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Certification and evaluation of the clinical ethics consultant. A proposal for Italy

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Abstract
Clinical ethics, as a sub-discipline of bioethics, is subject to growing professionalization in North America, Europe and elsewhere. Since the goal of clinical ethics is the identification, analysis and resolution of ethical dilemmas and conflicts in health care settings, specific competencies for practitioners and criteria to evaluate them are strongly needed. Regarding clinical ethics consultation (CEC) many efforts have been made by American clinical ethicists and scholars to delineate the core knowledge and skills to perform it, to settle specific professional responsibilities and tasks and to identify the fundamental training and quality requirements that candidates and actual professionals should satisfy in order to serve as ethics consultants. Starting from the analysis of two meaningful international experiences, the one American and the other German, the paper discusses the process of certification of the clinical ethics consultant and encourages its implementation in the Italian context trying to outline a model which is suited to it.

Key words
- ethics consultation
- clinical ethics
- certification
- credentialing
- professional competence

WHY IS THE CERTIFICATION OF THE CLINICAL ETHICS CONSULTANT NECESSARY?

As is very well known, bioethics has become an autonomous field of knowledge and clinical ethics, as a sub-discipline of the former, is subject to growing professionalization. Since the goal of clinical ethics is the identification, analysis and resolution of ethical dilemmas and conflicts in health care settings, specific competencies as well as criteria to evaluate them are strongly needed. Clinical ethicists may perform the traditional four main functions of clinical ethics, i.e. ethics education in the clinical settings, development of ethics guidelines and policies, theoretical and empirical research and clinical ethics consultation (CEC) [1, 2]. Regarding CEC, which is considered the most significant clinical ethics activity, many efforts have been made by American clinical ethicists and scholars to delineate the core knowledge and skills to perform it [3, 4], to settle specific professional responsibilities and tasks [5] and to identify the fundamental training and quality requirements that candidates and actual professionals should satisfy in order to serve as ethics consultants [6, 7].

Concerning the issue of professionalization, it soon became clear to American scholars and practitioners that in order for CEC to be acknowledged as a real profession, standards for educational requirements had to be defined and clear parameters to evaluate knowledge and training of future professionals had to be settled [8-10]. As Tarzian pointed out, "Proponents argue that professionalization is needed to ensure quality and accountability of those responding to ethics questions, concerns, and conflicts in health care settings" [11]. Besides, according to the American Society for Bioethics and Humanities (ASBH), CEC is the most relevant activity of clinical ethics; this means that CEC may have great impact on patient care, causing both good and harm [3]. Therefore, standards to assess the quality of an ethics consultation are also required, since the role of the consultant is to solve ethical uncertainties or conflicts among different stakeholders [9, 12]. Ethical quandaries such as activating or withdrawing medical care, breaching the confidentiality of patients by revealing their pathology to a third party and defining criteria to allocate organs for transplants, are crucial questions for patients, family members and health care providers. Given the above, a transparent and settled process of evaluation and attestation of competence and abilities of clinical ethics consultants may guarantee the whole society and make the profession a credible one. The topic of certification and credentialing of clinical ethics

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consultants now represents one of the most discussed issues in the international debate on clinical ethics [6, 7, 9-12].

CRITICAL ISSUES IN THE CERTIFICATION PROCESS PROPOSAL

As stated above, certification of clinical ethics consultants is amply debated in the international literature about clinical ethics and CEC as a profession. Two tendencies may be identified: on the one hand we note a practical position that aims to find coherent solutions to define a shared process of attestation and assessment of the knowledge and training of future consultants; on the other hand we still acknowledge theoretical opposition to the effort to identify standards of evaluation. However, this last position risks ignoring that ethics consultation is now a well-established practice in North America and is subject to continuous implementation in the rest of the world, hence this simple fact imposes the need of high guarantees [13].

The main criticality in the process of evaluation and certification of clinical ethics consultants deals with the interdisciplinary and pluralistic nature of clinical ethics. According to this view, a standardized process of evaluation may risk dismissing and reducing the richness of different educational backgrounds, experiences, approaches and ethical perspectives as the core features that have always characterized ethics consultation ever since it was born as a profession. Put another way, the effort towards the delineation of a core *curriculum* for clinical ethics consultants might emphasize mere regulatory and methodological aspects rather than proper ethical considerations. Besides, it may be asked how to deal with those professionals that for years have performed CEC, but do not conform with certification requirements. Furthermore, it should be taken into consideration that there are heterogeneous educational backgrounds, practical experiences, models for ethics consultation as well as several ways to conceive the goals that ethics consultation seeks to pursue [6, 14]. As Kodish *et al.* pointed out, "Because of CEC's inherent multidisciplinarity, developing a unitary set of entrance requirements for a varied constituency has presented formidable challenges" [6].

