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Core competencies for clinical ethics committees

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ABSTRACT – Clinical ethics committees (CECs) are increasing in number in the UK and have mostly developed in response to local interest, as opposed to being mandated as in the USA. However, there is no regulatory framework for UK CECs with no defined educational requirements or specification of core competencies for their members. The UK Clinical Ethics Network has consulted extensively with its members to set out, for the first time in the UK, the core competencies necessary for the provision of clinical ethics support. Recommendations for educational and membership requirements for CECs have also been made. Given the appropriate resources the standards proposed can be appropriately evaluated and are consistent with principles of ethical governance.

KEY WORDS: clinical ethics, competencies, ethics consultation

Introduction

There is growing recognition of the need for practical and intellectually rigorous ethics consultation and support to address the complex dilemmas posed by contemporary clinical practice.[1,2] Such support may be provided by individuals, small groups or even specialist ethics departments. In the UK this purpose is often served by clinical ethics committees (CECs), mostly in response to local need and interest with a similar development being recorded across Europe.[3,4] The number of CECs in the UK has increased from 20 in 2000 to 75 in 2007; the UK Clinical Ethics Network (UKCEN) provides them with support and enables them to pool their expertise.[5] In the UK CECs have supportive, educational and consultative functions that are advisory rather than prescriptive or quasi judicial.[6] As such they have been concerned with values per se rather than their compatibility with the law.[7] This contrasts to the 'top-down' approach to ethics consultations and CECs in the USA that has been driven by court recommendations, government advisory bodies and hospital accreditation requirements.[8,9]

In contrast to research ethics committees (RECs), there is no formal legal or regulatory governance framework for UK CECs, nor any defined educational requirements or specification of core competencies for their members.[10] It is therefore unsurprising that critics of CECs have questioned their legitimacy as bodies of ethical expertise, their function and purpose, and the extent to which governance and regulation should apply if their role is to be extended.[11] In particular there are concerns that UK committees may follow their US counterparts and pay insufficient attention to questions of formal justice and due process.[12]

A detailed response to these criticisms is beyond the scope and purpose of this paper as is engagement in the wider debate on whether CECs are the only, or indeed the most desirable, model of provision of ethics support and guidance in clinical practice. This paper starts from the position that CECs currently exist in the UK NHS and are increasing in number, and focuses on the key question of the competencies required to perform their functions.

In 2004 guidance on the structure, composition and function for established and developing CECs was published.[13] However, this guidance did not address the core competencies needed to perform these functions. In the following year, the Royal College of Physicians published *Ethics in practice*.[2] This recognised the role of CECs in providing ethics support and recommended that core competencies should be defined for those providing such support. Moreover, providers should receive education and training. Although a position paper defining core competencies had previously been published in the USA it is unclear to what extent its recommendations have been adopted, or the performance of CECs evaluated against its proposed standards.[14,15]

Developing core competencies for clinical ethics support

Accepting the need to develop formal core competencies for CECs, UKCEN initiated a consultation process with its member committees (>70). This document represents the summation of that process. An initial draft, using some of the features of the US document but modified for the UK context, was produced for members of the UKCEN board of trustees.[14] Following revision and agreement it was circulated via CECs that are members of UKCEN for discussion and feedback before redrafting and further discussion and consensus agreement. Although consensus as a means of developing policy can be questioned approximately 700 individuals have had an opportunity to review this document and to comment upon it.[16]

It sets out, for the first time in the UK, the core competencies (skills, knowledge and personal attributes) that committees, individuals and groups offering ethical support should possess. How they may be acquired and assessed have also been indicated. By providing guidance on the development of

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standards for clinical ethics support it is hoped that the document can be used by CECs and others to define training and development needs and provide a basis for evaluation and audit. The purpose of this article is to promote informed ethical debate by creating a governance framework in which it may occur, rather than by fettering it with undue bureaucracy or unrealistic expectations of essentially voluntary groups. However, it is accepted that the increasing profile of clinical ethics support will mean that those who provide it will ultimately need to demonstrate that they do so competently, and that they achieve appropriate ethical and legal governance standards.[11]

Competencies relevant to the provision of clinical ethics support

Provision of clinical ethics support may include consideration of individual cases, or debate on the ethical issues they raise, the education of health professionals on such issues and ethical input into trust policy and guidance. It is accepted that these functions require the identification and analysis of ethical problems within a legal framework, if criticisms of lack of 'due process' are to be addressed. Since ethical support may be provided by individuals, small groups or committees, the core competencies identified are to be considered as 'collective' in their application to a particular committee or group. It would be unrealistic to expect that each member of a committee should possess them all. One of the strengths of a committee or group as a model of clinical ethics support is the complementary and cumulative experience and expertise of individual members within the group.

