



Core competencies for Clinical Ethics Committees

A consensus statement from the UK Clinical Ethics Network

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CORE COMPETENCIES FOR CLINICAL ETHICS COMMITTEES

Introduction

There has been steady growth in the number of UK clinical ethics committees (CECs)¹. In contrast to the USA and elsewhere most have developed independently in response to clinical demand, local interest and enthusiasm. The UK Clinical Ethics Network (UKCEN) provides support for CECs and a mechanism to enable them to formally pool their experience. In 2005 the Ethox Centre, in collaboration with UKCEN, published specific practical guidance for both established and developing CECs, providing advice on their structure, composition and function.²

In contrast to the situation with Research Ethics Committees in the UK, there is no legal or regulatory framework for the functioning of CECs and no defined educational requirements or core competencies for members. The Royal College of Physicians report on Ethics in Practice (2005) supported the role of CECs in the UK in the provision of clinical ethics support and issued recommendations.³ The latter included the statement that 'there should be an agreed statement of core competencies for an effective CEC and the necessary training and education should be provided for members to meet them' (RCP Ethics in Practice page XII; Recommendation 10, page 38).

In response to this recommendation the UK Clinical Ethics Network Committee produced a discussion paper which was then circulated throughout UKCEN for further consultation. This final paper has been informed by the comments of individual committees during that consultation. A wide range of views was articulated by respondents ranging from concerns that the document was too prescriptive and paternalistic to criticism that the document did not set out key components of a curriculum including knowledge of specific ethical theories. Bearing in mind the diversity of views on the subject we have sought to produce a document that individual CECs can use to inform their development. It is not expected or desired that every CEC should follow every suggestion.

The purpose of the exercise was to develop guidance for CECs on appropriate standards for clinical ethics support that can be used to define training development and provide a framework for evaluation and audit of the work of CECs.. In doing so we were mindful of the fact that there is a need to foster the growth of Clinical Ethics support in the UK rather than stifle it with unnecessary bureaucracy or unrealistic expectations by others of what are essentially voluntary groups.. We wish to stimulate ethical debate and encourage as many as possible to participate in it. However the increasing profile of clinical ethics support will mean that those who provide it will ultimately need to demonstrate that they are competent to do so.

The document is presented in the following sections:

- I. Competencies required for the provision of clinical ethics support.
- II. Assessment of core competencies.
- III. Acquisition of core competencies.

Appendix Background to this paper.

I. Competencies relevant to the provision of clinical ethics support

It is important to emphasise that the core competencies discussed in this document are viewed as 'collective' in respect of a particular committee or group and it is not expected that each member of a committee should possess all competencies. One of the strengths of a committee or group as a model of clinical ethics support is the complementary experience and expertise of individual members within the group.

The key function of clinical ethics committees is to provide support and advice to health professionals, patients and families on the ethical dimension of patient care. The nature of this support may include specific advice on individual cases, education of health professionals on ethical issues and ethical input into Trust policy and guidance. The specific support offered by any given individual committee will differ in different types of NHS trust and the position the committee occupies within their trust - this may impact on the emphasis given to particular competencies that the committee wishes to focus on. Within this range of functions the main role of the committee is to identify ethical problems and facilitate their resolution within the context of, but not limited to current legal and professional requirements.

Core competencies necessary to provide clinical ethics support are founded on skills, knowledge and personal attitudes. Different levels of skill and knowledge will be required for the undertaking of specific functions. The aspiration is that all members of a CEC will possess basic levels of skill and knowledge and some members will possess advanced levels of knowledge and skills necessary for specific functions, e.g. leading a case consultation.

Individuals providing case consultation services separately from the CEC should possess all of the core skills, knowledge and personal characteristics identified here. They will require advanced skills and knowledge in some areas (see below).

If *teams* provide consultation the full range of core competencies should be available within the team, though not all individuals will possess them initially. All members of case consultation teams should acquire at least basic competencies.