Another criticism concerns the possibility to assess not the ability to provide ethics consultation in general, but in a specific health care setting. According to this view, in order to evaluate the capacity to perform ethics consultation, one has to take into consideration the specific context in which consultations are conducted, e.g. a small general hospital, a large academic health care institution, a long-term-care setting [14].

Finally, it is argued that a quality attestation for clinical ethics consultants, along with its general acceptance and public acknowledgement, may exacerbate the feeling that the so called "ethics expert" may take advantage of his/her role. Ethics consultants as "ethics experts" already raise several theoretical and moral concerns, hence a formal process of certification may lead to conferring on them a risky "authority" in ethics [6, 15].

The challenge of certification requires preserving diversity and variety in all of the aspects described above, not giving up the effort to find coherent ways to evaluate the quality of ethics consultation and to define high standards of practice [7].

CLINICAL ETHICS CONSULTATION: SIMILARITIES WITH MEDICAL CONSULTATION

In our understanding, there is a parallel between ethics consultation and consultation in the medical field [16-18]. It has been argued that the clinical ethics consultant has the same privileges and responsibilities as clinicians, since his/her role and tasks have, as mentioned above, important consequences on patient care [6].

Therefore, it is necessary to identify shared criteria in order to verify and certify core competencies and skills of clinical ethics consultants as has already been done for other health care professions dealing with patient care. Also in the medical and surgical field several methods, schools and approaches do exist, but this does not prevent specific professional skills and knowledge from being verified and assessed, even though a variety is acknowledged. A formal certification process does not necessarily preclude diversity in backgrounds, approaches and methods, but it just tries, respecting this diversity, to find common minimal professional requirements. As is clear according to the American perspective, in order to assess the clinical ethics consultant's expertise, what should be taken into consideration are the competencies and knowledge possessed and not the kind of degree obtained, e.g. in philosophy, law, medicine, etc. [3, 6]. In line with this, the proposal made by the ASBH regards the submission of a portfolio that should attest the clinical ethics consultant's expertise as a whole, not being limited to his or her studies or academic career: "Portfolios permit a wide variation in the bases of bioethics knowledge as long as the end result is within the accepted parameters of professional competence" [6]. The educational background is not decisive in determining the quality of the clinical ethics consultant's expertise, that is, additional proofs are required, e.g. a strong case-consultation experience, a personal way of conceiving the goals of the profession, etc. As a consequence, stable criteria to evaluate and attest credentials of clinical ethics consultants may influence the implementation and organization of *ad hoc* educational pathways and training programs, that will be modeled according to those criteria.

THE INTERNATIONAL SCENARIO: THE AMERICAN AND GERMAN PROPOSALS

Concerning a common and settled certification process that may be respectful both of the variety in educational backgrounds and approaches to CEC, the ASBH – the most renowned American bioethics association – chose to endorse an intermediate level of qualification requirements, namely a middle ground between a very specific competence required for particular health care settings and a more generic one aimed at providing ethics consultation [6].

The basic requirement consists of a portfolio, namely a collection of different elements that attest the quality

of clinical ethics consultation candidates. As indicated by Fins *et al.* [7], portfolios should include:

(1) education and training related to CEC, and CEC experience including time frames and practice settings;

(2) a written summary of the candidate's philosophy of CEC;

(3) letters of evaluation from people knowledgeable about the candidate's clinical ethics activities;

(4) six in-depth, detailed case discussions in which the candidate led or co-led the ethics consultation;

(5) six shorter case summaries to establish the breadth of a candidate's clinical ethics experience with regard to practice settings and types of ethical dilemmas, questions, and concerns.

We should note the relevance assigned both to practical experience and education obtained through an academic career, coursework or a fellowship. General categories, such as education and training, allow applicants to include a variety of experiences, while case discussions of consultations permit them to show competency in a wide range of clinical settings and ethical problems: "Candidates, knowing that they will be preparing their work for the assessment, will offer individual best practice and focus on achieving excellence given their skills. These portfolios are designed to be showcase portfolios, representing their own selection of their best work, to be used for evaluation of qualification to engage in CEC in the general practice of clinical ethics in the medical context" [6].

