for ethics consultants; that it would involve five assignments to be completed outside of the training (total time about five hours), and include six discussion sessions (total time about six hours); and that an important goal for this training was for participants to be able to use the ECQAT as a teaching tool at their facilities after the training to improve their own ethics consultations, and those of their ethics consultation services. After these announcements, 58 individuals expressed interest in participating in the ECQAT training course; 28 were available for the proposed dates and times of the sessions.

Outcome Measures

Calibration, or accuracy in scoring compared with expert-established quality scores for specific ECRs, was the primary outcome measure and was assessed two ways. First, we assessed the percent agreement with whether the score matched the dichotomous criteria; that is, less than acceptable (“below the bar,” or a score of one or two) versus acceptable (“above the bar,” or a score of three or four) rating. Second, we assessed the percent agreement with the more specific numerical score (that is, one to four). For the purposes of this pilot test training, the authors designated an 80 percent or higher level

of agreement as acceptable calibration for each of these approaches. This is less than the USDA standard (90 percent) for decisions pertaining to legal appeals, but was considered appropriate for this training because it was a first and untested experience offering the training course, and participants had a wide range of experience as ethics consultants. We compiled descriptive statistics (percentages) using Microsoft Excel (2016).

We also asked participants about their backgrounds (for example, training in ethics, health-care role) and assessed their satisfaction with multiple aspects of the course through SurveyMonkey.¹⁴ For example, we asked about whether the training objectives were met, and whether the trainer(s) seemed knowledgeable. We used a five-point Likert scale ranging from “strongly disagree” to “strongly agree.” The questions are presented in table 3. We also asked the participants for their qualitative feedback on the course and recommendations for improving the learning experience. We used descriptive statistics provided through SurveyMonkey to present the results.

This pilot training was not reviewed by an institutional review board (IRB) as it was considered to represent a quality improvement project according to Veterans Health Administration (VHA) policy.

RESULTS

Participants’ Characteristics

Of the 28 participants in the training, 18 had clinical backgrounds (64 percent) (see table 1). In response to the follow-up survey, 77 percent of the participants stated that they had a clinical background, and more than one-third reported having completed a fellowship program or received an advance degree in bioethics. Half of the survey respondents reported having received formal, direct supervision by an experienced member of a consultation service in performing ethics consultations. The median number of years conducting ethics consultations was eight. Two of the survey respondents reported zero years of experience conducting ethics consultations, but that they currently worked as members of an ethics committee or program.

Calibration

Over the course of the training, participants scored two ECRs at each numeric level of expert-established ECR quality. An acceptable calibration of 80 percent or greater occurred for “acceptable” versus “less than acceptable” ECR quality in the last three ECR assessments (84 percent, 100 percent, 100 percent; that is, aligned

TABLE 2. Levels of agreement in assessing ethics consultation quality between participants’ ratings and established quality scores (*N* = 28)

Temporal sequence of ethics consultation records	Standardized score (pre-scored)	Agreement with “acceptable” or “less than acceptable”		Agreement with the numeric score	
		<i>n</i>	%	<i>n</i>	%
1	3	11	39	10	36
2	4	25	89*	20	71
3	1	18	66	9	31
4	2	8	28	3	10
5	2	10	36	10	36
6	3	24	84*	11	40
7	1	28	100*	18	65
8	4	28	100*	24	85*

NOTES

Temporal sequence of ethics consultation records indicates the sequencing of ethics consultation records after the two records that were used in the practice sessions. Numbers and percentages have been rounded to the nearest whole number. Scores of 1 and 2 indicate less than acceptable quality ethics consultation documentation. Scores of 3 and 4 indicate acceptable quality ethics consultation documentation.

* Acceptable calibration with percent agreement at 80% or greater

with the second exposure to ECR expert-established quality levels of three, one, and four, respectively). Acceptable calibration occurred for the exact numeric score only on the final session and only for an ECR expert-established quality score of four (see table 2).

