

Professionalizing the practice of clinical ethics consultation: problems and perspectives

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Recently, efforts to transform clinical ethics consultation from a free, voluntary – sometimes activist – engagement into a recognized profession have intensified. The American Society for Bioethics and the Humanities' (ASBH) task force and its pilot program for accreditation of consultants have legitimized and centralized the professionalization process. Guidelines and a list of agreed upon competencies have been formalized in the ASBH core competencies manual.¹ This establishes a common frame of reference and contributes to the recognition and validation of clinical ethics consultation as a serious and rigorous process. Indeed, personal qualities, a body of acquired knowledge and well-defined relational skills are necessary in order to be a good consultant. The professionalization process will enable relevant authorities to screen for these required competencies and to choose the right candidates for the consultation. The consultants' necessary personal qualities depend on the purpose which is assigned to the consultation process. The ASBH list of core competencies that qualify a consultant as a true professional are mostly derived from the ASBH facilitation model of consultation, which consequently informs the list of relevant competencies.

The drive towards "professionalization" is certainly welcome for several reasons. First, it will alleviate fears among doctors and the public alike that "anything goes" provided that the main stakeholders (doctors, patients and family members) are satisfied with the decision, whatever satisfaction might mean in this context. Setting high standards for consultants will strengthen their role and increase trust in the consultation process and outcome. Secondly, professionalizing clinical ethics consultation will allow worthy and skilled people to be recognized, trained – and paid – like other professionals. They will be encouraged to pursue formal training which in turn will enhance their standing and will contribute to inscribing clinical ethics consultations into normal medical practice.

However, this trend has serious drawbacks. The very term of "professionalization" encourages several ill-advised inferences and may become an obstacle to the positive developments of clinical ethics consultation that everybody actively involved in the field wishes to

see realized. The first and most obvious danger is the possible exclusion of certain individuals or groups from the professionalization movement. Consultants will be divided into two mutually exclusive categories: those who possess the required competencies for the profession and those who do not. But this, someone might argue, is the name of the game: one cannot have one's cake and eat it. By exercising constant vigilance, one can avoid transforming the profession into a medieval guild and can ensure that its boundaries are not too rigid. While still retaining the advantage of making clinical ethics consultations a full-fledged and respected activity, interesting grass root experiments and innovative people will not be excluded. A second more serious problem consists in standardizing competencies and missing out on the lively and contextual elements that make someone an accomplished and effective consultant. "Perfect" consultants would be selected who are not so perfect after all. But this again is a matter of fine-tuning the selection and accreditation process. A good consultant will be like a good teacher: one that is not only competent and well-trained but also sufficiently motivated and adjusted to the specific context of her practice.

The professionalization movement, however, carries a third, more serious, risk, especially in Europe, where clinical ethics is still a widely diverse activity, responding to the constraints of different national and cultural contexts. Indeed, transforming consultation into a recognized profession risks setting its boundaries in a generic fashion and promoting general one-size-fits-all competencies, thus neglecting the complex and multifarious roles that clinical ethics consultants play. Indeed, experience shows that there are as many models and prototypes of clinical ethics consultations as there are hospitals and clinical ethics centers. The ASBH facilitation model is not the only existing theoretical model: expertise, mediation, and engagement are other prominent ones. Moreover, the same basic approach can translate into different organizational practices: individual or team consultations, different formats of stakeholder interviews, rules of case discussions, availability of a follow-up, etc. This suggests that consultants' professional standards have to be adjusted to a particular consultation model and fine-tuned to the complexity of the consultation process itself. Training, in turn, has to take into account the consultation model

1 American Society for Bioethics and the Humanities. Core competencies for Healthcare Ethics consultation, 2nd edition. Glenview, IL: ASBH; 2011.

adopted and the consultants' specific roles. Failing to do so would miss out on the right prerequisites for someone to be an accomplished professional and for the profession to possess a real identity rather than merely corresponding to a nominal category.

The example that I will develop is drawn from my own experience at the Cochin Hospital in Paris, where we have developed what we have called the "commitment" model of clinical ethics consultation. The model consists of four consecutive steps: A *multi-disciplinary team of consultants* meets with all stakeholders, including patients and family members; a larger *case conference group* reacts to the presentation of the case and to the arguments put forth by all concerned parties; the consultants provide a structured feedback to the same parties; and finally the team provides an open-ended follow-up if necessary. One of the basic features of the method is the necessary complementarity between the roles played by the *consultants* and by the members of the *case conference group*. While consultants meet with all stakeholders in order to collect their positions and arguments, the members of the case conference group react to the presentation of the case by the consultants, provide reasoned and iterative feedback, and present their own arguments for a possible solution of the case.²

These two functions, therefore – consultant and member of the case conference group – require different competencies and personal qualities. Consultants need to show empathy, to be able to mobilize the appropriate emotions and to react to the stakeholders' narratives in a personally engaged way. The consultants' involvement with the patients, their loved ones and the members of the medical or nursing teams allow them to understand the reasons and positions of all people involved "from within", so to speak. Members of the case conference group, on the other hand, will use their capacities of detachment and reasoning when they bring their own professional and personal experience to bear on the decision at stake. They will be collectively committed to the solution of the case rather than be personally engaged. And they will take collective responsibility for the recommendations that will arise from the case conference discussion and that the consultants will relay to the stakeholders. Based on the consultation experience in Paris, therefore, "professional clinical ethicists" require more than individual formal training, personal qualities and experience. Like an orchestra, an effective and reliable consultation service must take into account the coordination of different roles (which are sometimes assumed by the same person). Moreover, the intrinsic interdisciplinar-

ity of the consultation team brings in some constraints of its own and requires special consideration.

