

A CODE OF ETHICS FOR HEALTHCARE ETHICS CONSULTANTS: JOURNEY TO THE PRESENT &

IMPLICATIONS FOR THE FIELD

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ABSTRACT

For decades a debate has played out in the literature about who bioethicists are, what they do, whether they can be considered professionals *qua* bioethicists and, if so, what professional responsibilities they are called to uphold. Health care ethics consultants are bioethicists who work in health care settings. They have been seeking guidance documents that speak to their special relationships/duties toward those they serve. By approving a Code of Ethics and Professional Responsibilities for Health Care Ethics Consultants, the American Society for Bioethics and Humanities (ASBH) has moved the professionalization debate forward in a significant way. This first code of ethics focuses on individuals who provide health care ethics consultation (HCEC) in clinical settings. The evolution of the code's development, implications for the field of HCEC and bioethics, and considerations for future directions are presented here.

KEYWORDS: ethics committees, confidentiality & privacy, history, organizational ethics, professional ethics, virtues

A CODE OF ETHICS FOR HEALTHCARE ETHICS CONSULTANTS: JOURNEY TO THE PRESENT & IMPLICATIONS FOR THE FIELD

INTRODUCTION

For decades a debate has played out in the literature about who bioethicists are, what they do, whether they can be considered professionals *qua* bioethicists and, if so, what professional responsibilities they are called to uphold. Health care ethics consultants are bioethicists who work in health care settings. They have been seeking guidance documents that speak to their special relationships/duties toward those they serve. By approving a Code of Ethics and Professional Responsibilities for Health Care Ethics Consultants, the American Society for Bioethics and Humanities (ASBH) has moved the professionalization debate forward in a significant way. This first code of ethics focuses on individuals who provide health care ethics consultation (HCEC) in clinical settings. The evolution of the code's development, implications for the field of HCEC and bioethics, and considerations for future directions are presented here.

BACKGROUND

Jonsen (1993) described bioethics as a "movement" that originated in response to profound moral questions arising from burgeoning innovations in medicine and concerns about abuses in human subjects research. Over the past quarter century, bioethics has progressed from a movement to a specialized field (see Figure 1). Increasingly, criticism has been leveled against bioethicists for failing to reflect on the ethics of their field and to hold themselves accountable to professional standards (Loewy and Loewy 2005) (Scofield 2008) (Stohlberg 2001).

In 2005, Baker proposed a draft code of ethics for bioethicists, which elicited several open peer commentaries in the *American Journal of Bioethics*. The commentaries debated whether or not bioethicists are ready for a code, in part because a clear definition of what a bioethicist is remains elusive. There was general agreement that a code needs to be a living document, an axis around which the profession can evolve, and that the process used to create such a document ought to be transparent

and inclusive.

In the same year, the ASBH Board of Directors appointed an Advisory Committee on Ethics Standards (ACES) to conduct a needs assessment survey for a code of ethics. Of 533 survey respondents, 71% identified their professional field as bioethics (with about one third also identifying another professional affiliation). Forty-one percent indicated that they spent more than 50% of their professional time on bioethics (Baker et al. 2006). While 70% of respondents belonged to a profession with its own code of ethics, 61% supported developing a code of ethics for bioethicists. The ACES committee concluded with a recommendation that the ASBH Board “initiate a process of drafting and promulgating a comprehensive Code of Ethics that will be owned by its membership” (Baker et al. 2006, 29).

During this time, the field of clinical ethics consultation was becoming more established in health care settings. Fox and colleagues (2007) published findings from a national survey reporting that 81% of U.S. general hospitals randomly surveyed (and 100% of hospitals with more than 400 beds) had an ethics consultation service, and an estimated “29,000 individuals devoted more than 314,000 hours to performing more than 36,000 ethics consultations” in a one-year period (Fox et al. 2007, 271). Questions arose about the qualifications of health care ethics (HCE) consultants—particularly those who influence the care of patients in clinical settings. In 2009, the ASBH Board formed the Clinical Ethics Consultation Affairs (CECA) standing committee and charged it with the task of drafting a code of ethics for this subset of bioethicists—HCE consultants who do ethics consultation in clinical settings (colloquially referred to as “clinical ethics consultants”).