Concerning the German proposal, endorsed by the Akademie für Ethik in der Medizin [19], some differences may be noted when compared to the ASBH's proposal. The former distinguishes different degrees of required qualifications, depending on the role the professional is expected to play: whether he or she will serve as an independent clinical ethics consultant, a coordinator of the clinical ethics consultation service or an ethics consultants' trainer. in line with the ASBH's proposal, the general requirements include both education and practical experience, that will be proportionate to the different degrees and levels of responsibility assumed, i.e. they will depend on the specific role the candidate will play.

In the logic of professionalization, the US reflection on clinical ethics consultation practice has also led to the development of a Code of Ethics for Health Care Ethics Consultants [5]. Regardless of different opinions on the aptness of this Code, it is relevant to note that it fosters efforts towards the delineation of common principles and professional values that should orient ethics consultation's activity. We aim to consider three aspects of the Code that in our understanding are strongly related to the issue of certification and quality assessment of future clinical ethics consultants. It is still an open question who should verify whether a single ethics consultant respects those professional values and acts in accordance with them or, in case of non-adherence, which sanctions are provided for.

The first aspect that we want to highlight concerns potential conflict of duties that may arise in case a single ethics consultant carries out several roles and tasks in the same hospital setting [5]: how to appropriately take into account, in a single standard evaluation, the consultant who carries out this sole task, as his primary responsibility, and the consultant who just works as a part-time employee. Put another way: does the ethics consultant practices a specific profession or does he/she integrate his/her original professionalism with additional knowledge and skills? In the latter circumstance, how reliable are his/her qualifications? Namely, is it possible to perform more than one single role effectively? Moreover, in relation to the certification process, should this additional professional profile be taken into consideration, thus restricting the possibility of a single, unique evaluation?

The second aspect deals with the safeguard of the ethics consultant's integrity. According to the American perspective, in case of conflicts between professional duties and the consultant's moral conscience, the former should trump the latter [5]. Even though, on the one hand, this demonstrates that what counts as a guarantee of professional reliability are specific standards of behavior – not just personal traits or subjective aspects – that may be evaluated and standardized, on the other hand, this may put at risk other elements that in the practice of particular professions – especially those that have to do with ethics – are fundamental: e.g. the richness of personal ethics reflection, the importance of acting consistently with one's own deepest moral convictions, the responsibility of the professional as a person/moral agent himself.

Finally, the consultant would also perform the task of promoting a just health care system [5]. This means that on the ethics consultant is conferred a public ethics role, that goes far beyond the duties and responsibilities linked to a single ethics case consultation. How to verify and assess this additional public role? What's more, how much weight should this task have in the whole evaluation process?

HOW TO COMBINE THESE DIFFERENCES INTO A SINGLE EVALUATION IN THE ITALIAN CONTEXT?

According to the international literature, there are two fundamental elements that should be considered with regard to the delineation of standard criteria for assessing the credentials of ethics consultants: the need to pay special attention to the high variation in educational pathways and to the heterogeneity both in approaches and practical experiences and, as a consequence, the circularity between educational models and qualification criteria.

Concerning the Italian situation, we face two different modalities in the way ethics consultation may be offered: either through a single ethics consultant permanently employed in hospitals or through the establishment of a clinical ethics committee [20, 21]. While in the first circumstance the ethics consultation activity may be considered the main function, in the other case it is certainly peripheral/ancillary and limited in time. The Italian debate has also discussed which model for CEC is best suited: whether the full committee, the small group or the single ethics consultant [21-24]. The Document of Trento, approved 10 October 2013 by the

GIBCE[1], has encouraged the establishment of ethics consultation services, however it must be taken into account that ethics consultation's experiences, in a proper sense, are quite rare in the Italian scenario [25-27].

The available educational and training proposals consist of bioethics and clinical ethics Advanced Courses, Postgrad Programs [28] and PhD Courses. Despite the usual reference to clinical ethics as the main subject of these academic proposals, a real and structured clinical ethics exposure remains sporadic.

Considering the recent document of the Italian National Committee for Bioethics [21] and the various but limited Italian experiences, it may be appropriate also for Italy to align with the choice made by the ASBH to opt for an intermediate certification proposal by means of a portfolio. This means that regardless of which model one chooses for ethics consultation (whether an individual consultant, a small team or a committee) what will be evaluated is whether an individual meets the required standards of quality [6]. Moreover, differently from the German proposal that distinguishes three levels of qualifications depending on role responsibilities (consultant, coordinator and trainer), the US proposal aims to generally "ascertain whether an individual can perform a consultation independently or serve as a lead consultant when the process is team based" [6].

