Are Ethics Committee Members Competent to Consult?

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A significant amount of discussion in the bioethics community has been devoted to the question of whether individuals performing ethics consultations in healthcare institutions have any special expertise. In addition, articles in the lay press have questioned the "added value" that bioethicists bring to ethical dilemmas.[1] Those at the forefront of the bioethics community have argued repeatedly that those doing ethics consults cannot simply be well-intentioned individuals, that some training in bioethics, group process, and facilitation is necessary to competently execute a consult. As one bioethicist commented:

> if you approach any endeavor as an amateur activity, you will get, in the end, an amateurish version of the activity. Without a sufficient commitment of personnel, time, support, and financial resources, a healthcare organization will get the 'ethics' program . . . it set out to create: an inept, unskilled, inefficient, and highly risky 'program' in healthcare ethics and bioethics.[2]

In addition, there has been an ongoing debate within the bioethics community over what constitutes appropriate skills and knowledge for the performance of bioethics consults. This question is part of a larger debate about the source of moral authority of bioethics consultants. Two schools of thought on this issue have emerged based on one's view of the appropriate model for ethics consultation—a consultation model or facilitation model.[3] Proponents of the consultation model view ethics consultation as similar to a medical consultation in which the "expert" (physician) provides advice and a recommendation to address a complex medical problem. This perspective requires an expertise in moral theory on the part of the bioethicist. Proponents of the facilitation model view the consultant as a facilitator or mediator and accordingly place more importance on process skills than knowledge base in the performance of consults.[4]

In response to such concerns, the American Society for Bioethics and Humanities (ASBH) Task Force ("the Task Force") on Standards for Health Care Ethics Consultation ("the Standards")[5] developed a set of minimum "competencies" that those conducting ethics consults should possess. The final Task Force report was distributed in November, 1998.[6] The competencies are divided into skills and knowledge necessary for ethics consultation. Skills are divided into three categories: (1) ethical assessment skills, (2) process skills, and (3) interpersonal skills.[7] Examples of ethical assessment skills include the ability to "discern and gather relevant data," "assess the social and interpersonal dynamics of the case," and "distinguish the ethical dimensions of the case from other, often overlapping, dimensions."[8] Process skills, among other things, include the ability to involve "key decision-makers and involved parties and include them in discussion," "help individuals critically analyze the values underlying their assumptions, their decision, and the possible consequences of that decision," and "engage in creative problem solving."[9] Finally, examples of interpersonal skills include the ability to "listen well and to communicate interest, respect, support, and empathy to involved parties," "educate involved parties regarding the ethical dimensions of the case," and "elicit the moral views of the involved parties."[10]

Core knowledge areas necessary for ethics consultation include knowledge of moral reasoning and ethical theory, common bioethical issues and concepts, healthcare systems and clinical context, the local healthcare institution and its policies, relevant codes of ethics and profes-

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sional conduct, guidelines of accrediting organizations, and relevant health law.[11]

There are no data on whether those currently performing ethics consults possess the minimum competencies recommended by the Task Force. In fact, aside from their professional disciplines, there is little empirical literature describing the backgrounds of ethics committee members performing consults. No studies, to our knowledge, have provided evidence as to whether those performing ethics consults possess a set of skills and knowledge base believed necessary to competently perform a bioethics consult. There is considerable disagreement, in fact, as to whether those doing consults possess the "necessary" skills to perform the task. By way of illustration, a 1998 bioethics newsletter included a series of interviews with bioethicists reacting to the Task Force standards. In response to the question, "what level of skill and knowledge do most ethics committees doing consults have today?" one ethicist said, "I would say basic to none." Another said, "[t]he ones I know have more skills and knowledge than are outlined in [the Task Force] report. There is clearly the fear that there are inadequately qualified ethics consultants out in the world. It could happen, but I have never heard of any real case."[12]

In January 1998, we received funding from The Greenwall Foundation to examine whether those doing ethics consults are "competent" to perform them. Competence was to be determined by educational background and training in relevant disciplines and skills of those performing ethics consults, and by relying on the minimum competencies[13] recommended by the Task Force as guidelines to assess self-perceptions of skills and knowledge base. In addition, we assessed whether institutions had in place mechanisms to enable the competency of those performing ethics consults, such as a budget for member education. This article describes our study methodology and results.

Methodology

The study was conducted in two phases. Phase I included a written questionnaire mailed to hospital ethics committee chairs in Maryland; Phase II involved mailing a second written questionnaire to members of hospital ethics committees in Maryland who were identified in Phase I as able to perform ethics consults. Maryland is unique among states in that it requires, by statue, that all hospitals have a patient care advisory committee, or ethics committee, as most hospitals refer to them.[14]

Phase I

The two-part instrument for Phase I was sent to hospital ethics committee chairs. The first part requested data about the hospital's ethics committee, institutional support for the committee, and educational and training opportunities provided for committee members who perform consults. The second part was to be completed only by those chairs whose committees provided ethics consultation services. This section requested information concerning the number of consultations performed, who conducted consults, and the process used to conduct consults, i.e., contacts made, meetings held, documentation and evaluation of the consult.[15]