The CECA committee considered whether to continue with Kipnis’ iterative, empirical approach to developing a code of ethics by collecting narratives from clinical ethics consultants, as was done with the ACES survey (Kipnis 2005), or to adopt Baker’s approach of gathering precursor documents in the field. The committee decided to use a blended approach, using the empirical data already collected (albeit with the broader focus on bioethics and humanities), and the following precursor documents to

inform the first draft of the new code:

- ACES Report (Baker et al. 2006)
- ASBH's *Core Competencies for Healthcare Ethics Consultation*, 1st & 2nd editions (Society for Health and Human Values–Society for Bioethics Consultation 1998) (American Society for Bioethics and Humanities' Core Competencies Update Task Force 2011)
- Draft Canadian Model Code of Ethics for Bioethicists (2011) (MacDonald n.d.)

PRECURSOR DOCUMENTS

ACES Report

ACES survey respondents were asked to contribute narratives describing a situation in which, when acting as a bioethicist or medical humanist, they faced an ethical problem directly or observed a colleague acting unprofessionally in the bioethicist role. These narratives were analyzed and categorized into content areas to inform a code of ethics. They included: conflicts of obligation, conflicts of interest, righting wrongs, authorship (e.g., plagiarism and false authorship), the role of the consultant (e.g., role conflicts), information management (i.e., disclosure and withholding information), and making public statements (Baker et al. 2006). This report marked the beginning of an intentional effort to develop a code of ethics, albeit for the broader scope of bioethicists.

Core Competencies for Healthcare Ethics Consultation

In 1998, the same year that the Society for Health and Human Values (SHHV), the Society for Bioethics Consultation (SBC), and the American Association of Bioethics (AAB) merged to form ASBH, the ASBH published the SHHV-SBC Task Force's report, *Core Competencies for Healthcare Ethics Consultation* (first edition). This document—while taking a position *against* professionalizing the field—included a section entitled, "Special Obligations of Ethics Consultants and Institutions." The report acknowledged the potential for HCE consultants to abuse power in the health care institutions they serve, and recognized a duty among HCE consultants to avoid such abuses. Obligations in this category included:

respecting confidentiality of information obtained during HCEC; recusing oneself from HCEC when there is a personal or professional bias or role conflict, or disclosing significant personal or professional relationships that might bias role performance; avoiding conflicts of interest between the HCE consultant and the institution(s) he or she serves that could undermine the performance of HCEC; and not exploiting those served during HCEC.

The second edition of the *Core Competencies* (ASBH 2011) recognized areas where HCE consultants would welcome ethical guidance as to their professional obligations, as identified in the ACES survey: conflicts of interest, conflicts of obligation, confidentiality, making public statements, righting wrongs, and working conditions for ethics consultants. The professional obligations listed in the *Core Competencies* differ from those identified in the ACES report largely because the *Core Competencies* focuses on a subset of bioethicists—those who practice in a clinical setting as HCE consultants. Of note, the singular “HCE consultant” is used in the Code and in this manuscript for simplicity, and does not underlie a preference for a solo consultant versus a team or full committee model for doing HCEC.

Canadian Model Code of Ethics for Bioethicists

In 1999 the Canadian Bioethics Society established a Working Group to explore working conditions for bioethicists in Canada practicing in non-tenured settings. The Practicing Healthcare Ethicists Exploring Professionalization (PHEEP) group developed a draft code of ethics (MacDonald n.d.). Specific obligations include acting with professionalism, being aware of limits of expertise, maintaining confidentiality, avoiding conflicts of interest, not abusing power, contributing to the advancement of the field and to continuous learning of bioethics advances, avoiding actions that may damage the reputation of the field, advocating for conditions of employment, and striving to ensure that other bioethicists are subject to working conditions that support the goals of bioethics (MacDonald, n.d.). To date, this code has not yet been adopted. In 2011 PHEEP transformed into a voluntary professional association now

called the Canadian Association of Practicing Healthcare Ethicists (CAPHE). This group will continue its commitment to a process of deliberative engagement.

PROCESS OF CODE DEVELOPMENT

The CECA committee developed the initial draft Code from the precursor documents listed above. This initial draft included responsibilities that were believed to have the broadest and most relevant application to HCEC activities (see Table 1). An online survey was broadly distributed (i.e., beyond ASBH membership) between December, 2011 and January, 2012 to elicit feedback on the initial Code elements. Table 2 summarizes the survey results. Two hundred ninety-three (293) individuals took part in this survey, with most recommending that each element be kept "as is." Over 120 individuals commented on the survey. Qualitative comments, including suggestions for additional elements, were analyzed using content analysis and thematic sorting and informed revisions to the Code preface and responsibility statements. These also guided writing of the interpretive paragraphs for each Code professional responsibility. This version of the Code was presented during a workshop at the 2012 ASBH annual meeting, where additional contributions were solicited from workshop attendees.