Therefore, the proposal of a portfolio to attest the quality of clinical ethics consultants permits a good degree of flexibility that is respectful of the Italian different experiences: since we are still at the beginning of the ethics consultation implementation process in health care contexts, it may not be appropriate to preselect a single and unique model for ethics consultation as has been stated in the Document of Trento [25]. On the contrary, it might be wiser to experience different models and approaches and verify after a while which of those best fits for Italy.

Considering both the American and German proposal, educational and training experiences are the essential requirements that the portfolio should contain. Previous training and education must guarantee that the ethics consultant applicant possesses the core knowledge to conduct ethics consultation. An Advanced Course in bioethics may be not sufficient to prove one's credentials, nor the participation in bioethics and clinical ethics conferences. The main question is not what kind of degree the applicant possesses, but the competence he or she is able to exhibit and this must be certified by specific training focused on the performance of ethics consultation [3, 6]. Our proposal deals with the certification process and the evaluation of qualifications, i.e. with the attestation of the competence possessed by the candidates, and not with the accreditation of educational pathways [29].

Another essential criterion to evaluate the qualifications of the candidate consists in the number of ethics consultations that he/she has led or co-led. This is a fundamental requirement: just as the physician, in order to obtain the title of surgeon, must have taken part in a number of surgical interventions with an increasing degree of involvement and responsibility, the ethics consultant applicant must show the same practical experience. This is consistent with the settled analogy between medical consultation and ethics consultation as demonstrated previously. As already stated, in Italy it might not be easy to witness and take part in a high number of ethics consultations during the formal training undertaken by the applicant; hence, the opportunity to carry out an internship outside the country of origin might be a meaningful option. Of course, it is important to consider the ability of the candidate to handle several ethical issues regarding different clinical ethics fields, such as ethical issues at the beginning and at the end of life, transplants, etc.

Finally, it is necessary for the ethics consultant to demonstrate his or her ability to perform an ethics consultation by her/himself. The ways through which it is possible to verify and assess this ability may vary, but the candidate must prove that he or she possesses a wide range of mediation techniques – as is expected by the German proposal [19] – the ability to handle different moral perspectives and convictions, as is required in an ethically pluralistic society, and the capacity to make decisions in an emergency and when urgent clinical situations come up [25, 27].

We argue that the three elements in the portfolio, i.e. education, training and hands-on experience, should have the same weight and importance so that each applicant should be assigned a specific score for each area of expertise; each area is essential to guarantee the credentials required to serve as a consultant.

Concerning the evaluator, some criteria must be respected as well. The evaluator should carry out, as his or her main professional activity, ethics consultation and have a great experience in several clinical ethics activities or be familiar with a wide range of clinical ethics issues in health care. He or she should possess a PhD Degree or have completed a Postgraduate Program related to the field of ethics consultation or other evidence of qualification. A volume of scientific publications and teaching experience in the field of CEC is also needed. The evaluation of the qualifications of the ethics consultant candidate should be carried out by an examination board where each member, or at least the majority, satisfies the above requirements.

Considering the Italian situation, we argue that the formal examination should be structured at a national level in order to guarantee homogeneity in the assessment and, at the same time, transparency and standardization. This may help to strengthen the credibility in the profession and guarantee the correctness of the certification process.

PROPOSALS FOR THE FUTURE

To conclude, we would like to make some suggestions to encourage further reflection. With reference to education, considering the parallel between medical consultation and ethics consultation and the emphasis on hands-on experience, could a "clinical ethics residency"

[1]In Italy it has recently been established the Scientific Society named Interdisciplinary Group of Clinical Bioethics and Health Care Ethics Consultation (GIBCE). For further information, see https://eticaclinica.wordpress.com/.

in the Italian context represent the most fitting modality to train the future generation of clinical ethics consultants? The admission requirements should take into full account the peculiarity and interdisciplinary qualifications of the applicants.

Considering the low number of clinical ethics consultation services in Italy, it becomes necessary to give high relevance to national experiences that may guarantee tools and means to create an appropriate curriculum. At the same time, it will be of great importance to reflect on possible ways to evaluate the quality of clinical ethics consultation services when established, and the ongoing professional updating of ethics consultants.

We think it is time to work towards a European core *curriculum* for clinical ethics consultants, that may represent the fundamental step to set shared and standardized certification procedures for ethics consultants. Pursuing this goal would strengthen ethics consultation as a profession, facilitating its spread also in those countries where it is scarcely acknowledged and implemented.

Authors' contributions

MP contributed to the conception and design of the work, drafted and revised the paper.

AG contributed to the conception and design of the work, integrated and revised the paper.

FN contributed to the conception and design of the work and commented on the paper.

RP contributed to the conception and design of the work, commented on the paper and supervised the all project.

All authors read and approved the final manuscript.

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