Calibration improved with repeat exposure to ECRs at the same level of quality. When comparing first and second exposures to ECRs at the same overall level of quality (that is, “acceptable” versus “less than acceptable”), the range of improvement in calibration was 8 percent to 45 percent. When comparing first and second exposures to ECRs at the same numerical level of quality, the range of improvement in calibration was 4 percent to 34 percent. These results are presented in table 3.

Overall, there were three participants who achieved 100 percent accuracy between their scores and the expert-established quality scores in the last four ECRs at the expert-established quality levels of two, three, one, and four. All three had leadership roles in their ethics consultation services; two of the three worked outside the VA. There were seven participants who demonstrated 100 percent accuracy between their scores and the expert-established numeric quality scores in three of the last four ECRs. Five participants in this group had leadership roles with their ethics consultation services; four worked in the VA.

Participants’ Satisfaction

Participants who responded to the follow-up survey reported they were highly satisfied with the ECQAT training experience (see table

TABLE 4. Participants’ satisfaction with ECQAT training (N=23)

Questions	Scoring (Average)
1 The objectives of the training were clearly defined.	4.8
2 Participation and interaction were encouraged.	4.8
3 The content was organized and easy to follow.	4.3
4 The materials and handouts were helpful.	4.7
5 The training experience will be useful in my work.	4.7
6 The trainer was knowledgeable about the training topics.	5.0
7 The trainer was well prepared.	4.8
8 The training objectives were met.	4.4
9 I feel sufficiently trained to score an ethics consultation using the ECQAT.	3.8
10 The time allotted for the training was sufficient.	4.0
11 The technology used for the delivery of training was effective.	4.3
12 I would recommend this training to others.	4.7

NOTE

Follow-up survey with scoring: “strongly disagree” = 1, “disagree” = 2, “neutral” = 3, “agree” = 4; “strongly agree” = 5.

TABLE 3. Temporal tracking of levels of agreement in assessing ethics consultation quality between participants’ ratings and established quality scores (N = 28)

Prescored ethics consultation record	First exposure (%)	Second exposure (%)	Percentage increase
Prescored ethics consultation record at quality level 1			
Agreement at the less than acceptable level*	66	100	34
Agreement with the numeric score 1	31	65	34
Prescored ethics consultation records at quality level 2			
Agreement at the less than acceptable level*	28	36	8
Agreement with the numeric score 2	10	36	26
Prescored ethics consultation record at quality level 3			
Agreement at the acceptable level*	39	84	45
Agreement with the numeric score 3	36	40	4
Prescored ethics consultation record at quality level 4			
Agreement at the acceptable level*	89	100	11
Agreement with the numeric score 4	71	85	14

NOTE

* “Less than acceptable” represents scores of 1 or 2; “acceptable” represents scores of 3 or 4.

4). This was expressed in their perceptions of the course's content, materials, and overall experience. Most strongly agreed with the statement "I would recommend this course to others." The lowest scoring evaluation element was whether participants felt sufficiently trained to independently score an ethics consultation record using the ECQAT. The average score for this item was 3.8 on a five-point scale (five = "strongly agree," four = "agree," three = "neutral," two = "disagree," one = "strongly disagree").

Qualitative Feedback

The qualitative comments were favorable and generally consistent with the objective satisfaction ratings. The participants expressed a desire for more training, such as an ongoing series of tutorials that would include an opportunity for feedback. Several participants suggested they wanted the opportunity to use the ECQAT to rate the quality of their own ECRs. Another suggestion was to have the training demonstrate multiple ECRs at the same level of quality before assessing ethics consultations at a different level of quality. One participant expressed an appreciation for the level of proficiency that would be required in the reliable application of ECQAT before becoming a rater of other consultants' ECRs at the participant's facility.