CECA members were then assigned to subgroups to revise individual Code elements and to write interpretive paragraphs for each Code responsibility. Comments from the initial Code survey and the ASBH Code workshop, as well as relevant literature, informed the interpretive paragraphs. Wording for the code preface, responsibilities, and interpretive paragraphs was refined through successive meetings among CECA members. A second online survey was widely distributed between June and August, 2013. Three hundred ninety three (393) individuals completed the second survey. Table 3 provides a summary of the results. An overwhelming majority (90% or more) endorsed each Code element. Again, qualitative comments from the second survey were content analyzed and informed edits to the Code and interpretive paragraphs. Final edits to the Code, informed by data from the survey, were accomplished via monthly CECA teleconferences, small group work, and email exchanges.

In addressing the content analysis of qualitative comments from the second survey, if there was lack of consensus regarding whether to make a change based on individual comments, CECA committee members opted not to make the change given the high survey endorsement ratings. A final draft of the Code including seven professional responsibilities (two of the original eight were combined) was submitted to the ASBH Board and presented at the ASBH annual meeting in October, 2013. Minor changes (e.g., clarifying the use of “health care ethics consultant” versus “clinical ethics consultant”) were made and in January, 2014, the ASBH Board officially adopted the Code of Ethics (available at <http://www.asbh.org> under “Publications”). Below is an elaboration of each element of the Code, informed by Code survey qualitative feedback. Substantive survey comments discussed by CECA members but not addressed in the final version of the Code are discussed below. Please refer to Appendix 1 for the ASBH Board-approved Code and Interpretive Paragraphs.

PREFACE

Code survey respondents pointed to a need to clarify the Code’s scope as identified in this Preface. While HCE consultants often provide other ethics services (e.g., ethics “coaching” and ethics education outside of what occurs during HCEC, chairing an ethics committee, running an ethics consultation service, engaging in research or quality improvement initiatives, sitting on an institutional review board, publishing scholarly work, mentoring other ethics consultants or interns, providing proactive ethics services), this first code of ethics for HCE consultants focuses on one particular activity—HCEC, with a particular emphasis on case consultations. There are two main reasons for this approach. First, standards for HCEC have been identified and broadly endorsed (American Society for Bioethics and Humanities’ Core Competencies Update Task Force, 2011; Tarzian and the Core Competencies Update Task Force, 2013). Second, HCEC—case consultation in particular—is considered a “high stakes” activity with potential to have significant influence on patient care decisions that may have irreversible and far reaching consequences. Its practitioners should thus be accountable to professional

standards, and a code of ethics identifies and promotes such professional commitments (Baker, 2005). Despite the focus on ethics case consultation, however, these code responsibilities are considered translatable to the other ethics services that HCE consultants provide. That is, an HCE consultant who meets these Code responsibilities is well-equipped to provide the other ethics services listed above and to learn specialized HCEC skills and knowledge as necessary (e.g., those required to provide organizational and research ethics consultations).

The definition of HCEC in the Preface and the approach of “ethics facilitation” endorsed as the appropriate response to HCEC also raised questions about whether this adequately captures the diversity of approaches to HCEC. Ethics facilitation is sometimes misunderstood in this regard. Two core aspects of ethics facilitation include the *process* HCE consultants use during HCEC (e.g., facilitating meaningful communication with stakeholders such that they feel heard, respected, and supported) and the *outcome* of HCEC (e.g., resolving ethical questions or concerns prompting HCEC). Questions about how disagreements are resolved and who decides what is considered “ethically justifiable” are addressed in such cases by attending to both HCEC *process* and *outcomes*. Importantly, mere agreement among those involved in HCEC is not by itself evidence that an outcome is acceptable or defensible, although ethics facilitation involves attempting to reach agreement among stakeholders through communication and education strategies.

