

## POLICY FORUM

### Strategies to Improve Health Care Ethics Consultation: Bridging the Knowledge Gap

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Serious concerns have been raised about the quality of health care ethics consultation (HCEC) services in US hospitals, the fact that these services operate with little oversight, and the possibility that low-quality HCEC might harm patients [1-4]. The largest and most comprehensive study of HCEC to date was published in the *American Journal of Bioethics* in 2007 [1]. It found, among other things, that: significant resources are devoted to HCEC; HCEC practices vary widely; many HCEC practitioners have little training; and HCEC services are rarely evaluated for quality. This study was received as a “wake-up call” [3] by the bioethics field and catalyzed several national quality improvement efforts.

In the wake of this study, the American Society for Bioethics and Humanities (ASBH) spearheaded several projects designed to [improve HCEC quality](#). Most significantly, ASBH published a report on core competencies for HCEC that establishes specific quality standards [5]. ASBH has also developed an education guide for improving HCEC competencies [6]; a report on certification, accreditation, and credentialing [7]; a code of ethics for ethics consultants [8]; and a portfolio review process to assess the competency of HCEC practitioners [4]. Meanwhile, other groups have advocated for different strategies to improve HCEC quality. For example, one group proposed a written certification exam for HCEC practitioners [9, 10]. Other groups have proposed credentialing and privileging HCEC practitioners at the hospital level [3, 11, 12]. Still others have proposed accrediting HCEC services at the program level, as is done for institutional review boards [13, 14].

Right now, ASBH leadership is debating whether to pursue a certification process for HCEC practitioners, and the organization is [poised](#) to make critical decisions about next steps. The problem is that policy discussions are primarily taking place among members of the academic bioethics community who lack critical information about the US hospitals they seek to change. The field of bioethics in the US, including its national organizations and published literature, is dominated by academics who work in or are closely affiliated with universities. Bioethicists who practice HCEC typically do so in large teaching hospitals with relatively high-volume HCEC services. Some of these hospitals have multiple paid bioethicists on staff and perform up to 300 consultations per year [1].

But such hospitals are far from [typical](#). The majority of US hospitals are quite small: 74 percent have fewer than 200 beds, 54 percent have fewer than 100 beds, and 33 percent have fewer than 50 beds [15]. More than three-quarters of US hospitals have no medical school affiliations or residency programs [15]. And the “typical” US hospital performs very few consultations; based on data from the 2007 study, an estimated 19 percent of US hospitals have no HCEC service, and, in the majority of hospitals that do, the service performs between zero and three consultations per year [1].

To maximize the impact of improvement strategies, policymakers should target “typical” US hospitals, instead of the small fraction of hospitals that already have a bioethicist. Making assumptions about US hospitals by extrapolating from bioethicists’ experiences could lead to poor policy decisions. For example, the ASBH core competencies report distinguishes between basic-level HCEC competencies (required to handle straightforward cases) and advanced-level competencies (required for more complex cases) [5]. Based on the experiences of bioethicists, policymakers might reasonably assume that most hospitals need people with advanced-level HCEC competencies, and, as a result, might focus their improvement efforts on certifying HCEC practitioners at the advanced level. But what if the hospitals with the greatest quality problems rarely if ever encounter cases that are complex enough to require advanced-level HCEC competencies? In that case, an improvement strategy focusing on advanced-level competencies would be ineffective in hospitals that need it most.

To make prudent decisions, policymakers need to better understand: (1) current HCEC practices in US hospitals, (2) the gap between current practices and the quality standards established by ASBH, and (3) the perspectives of key stakeholders, especially in “typical” US hospitals.

First, there is a need for up-to-date information about HCEC practices. Much has changed since 2000, when the prior national study was completed. More recent studies have examined HCEC practices in a single US institution [16–21], at institutions outside the US [22–26], and at 44 children’s hospitals [27]. But none of these studies can be used to draw conclusions about general hospitals in the US.

Second, there is a need to understand the degree to which HCEC practices are consistent with newly established ASBH quality standards. To develop appropriate strategies, policymakers need information about specific quality gaps. Understanding how HCEC quality relates to HCEC service characteristics (e.g., consultation volume, level of training) would help policymakers further target interventions to maximize impact [28]. Ideally, HCEC quality should be assessed not only through survey methods, but also through review of HCEC records.

Third, policymakers need to understand the perspectives of key stakeholders to determine which improvement strategies would be most effective. A recent study asked a convenience sample of people who subscribe to national bioethics listservs about their preferred methods for assessing and improving the competence of HCEC practitioners [29], but most respondents were ASBH members and 70 percent had received advanced training in medical ethics (27 percent at the doctoral level, 26 percent at the master's level, and 17 percent in a certificate program or fellowship). These respondents are not at all representative of US hospitals, in which, one sample indicated, only 5 percent of HCEC practitioners had completed a fellowship or graduate degree program in bioethics [1].

For improvement strategies to succeed on a national level, they will need to appeal not just to the academic bioethics community but also to key stakeholders in hospitals more generally—especially the thousands of HCEC practitioners and hospital administrators who are directly responsible for HCEC practices but may have little or no connection to ASBH or the national academic bioethics community. To change practices on a broad scale, policymakers will need to influence stakeholders in “typical” hospitals, and, to do this, they need to understand stakeholder perspectives and values.

To help fill this knowledge gap, my team from the Center for Ethics in Health Care at the Altarum Institute is embarking on a new research study, supported by a grant from the Greenwall Foundation. We will ask HCEC practitioners and administrators in a random sample of 600 US hospitals about their HCEC practices and their views on potential improvement strategies. We also plan to assess HCEC quality through a review of 300 written consultation records using a rigorous scoring method I developed with my former colleagues at the National Center for Ethics in Health Care [30].

The Altarum study will answer the following questions:

- How have HCEC services changed since 2000? For example, has the level of training received by HCEC practitioners increased or decreased? Has the volume of HCECs changed?
- How do HCEC practices compare with recently established ASBH standards? For example, are hospitals meeting ASBH standards for documenting HCECs? Are HCEC services being evaluated as ASBH recommends?
- What are the perspectives of HCEC practitioners? For example, do they believe that the resources devoted to HCEC are sufficient? What do they think about ASBH standards for HCEC? What strategies to improve HCEC do they think would be effective?
- How much do hospital administrators know about HCEC services, and do their perspectives differ from those of HCEC practitioners?

- What is the relationship between hospital characteristics, HCEC service characteristics, HCEC practices, perspectives of HCEC practitioners, and perspectives of hospital administrators?
- How do hospitals score on HCEC quality as determined by systematic review of written HCEC records, and how do these scores relate to the variables above?

We hope and expect that the answers to these questions will help policymakers develop effective strategies to improve HCEC quality, especially in those hospitals that are most in need of improvement.

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ISSN 2376-6980**