DISCUSSION

We report here on a pilot study that assessed whether a brief virtual ECQAT training was effective in achieving participants' calibration for assessing ECRs at varying levels of expert-established quality. This training, to our knowledge, is the first of its kind focusing on assessment of overall ethics consultation quality as reflected in ECR content, and included an educational overview of the ECQAT and repeated supervised practice with expert-established quality scored ECRs. Several findings from our pilot study are noteworthy. First, repeat exposure to ECRs at the same level of quality improved participants' calibration. Over the course of the training, the participants' accuracy improved with repeated exposure at every numeric level of ethics consultation quality and with the dichotomous rating of "less than acceptable" (that is, consults rated one or two) versus "acceptable" (that is, consults rated three or four). Second, partici-

pants were generally more accurate when assessing consultation quality at the level of "acceptable"/"unacceptable" than with the more specific numerical ratings. In addition, participants had higher rates of accuracy with the extreme ratings of "strong" quality (that is, four) or "poor" (that is, one) quality, but were less accurate with the intermediate quality scores of two and three. Third, ethics consultants in leadership roles seemed to achieve better calibration than other consultants toward the end of the pilot training. The reasons for this were not explored in this pilot training, but level of experience may be a factor.

However, despite these gains, a brief virtual training did not result in our prespecified acceptable level of calibration; only a minority of participants achieved 80 percent or greater accuracy between their score and expert-established quality scores. These results suggest that ECQAT calibration training may take longer than a six-session, short course for most participants to achieve accurate scoring, and that modifications of the training protocol may be necessary to achieve an acceptable level of calibration for individuals who want to use the ECQAT as a method to reliably assess and improve ethics consultation quality.

More experience is needed to better understand how best to train raters to reliably assess the quality of ethics consultations using ECQAT. Training protocols that modify the sequencing of ECRs can provide more empiric information about how well and quickly raters can achieve an acceptable level of calibration. Future efforts should also explore whether training outcomes (for example, an "acceptable" level of calibration) vary depending on the level and type of ethics and ethics consultation experience and training of the participant. Similarly, comparative effectiveness studies of different ECQAT calibration training protocols can help answer which protocols work best for different the strata of consultant (for example, level of training, extent of experience, leadership roles in ethics, academic versus non-academic settings, VA versus non-VA consultants).

Limitations to this pilot study exist. The study was conducted with a small, convenience sample of mainly VA employees and is not intended to be generalizable. However, the sample was appropriate for quality improvement and the purposes of this pilot project, including laying the groundwork for future efforts. Second,

the training did not include a training fidelity measure to assess the degree to which delivery of the training adhered to the training protocol. Although fidelity is an important part of evaluating the effectiveness of an intervention, we considered this training to be formative and wanted to be able to incorporate trainers' experience and participants' feedback to subsequent training sessions. Third, as argued elsewhere, ethics consultation documentation alone may not be an accurate reflection of some aspects of the quality of an ethics consultation.¹⁵ This is a valid concern, especially when it regards interpersonal processes such as clear and thoughtful communication, attentive listening, and expressions of empathy. However, documentation in the health record is still considered the industry standard for demonstrating what occurs in a medical encounter and the rationale (that is, reasoning) for recommendations.¹⁶

The lack of calibration to the prespecified acceptable level of calibration and the need for further development of the ECQAT training protocol does not preclude the use of the ECQAT for training and educational purposes. For instance, the ECQAT can be used to promote discussion and education about the quality of ethics consultations with ethics consultants and ethics committee team members. ECQAT-based discussion among raters of the same ECR can promote mutual understanding of raters' opinions and perspectives on the quality of an ECR. Ethics consultants or services can apply the ECQAT as a "quality check" to assess whether their consultations include the key elements required in quality consultations. Finally, experienced consultants can use ECQAT for coaching sessions with individuals or teams.

CONCLUSION

The ECQAT establishes standards by which the quality of ECRs can be assessed. For this tool to be practical, reliable, and useful, ECQAT raters should have a high degree of calibration with expert-established quality scores. Trainings designed to enhance calibration are an important next step in ensuring that the quality of ethics consultations continues to improve.

DISCLAIMER

The contents reflect the view of the authors and do not represent the views of the United States Department of Veterans Affairs, the United States gov-

ernment, New York University School of Medicine, or the University of Washington School of Medicine.