CODE RESPONSIBILITIES

1. Be Competent

Codes of ethics traditionally call upon members of the profession to maintain standards of competence. This first code of ethics achieves this by referencing HCEC competency standards that have achieved wide acceptance in the field, such as those described in ASBH’s *Core Competencies* report (2011). Yet, how such standards are recognized and interpreted will require continual reflection and scholarship in the field. For example, because the *Core Competencies* recognizes that HCEC may be

performed by an individual, a pair, a team, or a committee, interpreting how competence in HCEC is to be understood depends on the nature of an individual HCE consultant's particular involvement. While all HCE consultants must have "basic" knowledge and skills listed in the *Core Competencies* report to satisfy this Code responsibility, those functioning as solo or "lead" consultants must have advanced knowledge and skills (as delineated in the *Core Competencies*). Moreover, those doing specialized ethics consultations such as organizational or research ethics consultations will need to have specialized knowledge and skills.

Some felt that the Code should more definitively reference the *Core Competencies* as delineating the established standards in the field. Others felt the Code should allow for other endorsed standards to be acknowledged. Task Force members thus opted for a middle ground approach, which recognizes the *Core Competencies* as one set of endorsed standards that does not preclude the possibility that other HCEC standards may achieve field-wide acceptance. One key question that arose from several survey respondents was, when is it appropriate to hold HCE consultants accountable to HCEC standards endorsed by a particular institution or organization? For example, is a HCE consultant providing services at a Veterans Affairs (VA) facility held accountable, by virtue of this Code, to the *Integrated Ethics* standards endorsed by the VA (Fox et al. 2006)? Is a HCE consultant at a Catholic hospital accountable to the Catholic Health Association standards governing HCEC? The CECA committee answers these questions in the affirmative if the organization's standards can be seen as consistent with the *Core Competencies* standards. HCE consultants are not accountable by virtue of this Code to standards that differ from those that have field-wide acceptance.

Some code survey respondents expressed the concern that a focus on the knowledge, skills and attributes necessary to effectively provide HCEC neglects other necessary qualifications, such as particular character traits, capacities, or commitments (e.g., to self-reflection or self-growth). These additional qualities are addressed in the *Core Competencies*, to which this Code responsibility element

holds HCE consultants accountable. We acknowledge, however, that it would be challenging to determine objectively whether, during a specific consultation, an ethics consultant failed to demonstrate the patience, compassion, humility, or integrity that was necessary to perform the role appropriately. What might constitute a breach of the Code is difficult to assess in this regard. HCEC knowledge and skills, on the other hand, are more readily evaluable. For example, if an HCE consultant responded to a case consultation about end-of-life decision-making without demonstrating basic knowledge of advance directives and standards of patient versus surrogate decision-making, or skills in facilitating communication among stakeholders, this would likely constitute a breach of the Code.

This element of the Code does not address *how* HCE consultants are to achieve the required competencies or how such competencies are to be evaluated. The latter is being explored by the Quality Attestation Presidential Task Force (Kodish et al. 2013). The former is being explored by the U.S. Association of Bioethics Program Directors. While the field is progressing toward accrediting graduate programs that educate and train HCE consultants, given that this is not yet a reality, expectations have not been articulated in the Code about the type of education, training, and hands-on experience required to achieve HCEC competence. The expectation is that one's education and training provide mastery of content areas from the *Core Competencies*, and that HCE consultants commit to lifelong learning and peer evaluation.

We anticipate that eventually, a professional HCE consultant will need to complete an accredited educational program that provides experiential training, and will undergo a certification process to demonstrate HCEC competency. While concerns were raised in the first edition of the *Core Competencies* about these developments, the same concerns arose for other professions facing the growing pains of professional development, including medicine, and more recently, chaplaincy and palliative care. Whether a professional code of ethics should precede or follow education/training program accreditation and/or individual certification is a chicken-egg question. One way out of this

conundrum is to embrace the chicken or the egg and move forward, understanding that a code of ethics will evolve with the profession.