Individual CECs will have differing functions or a differing balance between functions. The core competencies necessary to fulfil them require different levels of skill and knowledge depending on what is to be done. The idea of basic and advanced levels of competency have been adopted from the US model.[14] A basic level of skill or knowledge is that required to advise and help resolve a commonplace or straightforward case or situation. Advanced skill and knowledge is that required to achieve the same objectives in rarer, more serious or more complex cases or situations.

We envisage that all members of a CEC will possess basic levels of skill and knowledge and some will possess advanced levels necessary for specific functions, eg leading a case consultation.

Skills

The skills required of members of CECs can be described as ethical assessment skills, operational skills and inter-personal skills (Box 1). They are necessary to enable a CEC to facilitate resolution of moral dilemmas in real life situations rather than to engage in an abstract discussion of the theoretical issues. In particular operational skills and policies are necessary to satisfy the requirements of due process.

Knowledge

The knowledge required by a clinical ethics committee can be wide ranging (Box 2) and it is not possible for any one member to cover all areas. Advanced knowledge in specific areas, such as healthcare law, organisational structure and cultural context, can be provided by recruitment of appropriate individuals to the committee. Adequate knowledge of clinical terms and disease processes needs to be provided by clinical input with appropriate but detailed explanations for lay members. Advanced clinical knowledge in specific cases can be acquired by the CEC co-opting relevant expertise.

Personal characteristics

The acquisition and nurturing of certain personal characteristics are aspirations that individuals should pursue as a long-term

Box 1. Skills required of clinical ethics committees (CECs).

1 Ethical assessment skills comprise the ability to:
- identify and discuss the nature of the moral conflict and the need for consultation
- elicit and understand the moral beliefs and values of all parties:
  - analyse moral uncertainty and conflict
  - explain the ethical dimension of a case to those involved and to others
  - formulate and justify morally acceptable solutions.

2 Operational and procedural skills
- Facilitation, of both case consultation discussions and CEC meetings.*
- Mediation and negotiation of conflict resolution in situations of emotional distress.*

3 Interpersonal skills
- Communication skills* eg active listening, clarity, non-verbal communication.
- Advocacy skills to enable articulation of the views of those who find it difficult to express themselves.*
- Non-judgementalism, awareness of power imbalances.

*Advanced skill expected of chair, vice-chair or senior committee member involved in acute or retrospective case consultations.

project in an analogous way to continuing professional development. In themselves they may be regarded as virtues that are important for other aspects of life, rather then pure adjuncts or pre-requisites for ethical reasoning. However, they may enable core skills and knowledge to be acquired, applied and developed appropriately. The values listed in Box 3 are therefore important for ethics consultations.[14]

Assessment of core competencies

Deciding whether individuals, members of committees, prospective members, or committees themselves possess the relevant competencies and the extent to which they do so is sensitive and difficult. An essential prerequisite is that they should have the interest and commitment to acquire them. No single instrument can be used to assess each competency; hence a variety of instruments are required to capture the full picture of an individual's competence, as is the case for professional competencies.[17] Miller's proposed pyramid of learning model enables a different assessment instrument to be used at each level of the learning process and facilitates integrated assessment programmes.[19]

The US position paper suggested that delivery and assessment of core competencies might be facilitated if those responsible for educational programmes in ethics ensured that the competencies were taught and educational objectives achieved.[14] In the UK, however, many members of CECs are enthusiastic volunteers who may be unable to attend formal educational programmes and hence this mechanism for assessing competencies may be impracticable. However, there is a pressing need to demonstrate a basic level of competency if CECs are to be recognised as having an important and useful role for patients, their families and the health professionals caring for them. The following preliminary steps should be taken to develop a process that will ensure appropriate competencies among members of CECs within the NHS:

1 An initial exercise to assess the level of competency of existing and potential new members of established committees to include:
   - an application/registration form that details:
     - personal and professional details
     - any relevant publications or presentations
     - statement of commitment to develop competencies as outlined above
     - details of training in clinical ethics and/or a willingness to participate in training
     - example of personal response to an ethical dilemma.
   - an assessment of personal attitudes by two structured references
   - for prospective new members there should be also be a brief structured interview.
2 Maintenance of an individual or collective portfolio/record of relevant educational activities undertaken and participation in CEC functions.