Phase II

The purpose of Phase II was to (1) identify ethics consultation training and education of those performing ethics consults, and (2) measure their self-perceived and actual knowledge of substantive concepts relevant to the performance of ethics consultation. A literature and internet search failed to produce appropriate survey instruments with which to assess these domains. The survey instrument for Phase II, to be completed by those performing ethics consults, was developed uniquely for this study. It included six separate tools: (1) a demographic tool requesting information concerning the respondent's profession, employment, length of time on the ethics committee, education in bioethics, and the number of consults in which the respondent had participated in 1997; (2) a seven-item tool using a 1 to 6 Likert-type scale (1 = "not skilled" and 6 = "very skilled") to ask how skilled respondents self-assess their own ethics consultation initiation skills (perceived "*assessment*" skills, e.g., ability to identify an ethical conflict, to gather relevant medical information, and to identify key decision-makers); (3) a six-item tool using the same 1 to 6 rating scale to self-assess perceived ethics consultation process and interpersonal skills (perceived "*process*" skills, e.g., ability to involve key decision-makers and concerned parties, to gain trust of parties involved, and to elicit feedback from participants); (4) a six-item tool using a 1 to 6 rating scale (1 = "not familiar," 6 = "very familiar") to assess perceived familiarity with Maryland laws (e.g., laws on informed consent, withholding of life sustaining treatment, and laws regarding confidentiality); (5) a five-item tool using a 1 to 6 rating scale to assess perceived familiarity with hospital policies at the participant's healthcare institution (e.g., policies on informed consent, medical futility, and conflicts of interest); and (6) an eleven-item multiple-choice questionnaire intended to capture participants' knowledge of bioethics consultation concepts,[16] with a final question requesting open-ended comments about the respondent's participation in ethics consultations at his or her institution.

The questions for most of these tools were based, in large part, on the standards developed by the ASBH Task Force on Standards for Health Care Ethics Consultation. Thus, they explored respondents' "comfort level" with process skills as well as with knowledge deemed necessary for adequately conducting ethics consults. The self-perception

rating instruments consisted primarily of self assessment questions, that is, how respondents perceived their own ethics consultation knowledge and process skills, rather than questions objectively testing respondents' skills or knowledge. There were several reasons for this approach to the survey design. First, it is difficult to test actual consultation skills, such as those listed in the Task Force Standards (e.g., ability to listen, to educate parties about the relevant bioethics concepts, to "build a moral consensus" among parties involved in the consult, etc.[17]) in a written questionnaire. Observation of actual consultations would be required to effectively evaluate such skills. Time and resource constraints prevented this type of evaluation. Second, it has proven difficult to assess an individual's knowledge of bioethics concepts and their application of those concepts in a multiple choice or other quantifiable format. Research has shown that when bioethicists are given a series of questions about how an ethical dilemma should be resolved, the responses differ significantly.[18] Bioethicists argue that such differences are appropriate as there is often more than one "right" answer to an ethical question. Similarly, when we attempted to design multiple choice test questions regarding bioethics concepts, on pretesting with five bioethicists, responses given varied considerably. As a result, we included only the bioethics knowledge questions on which the experts agreed, which produced a tool with little variability in responses.

Content validity was obtained for the tools used in the Phase II survey through two methods. First, the questions were developed based on the Task Force criteria for the Standards for Health Care Ethics Consultation. Second, a panel of experts in bioethics reviewed and amended the survey tools. Due to time constraints, we did not undertake a pilot study. Reliability was demonstrated on the Likert-rated tools using Cronbach's alpha estimates, in which values above .70 are considered adequate measures of reliability. Reliability estimates were good for the ethics process skill tool (.89), ethics assessment skill tool (.81), familiarity with Maryland law tool (.94), and familiarity with hospital policies tool (.91). Reliability for the knowledge questionnaire was assessed using the intraclass correlation coefficient, which is also a value between 0–1.00, in which values above .70 are considered adequate. Using this estimate, the reliability for the knowledge questionnaire was only .31.[19] This is not surprising, given the difficulties already described in quantitatively measuring ethics knowledge. Due to this low reliability value, analyses of ethics knowledge based on the knowledge questionnaire scores were not included in the statistical analyses performed.

Survey distribution

The first survey instrument was sent to the chairpersons of hospital ethics committees at all 67 operating Maryland hospitals listed in *Profile of American Hospitals 1998: The AHA Guide.*[20] Chairpersons were identified by phone inquiries to hospital administrative personnel. Along with the survey questions, ethics chairpersons were also asked to provide a list of members of their ethics committee who participated in ethics consultations. With these lists, the second survey instrument was mailed to those persons identified by the chairperson. All participants contacted were aware that this was a research study and had the option of declining participation.[21] Confidentiality of responses was maintained for all survey respondents.

Analysis and results

Descriptive and inferential statistics were used to analyze the quantitative data. Content analysis was performed on the comments and open-ended questions.

Part I: Survey of ethics committee chairs

Demographic background

Forty of 67 hospital ethics committee chairs surveyed (60%) responded to the questionnaire. The median size of the hospitals from which respondents came was 248 beds, and the range was 20 to 650. There was no difference in bed size or rural/urban status between hospital chairs that responded and those that did not. Among the ethics committees represented in the survey, the mean number of members was 16 (median 13), with a range from five to 39 members. A small number of committees (4, or 10%) served more than one hospital.