Given this background, how should the training and professionalization process be conceived? The first remark is a well-kept secret: the quality of the consultation depends on the right choice of candidates. Although this may seem trivial, it is not. Promising candidates all share a characteristic which is relatively independent from their specific qualifications (knowledge and skills) in clinical ethics. The *ava raris* has to be at the same time a good professional in her own specific field (physician, philosopher, lawyer, psychologist, social worker, etc.) and be able to step out of her typical and usual professional role and reflexes. This is so because each specialty can contribute something unique to the case, but in no way can the issue be decided according to the standards of anyone discipline alone. For example, a psychologist can point to the ambivalence of parents' request to withdraw care from their handicapped newborn child. The lawyer for her part may note that the case stretches current law, and a physician can point to the margins of error in the prognosis. The philosopher for her part can note the high degree of elaboration and the soundness of the parents' arguments, and so forth. The final advice will result from a particular blend of all these diverse professional viewpoints, and the professional clinical ethicist should understand that no particular viewpoint alone can call all the shots. She must be aware that a good decision depends on a fragile equilibrium among several ponderable and imponderable considerations.

The second point is linked to the first and concerns the clinical ethics training that consultants should be required to have. Clinical ethics is less an established discipline – with its canons, body of required knowledge and curricula – than an acquired habit to work together on the solution of specific and very real cases. As I have already noted, most candidates, even young recruits, are already professionalized in their own respective field. What the formal training in clinical ethics teaches them – at least for those who will participate in the case conference group – is how to bring to bear their own knowledge and skills on the issues that arise in medical practice and how to integrate their own specific perspective to the outlooks of all the other participants. Accordingly, our two-year training program is thematic rather than disciplinary (end-of-life, assisted reproduction, organ donation, etc.). It consists both of several relevant disciplinary presentations and of the discussion of real cases, which are the focus of training. Each case is conceived as an open question (what would be good in this case and why?), quite independently from established norms, and allows participants to construct a common language and develop mutual understanding. Nevertheless, case discussions fall short of creating a common and fixed outlook and quite purposively so: a consultation is a lively instrument that acts as a bridge between a constantly evolving practice and an

2 The approach has many other features. For a detailed account of practical features of the method and of its conceptual foundations see our article: Fournier, V, Spranzi M, Foureur N, Brunet L. The Commitment Model for clinical ethics consultations: Society's involvement in the solution of individual cases. *Journal of Clinical Ethics*. Forthcoming.

equally changing society. As E. Erde writes: “The content of what is professional – professionalism – must continually be reformulated in non-arbitrary but perhaps novel ways.”³

The third relevant point concerns the training of consultants as such, rather than as members of the case conference group. Meeting doctors, nurses, patients and their loved ones is a difficult and sensitive task. Non-clinicians will need to display clinical skills that clinicians have already acquired: feeling what people need, responding to their concerns, displaying empathy and psychological strength. They have to accept that in the course of a conversation it is crucial to maintain the therapeutic relationship, quite like what happens during a medical consultation: clinical ethics consultations are not an exception to the general principle that patients cannot be made worse off by going through the medical process. It is them who set the tempo of the discussion, although a careful and skillful hand can focus it around the relevant considerations. A consultant’s appropriate attitude is neither prescriptive nor inquisitive for its own sake – wanting to know more than is needed for dealing with the case. These clinical skills consist of a series of pre-cognitive or tacit capacities to “find a path from the ‘what’ to the ‘how’”, and they are acquired by tutoring and imitation, rather than by direct teaching and formal techniques. Moreover, not everyone can do a consultation, and not everyone can be a consultant in any consultation. Here again, the team is like an orchestra where the role of each instrument is carefully calibrated according to the

situation. This means that personal experience with a particular issue can be both an asset and an obstacle to a satisfactory consultation process: having recently experienced a painful death in the family may help a consultant understand a loved one’s predicament in refusing to have life-saving treatment withdrawn. But it can also be emotionally taxing and prevent the consultant from seeing what the best solution to the case might be. Competencies and skills have to exist but the consultants’ personal histories and professional experience have to be carefully matched to fit the case at hand.

Finally, in order to complete the professionalization process, another more encompassing skill is required. This is a self-reflexive ability to constantly reassess and fine-tune one’s skills, capacities and attitudes. In this particular respect, professionalization is independent from certification and evaluation. It thrives on ongoing self-reflection and mutual constructive criticism. Professionalism appears to be a second-order competency in: being able to provide “accountability of choices and decisions made in situations where conflicting values and norms are prominent”.⁴

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3 Erde EL. Professionalism’s facets: ambiguity, ambivalence, and nostalgia. *Journal of Medicine and Philosophy*. 2008;33(1):6–26,21.

4 Verkerk M, Bree MJ de, Mourits MJE. Reflective professionalism: interpreting CanMEDS’ “professionalism”. *Journal of Medical Ethics*. 2007;33(11):663–666,664.