I. Competencies recommended for CEC Members

a). Skills

1. Ethical assessment skills

- 1.1 Ability to recognise and discuss moral conflicts within the clinical situation
- 1.2 Ability to understand the moral perspective of all parties
- 1.3 *Ability to explain the ethical dimension of a case to those involved and to others
- 1.4 *Ability to formulate and justify morally acceptable solutions
- 1.5 *Ability to review established practices that have generated moral concerns or conflicts, to determine whether change is necessary.

2. Operational skills

These are required in the process of resolving conflict, reducing uncertainty, and building consensus, and include

- 2.1 Ability to facilitate meetings, record cases etc.
- 2.2 Skills in facilitation, of both case consultation discussions and CEC meetings.*
- 2.3 Mediation skills required to negotiate conflict resolution in situations of emotional distress.*

3. Interpersonal skills

- 3.1 Active listening.
- 3.2 Communication skills.*
- 3.3 Advocacy skills to enable articulation of the views of those who find it difficult to express themselves.*

**Advanced" skill expected of Chair, Vice-Chair or senior committee member involved in acute or retrospective case consultations.

b) Knowledge

1. Introduction to ethical theory and 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. Awareness of the position of the CEC/Forum in the hospital framework and links to clinical governance
3. Relevant knowledge of clinical terms and disease processes.*
4. Beliefs and perspectives of patients and staff population and community staff.*
5. Relevant professional codes of ethics, e.g. GMC and Nursing Council.*
6. Relevant health care law.*
7. Local and national government policy, e.g. resource allocation.*

* Advanced knowledge in these areas should be provided by recruitment of appropriate individuals to the committee. These might include representative(s) from the multi-faith centre, health care law, and from a primary care trust. Adequate knowledge of clinical terms and disease processes needs to be provided by appropriate clinical input with explanations for lay members on the committee. Advanced clinical knowledge in specific cases can be acquired by co-opting a relevant expert on to the committee.

c) Personal characteristics

The acquisition and nurturing of certain personal characteristics are aspirations that individuals should pursue as a long-term project in an analogous way to continuing professional development. Personal characteristics enable core skills and knowledge to be acquired, applied and developed appropriately. It implies a commitment to values that include:

- Tolerance, patience and compassion
Enables disparate views to be held in difficult situations
- Honesty, fair mindedness, self-knowledge and reflection
Enables recognition of personal limitations and development of relationships based on trust and respect
- Courage
Enables voices of weak and vulnerable to be heard and dissenting views to be put to those in authority. It involves the skill of advocacy
- Prudence, humility
Enables individuals not to go beyond their level of competency and/or to acknowledge conflicts between personal moral views and role in consultation.
- Integrity
Enables pursuit of ethically relevant options when it might be convenient to do otherwise. Moral integrity should underpin all ethics consultations

II. Assessment of core competencies

There are few if any commonly agreed assessment tools to evaluate the relevant core competencies required to provide clinical ethics support. Deciding whether members of committees, prospective members, or committees themselves possess the relevant competencies and the extent to which they do so is both sensitive and difficult.

However, by analogy with other professional appointments the following may be helpful

1. Standardised application/registration form which could contain
 - a) Personal and professional details
 - b) Relevant qualifications
 - c) Any publications or presentations given in this area.
 - d) Willingness and commitment to develop skills, knowledge and personal traits as outlined above
 - e) Willingness to attend meetings at times specified and possibly be available for acute case consultation
 - f) Specific training undertaken in clinical ethics and/or a willingness to participate in clinical ethics training
 - g) Example of personal response to an ethical dilemma. This could involve a clinical situation or an issue of general concern for lay members (maximum 500 words).
 - h) Personal statement (200 words)

2. Assessment of personal attitudes by two structured references including report on personal attitudes as outlined
3. For new and prospective members there could be a brief structured interview to assess competencies and the willingness and commitment to acquire them.
4. For existing members there would seem to be no reason why similar details to those listed above for skills and knowledge should not be completed. It would also be helpful for members to reflect on their skills and knowledge and identify their own training requirements.

Suggested steps to ensure maintenance of core competencies

Committees should keep attendance records and those who do not attend regularly and who do not engage in education or training to develop or maintain their competencies should have their membership withdrawn. Each member could be elected for a period of say 3 years and reappointments subject to satisfactory attendance and 'appraisal'.