2. Preserve integrity

The previous version of this Code's interpretive paragraph failed to adequately define and delineate the relationship between personal and professional integrity. Code survey respondents aptly identified the following key concepts to elucidate in the final version of this Code element:

Clarify role of personal integrity: HCEC involves helping others to resolve uncertainty when values are in conflict. A HCE consultant's ability to preserve professional integrity, therefore, requires awareness of his or her core values and beliefs to be able to identify when personal and professional integrity may be in conflict. Preserving personal integrity alone is insufficient when doing HCEC. As one survey respondent pointed out, "If integrity means only 'acting in a manner that is consistent with one's core beliefs and values,' then psycho killers may do this, and it does little to promote trust." At a minimum, HCE consultants must be aware of their own core beliefs and values to know when these may interfere with professional integrity and their ability to provide effective HCEC. This awareness should also inform how the consultant negotiates working conditions where he or she practices as an ethics consultant. For example, an HCE consultant whose own core beliefs and values preclude endorsing late term abortion under any circumstances should not accept a position in a facility where this issue frequently arises and where the consultant would need to recuse him/herself from ethics consultations involving this issue. Likewise, an HCE consultant should not agree to provide HCEC in an institution where he or she would be prohibited from practicing according to accepted standards (e.g., not routinely including patients and/or designated surrogate decision-maker(s) in ethics case consultations where recommendations may affect the patient's care). The point at which preserving personal integrity interferes with one's ability to preserve professional integrity can be subtle, and requires ongoing reflection. Such reflection is supported by various obligations invoked by the Code, such as engaging in

peer review of HCEC activities, promoting HCEC process transparency, supporting HCEC quality improvement practices, and appropriately managing conflicts of interest and obligation.

Professional trumps personal integrity: The Code's emphasis is on preserving *professional* integrity, which requires attention to the distinction between personal and professional integrity as regards HCEC. Since personal integrity involves acting in a manner consistent with one's own core beliefs and values, it follows that HCE consultants whose core beliefs and values are aligned with the values underlying HCEC are best positioned to preserve professional integrity when doing HCEC. For example, an HCE consultant who believes that individuals are free to act in a manner consistent with their values as long as their actions do not interfere with others' rights, and that respecting differing opinions is to be valued, will likely be more successful at eliciting and identifying conflicting values among stakeholders involved in an ethics consultation. In contrast, HCE consultants who believe that clinicians' medical judgments should always trump patients' or family members' requests would likely be more challenged in setting this belief aside during HCEC. When personal and professional integrity are in conflict, preserving professional integrity should be the consultant's priority.

Identify core values underlying HCEC: Professional integrity involves a commitment to preserving the core values of HCEC when fulfilling the role of HCE consultant. There is a symbiotic relationship between action-guiding ethical principles that identify duties based on values, and virtues that predispose one to fulfill such duties. One is reminded here of Frankena's complementary pairing of ethical principles and virtues, such as the ethical principle of beneficence (a duty to promote others' well-being) paired with the virtue of benevolence (cultivating a disposition to act beneficently) (Frankena, 1973). The ethical principles and theories that HCE consultants have used in their ethical analysis and deliberation point to central values of the profession: fidelity, justice, beneficence, self-improvement, non-maleficence (Ross, 1930) and respect for persons (Kant, 1785). In the *Core Competencies* report, other core values emerge, such as thoroughness, conscientiousness, flexibility,

helpfulness, inclusiveness, open-mindedness, resourcefulness, and transparency. Other essential attributes specified in the *Core Competencies report* include tolerance, patience, compassion, honesty, forthrightness, moral courage, prudence, humility and leadership. The Code obligates HCE consultants to commit themselves to sustaining these core values and attributes when providing HCEC, and to preserve professional over personal integrity when the two conflict.

3. Manage conflicts of interest and obligation

The following assumptions undergird this Code element: (1) depending on contextual factors where a consultant provides HCEC, conflicts of interest (COI) and of obligation (COO) are inherent and should be anticipated; (2) discerning between a *possible* conflict and an *actual* conflict requires vigilance and continual self-reflection; and (3) adequately managing COI and COO requires institutional support to allow HCE consultants to follow best practices for HCEC. HCE consultants must be vigilant in evaluating their own and each other's practice to recognize and manage such conflicts through attention to procedural transparency in addition to (when warranted) disclosure (e.g., verbal disclosure that one is an employee or paid consultant for the institution during initial introduction, or institutional badge display) and recusal (e.g., finding another HCE consultant to handle the case). Simply being paid by an institution to do HCEC does not in itself create a COI.