Composition of committees

Committees were all multidisciplinary. All had physicians and nurses on the committee (100%); virtually all had a social worker (97.5%) and a representative of the institution's administration (95%) on the committee. A large majority included a chaplain or member of the clergy (87.5%); and slightly over half included a lawyer (57.5%). Fewer than one-third (27.5%) had a formally trained philosopher or bioethicist. Seventeen chairs (42.5%) listed various other individuals as members. Of these, nine chairs said their membership included lay persons, volunteers, or community members.[22] Half of the respondents (50%) said their committee had written criteria for membership.

The discipline of chairs, for the most part, was medicine (62.5%).[23] One chair had a Masters degree in bioethics. Twelve chairs (30% of respondents) said they had obtained a certificate in bioethics. Of those, three had attended a semester-long course at a private college's continuing education program. Others reported having attended the week-long intensive ethics course at the Kennedy Institute of Ethics at Georgetown University, having attended

seminars offered by The Hastings Center, or having completed graduate level courses in bioethics. One chair had a Masters degree in Theology and another had a Masters degree in Divinity.

Thirty-six of 40 chairs (90%) said their committee conducted ethics consultations; only four chairs (10%) said their committee did not conduct consults. Those committees that had conducted consults, on average, had been doing so for seven to eight years. During 1997, the average number of consults conducted was 8.5, with a range of one to 80 consults. The average number of consults in 1997 per 100 hospital beds was 2.87. All of the chairs participated in the consultations.

Consult Process

In over one-third of these 36 institutions (36.1%), consults were conducted by a subcommittee of the full committee. In other institutions, consults were conducted by a rotating team (22.2%) or by the full committee (13.8%). Six chairs said that they had used the services of an outside paid ethics consultant; however only one said the consultant was used to provide advice on a case.

Approximately two-thirds of the chairs (67%) said their committee had established written criteria for who may conduct consultations. Criteria included: membership on the ethics committee (52.9%); a clinical background in healthcare (20%); status as a hospital employee (14.3%); a specific length of time served on the committee (11.4%); some type of training or apprenticeship (11.4%); and some type of education in bioethics (8.8%).

Education of Those Performing Ethics Consults

A large majority of chairs (86.1%) said that their committees provided some type of education for members who provided consultation services. Types of educational approaches and the percentage of institutions that provided each appear in Table 1. Forty-two percent of committees that provided education simply provided readings in bioethics to those performing consults. Other approaches to education that chairs mentioned included attending presentations at ethics committee meetings, availability of ethics journals and videos, retrospective case reviews, and encouragement to attend outside programs. Four chairs (11.1%) said that they required those performing consults to participate in continuing education related to ethics consultation.

Institutional Support

A large majority of chairs, 89.5%, said that they believed the hospital administration adequately supported the ethics committee's efforts. In open-ended comments, chairs most often mentioned that the administration provided financial support for education and training activities, secretarial services, and accommodation for monthly meetings (e.g., meeting rooms or lunches). While 59% said they had a paid staff person, this support often consisted of a percentage of a secretary's time. In spite of the generally widespread belief of most chairs that their institution provided the committee with adequate support, only 10% of committees had a budget.

Part II: Survey of members performing consultations

Responses

In Phase I, 464 committee members were identified who could perform ethics consults. In Phase II, surveys were sent to these 464 individuals (including the committee chairs), and 192 surveys were returned. Thus, the response rate for this portion of the study was 41%. Although we do not have information on nonresponders per se, comparisons between institutional response rates[24] indicated there was no significant difference between various descriptive variables, such as hospital location (urban or rural) or hospital status (public or private). Hospitals that had a zero response rate (n=9) did not differ significantly in number of facility beds, number of members on the ethics committee, and number of consults performed in 1997 from committees that had at least one respondent (n=29, institutional response rates ranged from 17% to 100%, 0=51%). Only one significant difference was found between groups: institutions that had an ethics apprentice program (n=3) had a significantly higher response rate (79%) than institutions without an ethics apprentice program (n=33, 35%, p=.003).

Of the 192 individuals responding, 46 individuals (24.1%) had not performed any ethics consultations in 1997. Respondents who performed at least one ethics consult in 1997 (n=145) participated in a mean of five and a median and mode of three consults in 1997. The majority of those who had performed at least one consult (119 of 145 or 82%) had performed six or fewer consults in 1997.[25]

Respondents, categorized by professional discipline, included (in descending order of percent representation) persons from medicine, nursing, social work, administration, ministry, law, ancillary, "other," and philosophy/bioethics. Descriptive statistics are displayed in Table 2. Percent representation by profession of those who had performed one or more ethics consults in 1997 was approximately the same as those who had not performed an ethics consult in 1997 (see Table 2). Most individuals responding were employees of the hospital in which the committee resided (n=127, 66.1%). Twenty-six (13.5%) were independent practitioners with staff privileges, 19 (9.9%) were community representatives, and eight (4.2%) were representatives of affiliated organizations, e.g., nursing homes, hospices, and home health agencies. Twelve (6.3%) identified themselves in the "other" category (they included "edu-

cation specialist," "honorary staff," hospital board member, and pastoral volunteer). Most individuals had substantial experience working in a healthcare environment (twenty years on average), and had spent a mean of 4.6 years on the ethics committee.