Members may also find it helpful for their own CPD/CPE to keep records of conferences, courses they have attended and the impact this has had on their own practice.. New members should have attended at least one training course on ethics consultation within 2 years of appointment to the committee and once every 3 years thereafter.

Committee role in core competencies acquisition

1. Presentations, publications or other work related to clinical ethics could be documented in an annual report which should include details of case discussions and other activities of the committee.
2. The CEC should keep a record of training undertaken by either the committee or individuals and review this annually to ensure maintenance of core competencies within the committee. It would also be helpful for members to share their experience of courses at these events to enhance the expertise of the group.

III Acquisition of competencies

If we are to define competencies required to provide ethical support it is necessary to consider how they may be acquired by teaching and training. Indeed without some structure that is capable of delivering or obtaining some basic training; defining levels of competency may be counterproductive. It is noteworthy that some basic training in ethical theory and principles, moral analysis, argument and reasoning is offered to members of RECs and COREC/NPSA does provide topic based training.

It is important to recognise that other qualities e.g. operational and interpersonal skills are required to provide an ethics consultation service. We have assumed for the purposes of this document that these qualities are acquired by most people in the course of their professional training and that the ethics specific skills and knowledge that we have identified would be the main area for development in CEC members. The development of these characteristics is thus deemed to be a very personal process and

one that may occur in parallel with or independently of the acquisition of specific skills and knowledge in ethics.

The following are some ways in which skills and knowledge can be acquired

- Self-study/ self directed learning /problem based learning
- Study days often on very specific topics
- Attendance at ethics conferences
- Short courses e.g. 2-3 day introductions
- Modular education programme perhaps leading to a degree
- Degree programmes which will usually provide advanced skill and knowledge but not necessarily other skills (see above)

Possession of a higher degree in medical ethics or an appropriate subject might be a suitable qualification to undertake advanced work. However whilst such a qualification indicates individuals may have sufficient ethics knowledge base it does not guarantee that they will have the operational or interpersonal skills to apply their knowledge effectively in practice. This can only be confirmed by an acceptable and appropriate means of assessment that has to be regarded as fair and impartial. The nature of assessment may vary between committees according to their role and position within the institution. In some instances this may be an informal assessment agreed by committee members. In other situations a more formal assessment against specific standards might be required..

One problematic area relates to the identification of members who lack the skills identified as necessary by the committee. To some extent completion of questionnaires and self reflection may identify some but not all training needs especially if individuals lack insight or do not undertake reflection. Persistent non-attendance or non-contribution at meetings may be indicators in the absence of any other explanation. Specific identified needs can be met by training opportunities and the maintenance of the UKCEN website to provide details of these is vital.

Defining educational needs for any individual depends on:

- a. The level of knowledge and/or skills that they already have, as ascertained by objective criteria or self–assessment.
- b. The level of competence they wish or need to achieve. This will depend on the function of individual services and the members’ role within them.

It may be helpful to develop a suggested curriculum for education of CECs. This could help to persuade NHS Trusts of the importance of providing adequate resources for training and development of committees. A national consultation group could be convened to look at this. A useful precedent for such a group is that which produced a consensus syllabus for the teaching of ethics and law to undergraduates⁴

Conclusion

This paper has focussed on the core skills, knowledge and personal attributes that are desirable for competency in ethical decision-making.

It seems clear that the core skills for ethical decision making include the abilities to:-

identify the nature of moral conflict and need for consultation,
elicit moral views of all parties
analyse moral uncertainty or conflict,
explain the ethical dimensions of cases to those involved and to others,
justify morally acceptable solutions.

In order to exercise these skills there has to be knowledge of ethical theory and moral reasoning, of the specific bioethical concepts used in clinical practice, relevant knowledge of clinical terms and disease processes, a knowledge of local and national policies and procedures, familiarity with the local context and access to legal opinion.

Skill and knowledge should be backed up by development of appropriate personal characteristics.

Assessment of these domains for new applicants to CECs can be achieved by established recruitment techniques. Assessment of the competencies of current members of existing committees is more complex and sensitive but could be achieved by completion of a standardised questionnaire.