NOTES

1. American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, Ill.: ASBH, 2011).
2. N. Dubler et al., "Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation," *Hastings Center Report* 39, no. 6 (November-December 2009): 23-33; A. Favia et al., "A Model for the Assessment of Medical Students' Competency in Medical Ethics," *American Journal of Bioethics Primary Research* 4, no. 4 (October-December 2013): 68-83; M. Svantesson et al., "Outcomes of Moral Case Deliberation—The Development of an Evaluation Instrument for Clinical Ethics Support (the Euro-MCD)," *BMC Medical Ethics* 15, no. 1 (8 April 2014): 30; S.E. Bliss et al., "Measuring Quality in Ethics Consultation," *The Journal of Clinical Ethics* 27, no. 2 (Summer 2016): 163-75; K. Wasson et al., "Developing an Evaluation Tool for Assessing Clinical Ethics Consultation Skills in Simulation Based Education: The ACES Project," *HEC Forum* 28, no. 2 (2016): 103-13.
3. R.A. Pearlman et al., "Ethics Quality Assessment Tool: A Novel Method for Assessing the Quality of Ethics Case Consultations Based on the Written Records," *American Journal of Bioethics* 16, no. 3 (March 2016): 3-14.
4. *Ibid.*
5. Dubler et al., "Charting the Future," see note 2 above; K.A. Bramstedt et al., "Optimising the Documentation Practices of an Ethics Consultation Service," *Journal of Medical Ethics* 35, no. 1 (January 2009): 47-50; M. Repenshek, "Attempting to Establish Standards in Ethics Consultation for Catholic Health Care: Moving Beyond a Beta Group," *Health Care Ethics USA* 18, no. 1 (Winter 2010): 5-14; M. Repenshek, "Continuous Quality Improvement Initiatives in Ethics: A Proposed Communication Tool," *Health Care Ethics USA* 20, no. 4 (Fall 2012): 2-12; Svantesson et al., "Outcomes of Moral Case Deliberation," see note 2 above.
6. Pearlman et al., "Ethics Quality Assessment Tool," see note 3 above.
7. R. Klurfeld and S. Placek, "Rhetorical Judgments: Using Holistic Assessment to Improve the Quality of Administrative Decisions," *Journal of the National Association of Administrative Law Judiciary* 31, no. 2 (15 October 2011): 526-54.
8. Klurfeld and Placek, "Rhetorical Judgments," see note 7 above; R. Cherry and P. Meyer, "Reliability Issues in Holistic Assessment," in *Validating Holistic Scoring for Writing Assessment: Theoretical and Empirical Foundations*, ed. M. Williamson and B. Huot (Cresskill, N.J.: Hampton Press, 1993), 109-41; L. Beyreli and G. Ari, "The Use of Analytic Rubric in the Assessment of Writing Performance—Inter-rater

Concordance Study,” *Educational Sciences: Theory and Practice* 9 (2009): 105-25.

9. Klurfeld and Placek, “Rhetorical Judgments,” see note 8 above.

10. K.A. Berkowitz et al., *Ethics Consultation: Responding to Ethics Questions in Health Care*, 2nd ed. (Washington, D.C.: Department of Veterans Affairs, 2015), https://www.ethics.va.gov/docs/integrated-ethics/ec_primer_2nd_ed_080515.pdf

11. For a more complete description of ECQAT, see Pearlman et al., “Ethics Quality Assessment Tool,” see note 3 above.

12. Klurfeld and Placek, “Rhetorical Judgments,” see note 8 above.

13. Pearlman et al., “Ethics Quality Assessment Tool,” see note 3 above.

14. SurveyMonkey, Advantage Plan, Survey Monkey, Inc., San Mateo, Calif., 2018, www.surveymonkey.com.

15. C.R. Bruce and T.M. Bibler, “Not There Yet: Evaluating Clinical Ethics Consultation in an Accountability Culture,” *American Journal of Bioethics* 16, no. 3 (2016): 46-8; B. Molewijk et al., “What Quality Is Actually Assessed Within Written Records?” *American Journal of Bioethics* 16, no. 3 (March 2016): 48-50.

16. A. Donabedian, “The Quality of Care: How Can It Be Assessed?” *Journal of the American Medical Association* 260, no. 12 (1988):1743-8.