The Code responsibilities to *Be Competent*, *Preserve Integrity*, and *Promote Just Healthcare within HCEC* are relevant here. Disclosure in the form of transparency as a strategy to manage COI and COO is built into the process of HCEC. For example, when ethics consultants initially introduce themselves to stakeholders involved in an ethics consultation and clarify their roles and obligations, their commitments are made clear and are, therefore, less easily breached. Such commitments include elucidating and valuing each stakeholder's perspective, uncovering and understanding relevant facts, upholding standards of ethical decision-making, and identifying recommendations that have sound ethical justifications (ASBH, 2011). For example, consider a situation in which an intensive care unit (ICU)

physician requests an ethics consultation to inform whether extracorporeal membrane oxygenation (ECMO) may be stopped for a patient for whom ECMO is not achieving its intended goals when the patient's surrogate decision-maker insists that it be continued. Assuming the facility receives a capitated reimbursement for the care of this patient, stopping ECMO would save the institution money by freeing up a bed that could generate greater revenue. Thus, it could be argued, there is a potential COI if the HCE consultant stands to benefit by pleasing the institutional officials who pay his wages or decide on his employment contract. If the HCE consultant recommended stopping the ECMO without using ethics facilitation techniques to involve relevant parties, and without providing an adequate justification for the recommendation, there is greater concern that the HCE consultant's recommendation may be influenced by COI. Even when this part of the process is followed, the ethics consultant must always monitor her/himself to ensure that (s)he is not slipping out of the HCE consultant role (e.g., a physician consultant challenging a treating physician's choice of antibiotic during an HCEC stakeholder meeting). The same is true for other types of COI, such as when promotion, tenure, and teaching opportunities of an HCE consultant may be affected by the nature of HCEC recommendations.

The practice of HCEC is currently performed by a number of individuals, including HCE consultants employed full time to provide ethics services, as well as professionals who do HCEC in addition to other professional services (e.g., chaplaincy, medicine, nursing, social work). Having more than one professional role in the facility where one does HCEC is common. Merely disclosing this during HCEC alone is insufficient. HCE consultants must be clear when they are functioning as HCE consultants and when they are functioning in another professional capacity (particularly if the badge they wear identifies them with another professional role). Whenever possible, HCE consultants should recuse themselves when close personal relationships among HCEC stakeholders compromise their ability to overcome conflicts of interest or obligation when performing HCEC. While several Code survey respondents requested that this element of the Code more definitively require recusal in such

circumstances, this is not possible in some settings (e.g., rural communities with few available competent HCE consultants). As the quality of HCEC services becomes more dependable from one health care institution to the next, and as distance technology improves, it will become less common to forego recusal when appropriate simply due to the lack of availability of another qualified consultant. HCE consultants should exercise due diligence in finding an alternate consultant before concluding that recusal in a situation warranting it is impossible. A suggested interim strategy is to perform the HCEC but to seek review from HCE consultant colleagues outside of the institution.

In response to the last sentence of this Code responsibility, survey respondents expressed the theoretical concern that HCE consultants who belong to other health professions could find themselves in conflict by being held accountable to competing codes of ethics. No examples were identified whereby this Code's responsibilities would conflict with those of another professional code. However, if this occurred, the HCE consultant should resolve the conflict through mechanisms described above.

4. Respect privacy and maintain confidentiality

Privacy and confidentiality are related, but distinct, concepts. Both demand that HCE consultants protect stakeholders involved in HCEC against breaches. A privacy breach involves an unauthorized disclosure of an HCEC stakeholder's private information. For example, if a patient disclosed her sexual orientation to an HCE consultant and the consultant then shared this with the patient's sibling without the patient's permission, this would constitute a privacy breach. A confidentiality breach involves unauthorized access to information contained in patients' medical records and other sources. For example, if an HCE consultant left a written summary of a case consultation in the facility cafeteria with identifiable patient information on it, this would constitute a confidentiality breach. HCE consultants must have access to private information to perform HCEC responsibly. At the same time, HCE consultants must establish trust with those they serve when doing HCEC. As such, it is imperative that HCE consultants only access private information that is relevant to

the HCEC, and that they guard against inappropriate disclosures. Each facility should have established standards identifying expectations for protecting confidentiality and privacy during HCEC.