Acquisition of competencies is more difficult in the absence of central resources for the purpose but at the very least applicants/new members (as well as established ones) should express their commitment to achieve the standards of basic skills and knowledge outlined in this document and commit themselves to work towards attaining the necessary personal attributes.

References

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3. Ethics in Practice. Background and recommendations for enhanced support. Royal College of Physicians London June 2005. www.rcplondon.ac.uk
4. Consensus Group of Teachers of Medical Ethics and Law in UK Medical Schools. Teaching medical ethics and law within medical education: a model for the UK core curriculum. *J Med Ethics*. 1998;24:188–192.

Appendix

Background to discussion document: The need for core competencies for clinical ethics support.

As CECs develop in the UK there is likely to be an increasing demand for evidence that they are appropriately constituted and have the required expertise to provide ethics support to health professionals in their host organisation. Records of CEC discussions of individual cases may be considered in law to form part of the patient record and will therefore need to satisfy the same criteria that the Common Law demands for such records. Moreover CECs themselves, or those providing clinical ethics support, will need to demonstrate a reasonable standard of care in undertaking their work and have the competencies necessary to do so. Following the recommendations of the Royal College of Physicians' Report in 2005, the UKCEN steering committee has considered the need for a statement of core competencies for CECs. In doing so it has drawn on the experience of the American Society for Bioethics and the Humanities (ASBH) who developed its own core competency document in 1998. (American Society for Bioethics and Humanities, Core Competencies for Health Care Ethics Consultation, 1998)

The ASBH paper discussed various approaches to ethics consultations and the competencies necessary to deliver them. It recommended what it termed an ethics facilitation approach that did not exclude the patient (or their appropriate representative in the case of incompetent patients) from the decision making process. The approach suggested is very similar to that used by UK CECs in the discussion of individual cases that involve conflict as a cause of moral concern. In particular, this is likely to involve situations where the parties disagree about what action is ethically appropriate, or where there is tension between moral principles. It involves the identification and analysis of ethical issues with a view to achieving consensus over what action might be taken. Whilst this approach may not be appropriate for all societal contexts it does identify the key tasks involved in providing ethics support in individual cases.

These key tasks involve

- Gathering relevant data
- Clarifying relevant concepts, e.g. consent, confidentiality, best interests, autonomy, justice.
- Identifying and clarifying personal moral and other values of those involved in the decision-making process.
- Clarifying relevant normative issues, e.g. societal values, law, policy.
- Assisting in the identification of a range of morally acceptable options.

To carry out these tasks effectively requires certain competencies. Although these competencies are primarily those necessary for case consultation, they are also relevant for other documented functions of CECs in the UK. The latter include:

- Contribution to the development of ethical policies and guidelines
- Teaching and training
- Research and development

The American Society for Bioethics and Humanities classified the competencies required for ethics case consultation as either basic or advanced, which it defined in functional rather than absolute terms. Thus a basic level of skill or knowledge is that required for the resolution or discussion of a common and straightforward case whilst an advanced level of skill or knowledge is that necessary to achieve similar objectives in more advanced or complex cases. A similar approach has been used in drawing up core competencies for clinical ethics committees in the UK.

The aspiration is that all CEC members will possess basic knowledge and skills and some members will possess advanced level knowledge or skills necessary for specific functions for example leading a case consultation. The mixed clinical and lay membership of CECs provides a wide range of skills and knowledge, and in the initial development of a CEC it would be acceptable for the specified competencies to be present in the committee as a whole (with different members possessing different relevant skills and knowledge). In addition, if specific knowledge or skills are necessary in a particular case the committee should be able to access this expertise externally to supplement the discussion, just as clinicians are able to obtain specialist or second opinions in challenging cases. Examples might include consulting a specialist in a particular clinical field or an expert in data protection or public health policy.

Many cases are discussed retrospectively as a means of reflecting upon ethical issues that might inform practice in the future and may not therefore require assembling individuals with advanced skills and knowledge in an acute setting. However, most CECs provide acute case consultations by a small number of committee members or occasionally by an individual ethicist. It is particularly important that one of the members involved in the acute case consultation should have experience with complex clinical situations and the ethical dimensions of such cases.