Seventy-three (38%) of the total sample reported receiving some formal education in bioethics. Two individuals had Masters degrees in bioethics. Twenty-two (11.5%) had received a certificate from a program in bioethics. Twenty-eight (14.6%) had a Masters or a Ph.D. in ethics or "a discipline relevant to ethics." "A discipline relevant to ethics" was not defined. Twenty-one (10.9%) had a Bachelors degree in ethics or a discipline relevant to ethics. Of note is that 62% (n=119) of the total sample reported having no formal educational background in ethics. "No formal ethics education" meant that the respondent did not have a graduate degree or certificate in bioethics or a Bachelors, Masters, or PhD in bioethics, philosophy, or "a discipline relevant to ethics," as defined by the respondent. See Table 3 for a summary of ethics education background for all respondents and for those who performed at least one consult in 1997.

Ethics consultation inservices/external educational programs

Respondents reported attending, on average, 4.3 hours of inservice education relevant to ethics consultation in 1997 (median 2.0), and 5.4 hours of out-of-hospital education relevant to ethics consultation (median 0). Eighty-two individuals (43.9%) stated they had attended zero hours of hospital inservices related to ethics consultation in 1997. Ninety-nine individuals (52.4%) stated they had attended zero hours of out-of-hospital ethics consultation-related education in 1997. Fifty-eight individuals (30%) stated they had received zero hours of either inservice or out-of-hospital education related to ethics consultation in 1997.

Self-perception of competency

Most individuals surveyed perceived themselves as fairly skilled at ethics consultation (both assessment and process skills), familiar with Maryland law, and familiar with their own ethics-related hospital policies. On a Likert-type scale where 1 = "not skilled" and 6 = "very skilled," the mean score for perceived ethics assessment skills was 4.6 (SD =.80), and the mean score for perceived ethics process skills was 4.5 (SD=.79). On a similar scale, where 1 = "not familiar" and 6 = "very familiar," familiarity with Maryland law received a mean rating of 4.5 (SD=1.1). Familiarity with ethics-related hospital policies received a mean rating of 4.6 (SD=1.2).

Self-perceptions among different professions

Analysis of variance (ANOVA) with Tukey post-hoc testing was used to compare scores on the self-perception tools used in Phase II.[26] This revealed that physicians perceived themselves as more skilled in the assessment content of ethics consultation than respondents from administration, ministry, and nursing. Differences in scores for process skills among these different professions, however, were not significantly different. Social workers' self-perceptions of their familiarity with Maryland law were higher than all other groups (5.09).[27] Clergy respondents had the lowest self-perception of knowledge of Maryland law (3.90). The difference between the two was statistically significant (p=.006). Others' self-perceived knowledge of Maryland law ranged from 4.22 to 4.58. Clergy also self-reported lower ratings for familiarity with ethics-related hospital policies (3.79) than did physicians (4.87, p=.03) and nurses (4.99, p=.011).

Perceived competence based on ethics education

Perceived ethics assessment skills of respondents with no formal ethics education (n=119, 0=5.15) were lower than those with a certificate degree in bioethics (n=22, 0=5.79, p=.011) or an ethics-related graduate degree[28] (n=30, 0=5.70, p=.015). Perceived ethics process skills were lower in general than perceived ethics assessment skills, but differed significantly only between those with no formal ethics education (0=4.30) and those with an ethics-related graduate degree (0=5.05, p<001). On average, individuals who reported having an ethics-related graduate degree performed more ethics consults in 1997 (0=8.98) than those without a graduate degree (0=3.13, p=.004).

Perceived competence based on number of consults performed

Process skill perception was lower for those who had not performed any consults than for those who had performed at least one consult (0=4.27 versus 0=4.57, p=.033). The same trend was present for assessment skill perception, but the difference was not statistically significant. There was no difference in perceived familiarity with Maryland law between respondents who had and had not performed consults, but those who had performed consults rated themselves as more familiar with ethics-related hospital polices than those who had not performed consults (4.8 versus 4.2, p=.014).

Persons who had performed one or more consults in 1997 attended more mean hours of hospital ethics education inservices (5.13) than those who had not performed any consults in 1997 (1.98, p<.001). Those who had performed one or more consults also attended more out-of-hospital ethics education programs in 1997 (5.87) compared to those who had not performed any consults (3.93), but this difference was not statistically significant.

There was a statistically significant correlation between number of consults performed and perceived familiarity with ethics-related hospital policies[29] (.33, p<.001), perceived ethics assessment skills (Pearson's r=.31, p<.001),

and perceived ethics process skills (r=.24, p=.005). Perceived familiarity with Maryland law did not correlate with the number of consults performed.

Relationship between perceived and actual knowledge
Although we were unable to determine the relationship between respondents' self- perception of process skills and their actual process skills, we were able to explore whether respondents' perceived knowledge in one area—Maryland law regarding healthcare decision-making—was related to their actual knowledge of that law. The low reliability of the knowledge questionnaire precluded testing correlations between perceived familiarity with Maryland law and actual knowledge. Instead, perceived familiarity ratings between those who answered individual knowledge questions correctly and those who answered them incorrectly were compared. For example, one question on the knowledge questionnaire asked, "In Maryland, if there is a dispute among surrogates of the same class (e.g., parent vs. parent, adult sister vs. adult brother), how is the dispute to be settled?" Respondents chose one of three multiple-choice answers. Those who correctly identified the next step when surrogates of the same class are involved in a dispute (n=98) rated themselves as more familiar with Maryland laws on advance directives (p=.028), surrogate decision-making (p=.008), and guardianship (p=.047) than those who incorrectly answered this question (n=80). Also, T-tests revealed a higher mean perceived familiarity with Maryland law on surrogate decision-making for those who correctly identified the order of surrogate decision-making in Maryland (n=167, 0=4.81) than for those who incorrectly identified the statutory order (n=20, 0=4.12) (p=.018). However, in answering a true or false question of whether, in Maryland, "a family member can refuse life-sustaining treatment on behalf of a patient only if the patient lacks decision-making capacity and is terminally ill," those who correctly answered "false," (n=95, 50.5%) had almost identical ratings of perceived familiarity with relevant Maryland laws (on advance directives, informed consent, guardianship, surrogate decision-making, and withholding life-sustaining treatment) as those who answered incorrectly (n=93, 49.5%).