In the United States, the Health Insurance Portability and Accountability Act (HIPAA) governs what protected health information (PHI) health care providers of covered entities may legally access or disclose. HCE consultants in the United States must abide by HIPAA privacy protections which allow for PHI uses and disclosures that, in the exercise of good professional judgment, are required for the patient's care or are necessary to health care operations. This use extends to quality improvement activities with the understanding that only the minimum necessary amount of PHI be used and disclosed. However, what is considered minimum necessary information for a particular purpose is still subject to interpretation. Moreover, abiding by HIPAA is necessary but not sufficient to protect privacy and maintain confidentiality while performing HCEC. HCE consultants must use professional judgment and practice consistent with evolving policies, laws, and regulations to avoid privacy and confidentiality breaches when doing HCEC.

Since ethics case consultations are contextually situated, it may not be possible to completely de-identify a summary of a case. In such instances, all should be done to remove direct identifiers (e.g., name, address, social security number, etc.). Further protection against confidentiality breaches includes limiting who has access to case summaries containing potentially identifiable contextual details (for example, ensuring that case summaries shared via the internet or intranet or through hard copy summaries are received and safeguarded only by authorized persons). In most cases, where review is internal to the institution (e.g., a meeting of the ethics consultation team, the ethics committee, or a facility unit-based retrospective case review), these procedures will be sufficient to maintain confidentiality of HCEC stakeholders.

When should consent be sought from individuals whose private information will be shared beyond those directly involved in an HCEC? This also depends on contextual factors. The greater the

likelihood that persons not involved in the HCEC may view detailed summaries of cases that could identify individuals, the greater the obligation to obtain consent to share details of the case from stakeholders whose identities may be revealed. If obtaining consent is not possible, the HCE consultant should modify contextual details sufficiently to make the case reasonably unrecognizable to those involved, and/or should consider anonymous authorship, if publishing a summary or analysis of the case consultation. HCE consultants who provide advice or feedback about active case consultations to colleagues from other institutions or settings are obligated to these same standards.

Situations in which an HCE consultant is obligated to disclose private information against an HCEC stakeholder's wishes should be reserved for those rare cases where this is mandated by law or institutional policy, or when no other course of action can prevent a loss of life or serious harm. For example, should a HCE consultant receive information that suggests that a patient's dementia has progressed to such an extent that it is likely that he can no longer operate a vehicle safely, it might be necessary for that HCE consultant, according to local policies and laws, to alert appropriate persons who are in a position to protect the patient and others from this danger (e.g., the patient's physician or the department of motor vehicles). From this it does not follow, however, that this patient should have no expectation of privacy with respect to this health-related information. The patient has the right to decide when and with whom he wishes to share his diagnosis so long as his decision presents no serious or immediate harm to himself or others.

The HCE consultant should safeguard trust with HCEC stakeholders by disclosing limitations of privacy and confidentiality protections at the onset of HCEC, whenever possible. This is more common during case-consultations than non-case consultations. For example, this may be done during an initial meeting with stakeholders where the HCE consultant explains that what is discussed will be kept confidential, with some exceptions (for example, disclosures of child or elder abuse or information that puts someone in immediate danger). HCEC stakeholders should be informed whether case consultation

summaries will be placed in a patient's medical record, and any limitations placed on such documentation should be communicated in advance (e.g., whether anonymous requestors may be identified).

5. Contribute to the field

This Code element provides examples of ways that HCE consultants may contribute to the field. It is suggested that individual HCE consultants need to determine for themselves how best they can contribute. Those who identify primarily as HCE consultants (rather than with another professional title) may justifiably engender higher expectations from their peers and the public with respect to how they meet this Code responsibility/address this Code element. For example, a hospital social worker or nursing home chaplain who does HCEC as a "secondary activity" may contribute simply by acceding to a request to participate in a survey that could improve the quality of HCEC. An HCE consultant who is employed full time to do HCEC and to provide other ethics services may contribute by conducting HCEC research and publishing findings. Since the advancement of a profession rests on future generations of practitioners, all HCE consultants should contribute in some way to supporting and mentoring junior consultants.. HCE consultants have an obligation to foster the values espoused by the code by promoting collegial relationships and seeking out opportunities for the improvement of one's practice.

