Assuring Quality for the Future

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To cite this article: Valerye M. Milleson & Claire I. Horner (2016) Assuring Quality for the Future, The American Journal of Bioethics, 16:3, 54-55, DOI: 10.1080/15265161.2015.1134710

To link to this article: http://dx.doi.org/10.1080/15265161.2015.1134710

Published online: 25 Feb 2016.
The authors of this commentary, who are current fellows in a clinical ethics fellowship program, believe that the main problem with the proposed attestation tool advocated by Fins and colleagues (2016) and other members of the QAPTF is that its orientation is inexorably retrospective. It prioritizes the evaluation of work already done by existing, and presumably active, consultants, establishing the initial basis for quality assurance on the path to professionalization of clinical ethics consultation. We believe that there are three particularly problematic consequences that follow from this emphasis.

First, this model fails to address the formation and development of new ethics consultants who are currently in training or just entering the field. Despite the existence of Core Competencies for Healthcare Ethics Consultation, 2nd ed. (ASBH 2011), translating an academic understanding of bioethics into clinical ethics consultation skills is difficult, if not impossible, without mentorship. As fellows, we recognize that this structured training program has provided certain skills that not only were not obtainable through an academic program, but also were unanticipated as being integral to clinical ethics consultation. Since patients and patient cases are never truly standardized, the translation of textbook bioethics to real-world clinical ethics is not seamless, and clinical ethics skills and knowledge in the abstract do not guarantee clinical ethics skills and knowledge in context. Some capabilities essential to effective clinical ethics consultation either are learned through practice or are highly situational, such as the social and professional navigation of hospital culture, uncovering and balancing competing values and value systems among the myriad individuals involved in a patient’s care, and translating and negotiating these values to the various interested parties. There are also important gains to be made in a consultant’s adaptability to evolving health care circumstances, confidence in consulting technique and aptitude, humility and willingness to seek assistance with complex cases, and general efficiency with consultation analysis, case writeups, and multiple-case triaging.

Our experience suggests that training consultants requires not only a standard set of expectations for quality consultation, such as the Core Competencies, but also a consistent feedback mechanism to help new consultants recognize and meet these expectations by guiding them through the process of understanding the appropriate steps to take in the consultation process. Without this mentorship, a new consultant would be left managing consults in a relatively ad hoc manner without any assurance that his or her performance is aligned with what would be considered a high-quality ethics consultation. This is problematic not only for the new ethics consultant in terms of navigating this complex process, but also in terms of that person’s ability to develop the skills necessary to even qualify to become a certified ethics consultant using the portfolio- and-attestation evaluation model. With the given model there is a question of how the aspiring consultant can even be considered qualified to perform clinical ethics consultations (since, after all, he or she is not certified), or how, if qualified provisionally, this person can ever be assured that he or she is performing consultations at the level required to develop the kind of portfolio he or she would need to eventually become certified.

The second consequence, a likely result of the first, is that having an evaluation model that can only ensure quality ethics consultation via back-end assessment does not eliminate the risk of less than fully qualified consultants performing ethics consultations within the health care setting. Since methodologically this model can only test for quality after a requisite number of ethics consultations have been performed and supplied in a portfolio compilation, the acquisition of which requires carrying out consultations in what may be an unguided or unqualified manner, we run the risk of subjecting patients and their families to poor-quality or perhaps even ethically concerning consultation experiences. As such, not only does this evaluation schema present emerging consultants with a
problem of how to be qualified to perform the consultations needed to prove they are qualified to perform (quality) consultations for the purposes of certification, a sort of ethics consultation Catch-22; it also suggests that rather than ensuring that consultants “demonstrate competency to respond effectively to ethics consultation requests” (Fins et al. 2016, 22), they might actually end up harming patients, which is contrary to the asserted goals of implementing a quality-assuring “evidence-based process that is consistent with the quality and safety movement in health care” (Fins et al. 2016, 16).

The third problem with this retrospective model has to do with its proficiency and practicality in assuring quality for the future and allowing for a genuine professionalization of the field of clinical ethics consultation. With the expansion of clinical ethics consultation services (Chwang et al. 2007), there appears to be good reason to be skeptical about the abilities of this model to timely maintain the growing demand of certification for clinical ethics consultants. As a result, by focusing our efforts retrospectively on certification of already-practicing consultants, it seems as though this process would be playing “catch-up” indefinitely, only able to spot-check the quality of consultants already in the field instead of ensuring the quality of consultants as they enter it. One can only speculate if and when we would reach a point where all consultants are deemed qualified before acting as a lead or solo consultant.

Thus, we suggest that a more effective approach would be to refocus quality assurance efforts on an urgent need to address the standardization of quality in clinical ethics consultant training, toward future clinical ethics consultants, rather than simply evaluating the quality of current consultants. This would ensure that new and training consultants are performing consultations appropriately and would reduce the possibility that patients and families will be subjected to well-meaning but unqualified or underqualified consultants. It may also eliminate the need for portfolio review of new consultants altogether, since they will enter the profession with a portfolio that has been developed under the guidance and supervision of education mentors who can attest to the quality and variety of the consultant’s portfolio. As more and more employers are requiring fellowship training as a prerequisite for incoming ethics consultants, in addition to formal bioethics education, such programs should be standardized to accommodate this requirement. This will help aspiring bioethicists understand the path they must follow to begin working as a professional clinical ethicist, in the same way that professional and educational requirements are clear for other health care professionals. It will also provide employers with knowledge and assurance of the particular education and skill set a consultant has developed during the course of a fellowship, as standards and expectations for professional development will be clear and universal.

Ultimately, if clinical ethics consultation is to develop into an established profession of the same professional caliber as other health care disciplines, then the field should adopt the same sort of training and quality assurance standards expected of those other professions, which starts with quality assurance in the development of new professionals.

REFERENCES