Study weaknesses

As with any survey instrument and study, this research was dependent on the survey instruments returned and the carefulness with which participants completed the survey instruments. The response rate of 60% for Phase I and 40% for Phase II may have resulted in a biased sample of respondents. The limited comparisons we were able to make between responders and nonresponders, however, did not reveal significant differences. In Phase II, it is possible that some respondents were erroneously identified as able to perform consults, and completed the questionnaire despite it being clearly labeled as a questionnaire for ethics committee members who are able to perform consults. An alternate explanation for why 46 respondents in Phase II had not performed an ethics consult in 1997 is that the number of individuals who are identified as able or eligible ("on call") to perform consults exceeds the number who actually perform consults in a given year.

Lack of standardized tools was also a limitation of the study. Although attempts were made to produce valid and reliable tools, the tools used were not validity-tested using other methods, such as discriminant or concurrent validity testing. Moreover, the self-perception measures used in the Phase II survey are substituted measures of actual ethics skill, familiarity with Maryland law and familiarity with hospital policies. Scores for these tools could be inflated for various reasons, including attempts to impress the researcher, or self-perceptions that overestimate actual knowledge or skills. However, a self-report questionnaire was the most feasible choice for Phase II of this preliminary, descriptive study. Weaknesses of the ethics knowledge questionnaire were discussed earlier in the article.

Lastly, respondents interpreted what constituted having a degree "in a discipline relevant to ethics" differently. For example, among those who claimed they had a graduate degree in an ethics-related discipline, the following were mentioned: a Masters in clinical psychology, divinity, human development, nursing, public health, social work, sociology, religion and theology, and a degree in law or medicine. Some respondents explained that they had course work in bioethics during their graduate work in these disciplines. Although all of these disciplines contribute to the field of bioethics, having a degree in any one of them is not synonymous with having a degree in bioethics per se. However, this would mean that the number of respondents with a formal education in bioethics is actually lower than what we reported. Although this might cast doubt on the findings that those who performed more consults had more *bioethics* education, it underscores our more general finding that individuals performing ethics consults lack formal education in bioethics.

Discussion

Significant findings from Phase I of the study indicated a lack of formal educational preparation on the part of ethics committee members who perform consults, and a general lack of institutional support for ethics committees, despite chairs' perceptions of positive institutional support.

Regarding training of committee members and those performing ethics consultations, fewer than one third of the committees had a formally trained philosopher or bioethicist in their membership. Only one chair had a degree in bioethics and none had a background in philosophy.

Furthermore, committee or institutional criteria for being able to perform consults was generally minimal in most institutions (e.g., the consultant must be a member of the committee or have a clinical background in healthcare). Few committees required completing some type of training or apprenticeship (11.4%) or having had education in bioethics (8.8%). Although a significant majority of chairs (86%) said they provided education for members performing consults, that education often consisted of readings in bioethics. Only a very few chairs provided a formal orientation (5, 13.9%) or an apprenticeship (3, 8.3%).

These findings alone leave us with the impression and support the contention that many committees function based on the belief that no special expertise is necessary to perform an ethics consult. This conclusion was also confirmed by the comments of one committee member who said (s)he was offended by a survey question that asked whether (s)he had any educational preparation for performing consults (e.g., a certificate in bioethics, or a degree in philosophy or a discipline related to ethics). (S)he further stated that the question "implies that this [ethics consultation] requires some sort of degree certificate." This, (s)he said, "may be a necessity for being a developer of ethical principles but not for day to day elucidation. Don't professionalize ethics committees."

The second significant finding of Phase I was the lack of institutional support for ethics committees. The Standards speak to fostering an institutional climate that enhances the consultation process, and state that "Health care institutions must be responsible to those who utilize ethics consultation services by providing support for ethics consultants in their institution."[30] This support is shown by "a clear process by which ethics consultants are educated, trained and appointed."[31] Hospitals must be assured that those providing consultation services in their institution are competent to perform their duties. This includes support for continuing education as well as access to basic bioethics course work and other resources. The type of support described by committee chairs does not appear to match the Task Force Standards regarding institutional support for ethics committees. Only 10% of committees had a designated budget from their institution. Although almost 60% of committee chairs said they had a paid staff person working with the committee, this person was most often a secretary who had many other duties. Despite these apparent constraints, most chairs felt they received adequate support from their institution's administration. The discrepancy may be explained by low expectations, or perhaps by a sense that the administration considered the work of the committee important in spite of a lack of financial support.