Regular attendance and evidence of engagement with educational activities should be a requirement of membership and monitored on an annual basis. New members should have attended at least one training course on ethics consultation within two years of appointment to the committee and once every three years thereafter.

Acquisition of competencies

Although competencies may be acquired by exposure to practical ethical dilemmas it is believed that teaching and training are necessary to acquire basic competencies. This is analogous to the mandatory requirement for members of UK RECs to

Box 2. Knowledge required of clinical ethics committees (CECs).

1 Basic concepts of ethical theory and principle and the application and practice of moral reasoning. (Advanced knowledge of ethical theory and moral reasoning required by at least one committee member and the lead member of any case consultation group.)
2 Knowledge of the position of the CEC in the hospital framework and links to clinical and legal governance.
3 Relevant knowledge of clinical terms and disease processes.*
4 Cultural context of patient and staff population and of local community.*
5 Relevant professional codes of ethics, eg General Medical Council and General Nursing Council.*
6 Relevant healthcare and statute law, including UK human rights legislation.*
7 Local/national government policy, eg national guidelines on funding of treatments.*

Box 3. Personal characteristics and values important for ethics consultations.

- Tolerance, patience and compassion
- Honesty, fair mindedness, self-knowledge and reflection
- Courage
- Prudence, humility
- Integrity

The possession of these values enables:

- disparate views to be held in difficult situations
- recognition of personal limitations and development of relationships based on of trust and respect
- recognition of power imbalances between individuals and how to address them
- voices of the weak and vulnerable to be heard and dissenting views to be put to those in authority, involving the skill of advocacy
- individuals not to go beyond their level of competency and/or to acknowledge conflicts between personal moral views and their role in consultation
- pursuit of ethically relevant options when it might be convenient to do otherwise
- sensitivity to changing circumstances that have ethical impact

undergo basic training in ethical theory and analysis under national governance arrangements.

Importantly both operational and interpersonal skills are required to provide an ethics consultation service. At a basic level most members of CECs may acquire these in the course of their professional or other training. However, more advanced skills will be necessary for those leading on specific functions, eg case consultation groups, and therefore specific training in this area may be required. Some of the ways in which skills and knowledge in ethics can be acquired are shown in Box 4.

Defining educational needs

Completion of questionnaires and self-reflection may identify specific training needs at committee level. It is believed that the model of a national consultation group, similar to that used to develop an undergraduate curriculum for the teaching of ethics and law,[19] should be used to develop a core curriculum for CECs and members. This could help to persuade NHS trusts of the importance of providing adequate resources for training and development of committees.

Conclusion

In this document the core competencies necessary to provide clinical ethics support have been defined and a mechanism for their assessment, maintenance and acquisition outlined. In setting out these core competencies the authors do not intend to stifle continuing debate as to how, and by whom, such support should be provided. Nor do they wish to limit vigorous ethical debate in response to the increasing number and complexity of ethical dilemmas posed by clinical practice. The authors have therefore sought to create a framework in which debate may occur and in which opinions on ethical issues can be expressed that will fulfil ethical and legal governance criteria and which is compatible with previously published guidance.

One way in which the proposals discussed here can achieve practical realisation is their incorporation into terms of reference and standard operating procedures of all CECs. It is believed that, given appropriate resources, the standards proposed can be evaluated, and are consistent with principles of ethical governance. The time has come for CECs to develop a more structured and accountable framework for their work.

Box 4. Acquisition of skills and knowledge in clinical ethics.

- Self-directed learning for individual members
- Group directed learning within the committee (for example away days, specific committee training workshops, setting aside a clinical ethics committee meeting for education)
- Study days often on very specific topics
- Attendance at ethics conferences
- Short courses, eg two- to three-day introductions
- Modular education programme perhaps leading to a degree
- Degree programmes which will usually provide advanced skills and knowledge

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