Results of Phase II revealed that those who performed one or more ethics consults in 1997 did attend more hours of inservice and out-of-hospital ethics education during that year than those who did not perform consults, and those with an ethics-related graduate degree performed significantly more consults than those without. One can conclude from these results that those actually doing consults may have more education in bioethics than those who do not perform consults.

Since the number of consults was positively correlated with perceived ethics skill (both assessment and process), one could conclude that performing consults increases one's perception of competency. This was the opinion of one respondent, who wrote in the comment section of the survey: "Participation in consults seems to me to be the best education. I find hands-on is better than reading or lectures, although the latter two are essential to a full, rounded ethics education." This result could also be interpreted as meaning individuals with increased self-confidence in ethics consultation perform more consults. This is consistent with research in theories of self-efficacy—one's belief in his or her ability to perform a behavior successfully. Bandura[32] found that individuals who strongly believed in their ability to perform a behavior successfully were more likely to initiate and continue with the behavior, even if difficulties arose. Those with poor self-efficacy beliefs avoided the task or abandoned it when they faced difficulties. It is likely, then, that those who are more confident in their ethics consultation skills will perform more ethics consults. Whether such confidence correlates with better skills, however, is open to question. Parle, Maguire and Heaven caution that there are healthcare professionals "whose strong self-efficacy ratings are substantially inaccurate when compared with their actual . . . behaviours."[33]

Despite the encouraging findings in our study that those performing more ethics consultations have more ethics education, individuals with such education remain in the minority. Phase II of this study revealed that the majority of ethics committee members identified as able to perform consults had no formal educational preparation in bioethics, and nearly one-third had received no inservice or out-of-hospital ethics consultation education. One participant voiced frustration in the lack of ethics education of ethics committee members, writing in the comment section of the survey:

> I am *always* troubled by the *total* lack of knowledge re: ethical principles of a majority of the committee members. I have expressed this concern to our chairperson repeatedly, but I believe he is hampered by the dearth of eligible persons to serve on the committee. At our last meeting, we actually had to *explain* the definition of an 'ethical dilemma' to one of our physician members. At a recent meeting, a member (pediatrician MD) suggested that 'one' member handle all the questions that come in and *only* call a meeting if that member and the other involved party couldn't reach an agreement. Some of our members actually

> believe that a decision of the committee is a *mandate*, when in fact, it is just an advisory statement. It is extremely frustrating to work in this environment.... I was *thrilled* to receive this questionnaire, as it means that someone is now assessing the makeup of these committees. I have been ready to resign from the committee many times, but instead have hung in there, providing photocopies of relevant articles to the committee members. Of course, there is no guarantee the articles are read. . . .

While this respondent was writing about lack of education and competence among ethics committee members but not necessarily among those performing consults, similar frustrations may arise when individuals who are not competent to perform ethics consults do so with little education, training, or evaluation of their performance.

We found that individuals performing consults lacked formal education and training in ethics consultation, yet they perceived themselves as fairly skilled in the ethics consultation process. What is not known is whether perception of ethics consultation skill mastery translates into adequate ethics consultation performance. The fact that physicians rated themselves the highest in perceived ethics assessment skills conflicts with other evidence (e.g., the SUPPORT study[34]) that many physicians lack certain skills (e.g., effective communication) necessary to avert ethical conflicts. One explanation for this discrepancy is that the physician members of these ethics committees are not representative of mainstream physicians. An alternate explanation is that perceptions of proficiency do not match actual performance.

Because we were unable to measure actual ethics consultation knowledge or skills and compare them to perceived knowledge or skills, we are unable to state whether perceptions of skill proficiency correlate with actual ethics knowledge or ethics consultation performance. A likely conclusion of this study is that ethics consultation performance needs to be observed and evaluated to determine if perceptions match performance. Interpretations of self-reported measures are always limited to the extent that they can be affected by a respondent's inaccurate self-assessment, or attempts to please the researcher. Even if one had a robust objective measure of cognitive knowledge with which to "test" whether self-assessment of cognitive knowledge matched actual knowledge, this methodology would be insufficient to evaluate process skills. Since this study provides evidence that those performing ethics consults lack sufficient education about ethics in general, and ethics consultation in particular, attention must focus not only on cognitive knowledge of ethics consultation, but also on process issues. In particular, the Standards recognize the need for education in interpersonal/communication skills. It has been observed that poor communication is at the heart of many, if not most, ethics consultations.[35] However, education in this area rarely addresses group communication and facilitative skills, which are highlighted in the Standards. Further research in communication skill mastery of persons performing ethics consults would be a logical next step for inquiry.[36]

Conclusions and implications

We set out to investigate whether individuals performing ethics consultations in Maryland healthcare institutions were competent to perform them. We assessed competency by educational background, degree of continuing education or inservice training in ethics consultation, self-perception of knowledge and skills based on the Task Force standards, and a limited assessment of actual knowledge of ethics consultation concepts. In addition, we looked at whether ethics committees performing consults received institutional support, as specified by the Task Force Standards. We found that formal bioethics education was lacking for many ethics committee chairs, most ethics committee members, and approximately two-thirds of those individuals designated to perform ethics consultations. Although committee chairs believed they receive adequate institutional support for the functioning of their ethics committees, their definitions of institutional support did not match the Standards set out by the ASBH Task Force.

It is encouraging to note that those who had actually performed ethics consults in 1997 had more ethics-related education than those who had performed no consults in 1997. However, individuals with formal bioethics education were in the minority—62% of Phase II respondents had no formal ethics education, and nearly one-third of all respondents had received no inservice or out-of-hospital ethics education in 1997. Although perceptions of ethics consultation skills were above average for all respondents, these ratings were higher among those who had actually performed ethics consultations. Some research has shown that perceptions of an ability to perform a skill are correlated with skill mastery. However, more research is needed to determine whether perceptions of ethics consult skills match skill performance, whether ability to perform a skill translates into the actual skill behavior in practice, and whether successful performance of ethics consult skills in practice leads to better outcomes for those involved in an ethics consult. Thus, the questions remain, are the skills for ethics consultation outlined in the Standards the "right" skills to achieve the best outcomes in ethics consultation? If they are the right skills, how many individuals performing ethics consultations possess them, how many use them effectively in practice, and do these skill behaviors lead to positive outcomes (in the broadest sense of this term) for all those involved in ethics consultations? These are questions for future research.

Table 1: Education Provided to Members Who Participate in Ethics Consultation (Phase I)

	Total *n* of hospitals	% valid total
Collection of relevant readings in bioethics to read on own	22	61.1
Sponsor attendance at outside bioethics course work	15	41.7
Other methods of educating members	14	38.9
Collection of relevant readings in consultation skills to read on own	10	27.8
Hospital-designed handbook to read on own	8	22.2
Formal in-house orientation workshop for new committee members	5	13.9
Formal in-house apprenticeship/training program	3	8.3

Table 2: Occupation of Phase II Respondents

	Total *n*	%	*n* for 1 or more consults in 1997	%	*n* for no consults in 1997	%
Medicine	52	27.1	37†	25.7	14†	30.4
Nursing	50*	26.0	39	27.1	11	23.9
Social Work	23*	12.0	19	13.2	4	8.7
Administration	19	9.9	14	9.7	5	10.9
Ministry	19*	9.9	16	11.1	3	6.5
Other	12	6.3	7	4.9	5	10.9
Law	9	4.7	6	4.2	3	6.5
Ancillary	6	3.1	5†	3.5	1†	2.2
Philosophy/ bioethics	2	1.0	1	0.7	0	0
TOTAL:	192	100	144	100	46	100

*Three individuals represented more than one profession: one from ministry and social work, one from nursing, social work, and administration, and one from social work and administration. They were coded as representing, respectively, ministry, nursing, and social work.

† One respondent from medicine and one from ancillary services left the question regarding number of consults performed in 1997 blank. Percentages reflect valid totals.

Table 3: Ethics Education Background of Phase II Respondents

	Total *n*	%	*n* for 1 or more consults in 1997	%	*n* for no consults in 1997	%
None	119	62.0	86	59.7	33	71.7
Certificate from program in bioethics	22	11.5	15†	10.4	6†	13.0
MA in discipline relevant to ethics*	18	9.4	15	10.4	3	6.5
BA in discipline relevant to ethics*	16	8.3	14	9.7	2	4.3
BA in philosophy	5	2.6	3	2.1	2	4.3
MA in philosophy	4	2.1	4	2.8	0	0
PhD in philosophy	4	2.1	3†	2.1	0†	0
MA in bioethics	2	1.0	2	1.4	0	0
PhD in discipline relevant to ethics*	2	1.0	2	1.4	0	0
TOTAL:	192	100	144	100	46	100

* "Discipline relevant to ethics" was not defined; it was interpreted by respondents.
† One respondent who had a certificate from a program in bioethics and one who had a PhD in philosophy left the question regarding number of consults performed in 1997 blank. Percentages reflect valid totals.

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1. R. Shalit, "When We Were Philosopher Kings: The Rise of the Medical Ethicist," *The New Republic*, 216, no.17 (1997): 24–28; R. Bailey, AWarning: Bioethicists May be Hazardous to Your Health: The Moralists' Attack on Medical Progress and Patient Freedom,@ <http://reason.com/9908/fe.rb.warning.html> (August/September, 1999): 1–13.

2. D. Blake, *Vital Signs* 75, (September, 1998): 1–2.

3. "Experts in Ethics?: The Authority of the Clinical Ethicist," *Hastings Center Report*, 28, no. 6 (1998).

4. The Task Force adopted an "ethics facilitation approach and rejected an "authoritarian" and "pure facilitation" approach. The ethics facilitation approach includes two core features: "identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus." *See "Core Competencies for Health Care Ethics Consultation,"* American Society for Bioethics and Humanities, (1998), herinafter "*Core Competencies*," at 6.

5. The Task Force consisted of scholars from the Society for Health and Human Values and Society for Bioethics Consultation. These two groups subsequently merged and are now the American Society for Bioethics and Humanities.

6. See *Core Competencies*, *supra* note 4.

7. *Id.* at 12.

8. *Id.* at 13.

9. *Id.* at 14.

10. *Id.*

11. *Id.* at 16–21.

12. *Ethical Currents*, no. 52 (Winter, 1998).

13. The Task Force delineates basic ethics consultation skills and knowledge that each member of a consulting team needs to be deemed "competent." In addition, the Task Force recommends that at least one member of the consult team have advanced knowledge in certain areas. The only advanced skill that we included, which was not required for all team members, was "the ability to educate involved parties regarding the ethical dimensions of the case." *See "Core Competencies," supra* note 4 at 15)

14. See MD. CODE ANN., HEALTH-GEN. II " 19-371 to 374 (1996).

15. It was modeled, in part, after a survey conducted by Hoffmann in 1990 that gathered information on demographics and operations of ethics committees, but did not ask about education of committee members. *See* D.E. Hoffmann, "Does Legislating Hospital Ethics Committees Make a Difference? A Study of Hospital Ethics Committees in Maryland, The District of Columbia, and Virginia," *Law, Medicine & Health Care,* 19, nos.1-2 (1991): 105–119. This instrument was used in order to compare changes in committee structure and operations of ethics committees in

Maryland between 1990 and 1998.

16. Knowledge questions included general ethical concepts as well as content specific to Maryland healthcare policy.

17. See "*Core Competencies*," *supra* note 4 at 14–15.

18. E. Fox and C. Stocking, "Ethics Consultants' Recommendations for Life-Prolonging Treatment of Patients in a Persistent Vegetative Stage," *JAMA*, 270 (1993): 2578–2582.

19. This demonstrates the problem of attempting to measure ethics knowledge quantitatively—since the only questions included were ones in which there was consensus among experts as to the answer, the result was a low variance in response scores, which contributed to the low reliability score.

20. Healthcare Infosource, Inc., a subsidiary of American Hospital Association, One North Franklin, Chicago, IL. Three of the 70 hospitals listed had either closed or had merged with another hospital making the total sample size 67.

21. The study was determined to be exempt from the University of Maryland's Institutional Review Board (IRB) process. (Memo to Diane Hoffmann from the University of Maryland, Baltimore IRB on June 8, 1998.)

22. Other types of members listed by one or two committees included risk managers, patient representatives, hospital security services, representatives from hospice, mental health, home health and the hospital board. This is relatively consistent with findings of a study of ethics committees in 1990 in Maryland, the District of Columbia, and Virginia. See D.E. Hoffman, *supra* note 15, at 108. However, this more recent study found that more committees included a representative of the hospital administration, more included a lawyer, and fewer included an ethicist, than was the case ten years ago.

23. Just over ten percent of committees (12.5%) had chairs who were social workers, nurses, or administrators. Two committees (5%) had chairs who were chaplains or members of the clergy.

24. Institutional response rate = percentage of individuals at each institution who were identified by chairs as able to perform ethics consults, and who responded. Thus, if in Phase I a chair identified 9 individuals as able to perform ethics consults and 3 returned the survey in Phase II, the institution would have a 33% response rate.

25. One individual did not answer this question, one reported performing 40 consults, and one reported performing 80 consults. To avoid inflation of the mean number of consults due to the outlier of 80 consults performed, that value was "windsorized' in statistical computations from 80 to 41.

26. Statistical significance levels should be interpreted conservatively, as assumptions for statistical tests were not always met (e.g., unequal group sizes were unavoidable, and severely skewed distributions were corrected through logarithmic transformation for running the Pearson correlations but not for the ANOVA tests). In addition, multiple testing increased the possibility of a fishing error. Results could be interpreted more cautiously by using a significance level of .025 instead of .05 to determine statistical significance.

27. Lawyers' responses were not analyzed separately as the group was too small (n=9) for a statistically robust comparison.

28. This includes two individuals with a Masters in bioethics, and the rest with a Masters or PhD in an ethics-related discipline (see text for how this was interpreted by respondents).

29. Negatively skewed distributions for "number of consults performed" and "perceived familiarity with ethics-related hospital policies" were normalized through logarithmic transformation.

30. See "*Core Competencies*," *supra* note 4 at 30.

31. *Id.*

32. A. Bandura, "Self-Efficacy: Toward a Unifying Theory of Behavioral Change," *Psychology Review,* 84 (1977): 191–215.

33. M. Parle, P. Maguire, and C. Heaven, "The Development of a Training Model to Improve Health Professionals' Skills, Self-Efficacy and Outcome Expectancies When Communicating with Cancer Patients," *Social Science & Medicine*, 44, no. 2 (1997): 231–240.

34. The SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), *JAMA*, 274, no 20 (1995): 1591–1598. See also W.F. Baile, et. al., "Communication Skills Training in Oncology. Description and Preliminary Outcomes of Workshops on Breaking Bad News and Managing Patient Reactions to Illness," *Cancer*, 86, no. 5, 887–897, and see B.M. Cantwell and A.J. Ramirez, "Doctor-Patient Communication: A Study of Junior House Officers," *Academic Medicine*, 74, no. 11, 1242–1248.

35. L.L. Northouse and P.G. Northouse, *Health Communication: Strategies for Health Professionals*, 3rd ed. (Stamford, CT: Appleton & Lange, 1998).

36. For examples of such research, see T. Hope and K.W. Fulford, "The Oxford Practice Skills Project: Teaching Ethics, Law and Communication Skills to Clinical Medical Students," *Journal of Medical Ethics*, 20, no. 4 (1994): 229–34; and M. Parle, P. Maguire and C. Heaven, "The Development of a Training Model to Improve Health Professionals' Skills, Self-Efficacy and Outcome Expectancies When Communicating With Cancer Patients," *Social Science & Medicine*, 44 (1997): 231–40.