6. Communicate Responsibly

Communicating in the "public arena" includes any sharing of information that is intended to be accessed by society at large (e.g., through professional and lay publications and presentations, media outlets such as television, cable, and internet journalism, and social media). Some Code respondents expressed a concern that this Code responsibility would limit freedom of speech, and suggested that rather than prohibiting public sharing of "outlier" viewpoints related to HCEC through a professional code of ethics, we should rely on other social conventions such as loss of reputation to rein in HCE consultants who make unhelpful public comments. It should be clarified, therefore, that the purpose of

this Code element is not to force conformity to a narrow range of viewpoints nor is it to discourage sharing of contrary or controversial points of view. Rather, this Code element is designed to recognize that when one is publicly identified by a title referencing “ethics,” this may itself convey authority that has a potential for abuse. HCE consultants should be mindful of this.

Those with social media accounts (e.g., Facebook, Twitter, blogs) should be aware that if they are identified as ethics experts, the opinions that they share related to HCEC should be informed, supportable, and should indicate whether their views are shared by a majority or a minority of those practicing in the field. For example, say an HCE consultant posted on his Facebook page that brain death criteria constitutes an arbitrary line for declaring death and was only created to make more human organs available for transplantation. Such a statement could be defended, but it fails to include other endorsed ethical justifications for declaration of death by neurologic criteria. The HCE consultant’s obligation to acknowledge other ethical perspectives on this topic is influenced by many factors, including: (1) the degree to which the individual is recognized as an HCE consultant (e.g., is he identified as an HCE consultant on his Facebook page? Does she have a longstanding reputation in the field and a strong media presence as an ethics expert?), (2) whether the individual is providing a personal or professional opinion (e.g., posting a comment on Facebook under a friend’s photo versus sharing an opinion on a medical futility blog about a case reported in the media), (3) the degree of consensus among HCE consultants about other ethical perspectives on the topic (e.g., there is widespread consensus that ventilator support should be stopped after death is confirmed by neurologic criteria, but no widespread consensus on whether ventilator support should be stopped after persistent vegetative state (PVS) is confirmed), and (4) unavoidable constraints on the HCE consultant’s ability to fulfill these obligations (e.g., “tweets” are limited to 140 characters, and media outlets favor “sound bites” and often do not give interviewees control over what is ultimately published or broadcast).

This Code element, like the others, depends on one’s ability to meet other Code responsibilities.

For example, the responsibility to protect against privacy and confidentiality breaches during HCEC precludes an HCE consultant from commenting in public about a particular case with which he or she has been involved without permission from those involved. However, it is also important to educate the public responsibly about ethical issues and to encourage informed debate, particularly with regard to issues that receive widespread media coverage. As such, the responsibility to “Be Competent” obligates HCE consultants to support their public statements by presenting cogent arguments that reflect diversity of opinion when such exists, and to meet ethical standards when doing so (e.g., giving proper attribution to others’ work). Campbell (2012, p. 440) proposed a vision of public engagement that “is more than just a consensus-seeking and policy paper-drafting endeavor; rather, the ‘outcome’ becomes an ethics-informed process.” Along these lines, “cultural humility” (Tervalon, 1998) is embraced as an ideal in this Code element to accentuate that when HCE consultants communicate publicly about HCEC topics (i.e., outside of the facility where they do HCEC), they should model the same core values undergirding HCEC, such as respect for divergent values and beliefs and a fair process for resolving disagreements, along with their commitment to factual accuracy and logical reasoning.

7. Promote just health care within HCEC

This Code element, above all others, engendered the most divergent viewpoints. This is not surprising, given that when the topic of ASBH taking public positions on substantive moral issues was debated, some members resigned in protest of the Board’s decision to forego changing its bylaws to allow this. Similarly, some survey respondents expressed the view that if this responsibility were *not* included in the Code, they could not endorse the Code, whereas others stated that if it *were* included in the Code, they could not endorse it. Given this divergence, a compromise position was adopted whereby HCE consultants are recognized as minimally obligated to promote just health care *within* a given ethics consultation, recognizing that systemic injustice (i.e., within an organization, a health care system, a state, or a country) often has a trickle down effect on individual ethics consultations.

“Just health care within HCEC” refers to both *process* and *outcomes*. When conflicting values create uncertainty about the best decision or action in a health care encounter and an HCE consultant is called upon to help, justice involves (as explained earlier) attention to *process* and *outcomes*. Some code survey respondents questioned the interpretability of this Code element given that there is no one standard of justice to be promoted during HCEC. Yet, this Code responsibility does not obligate an HCE consultant to endorse one particular outcomes-based standard. Instead, it obligates the consultant to follow process-based standards for involving affected stakeholders and to provide ethically persuasive justifications for any recommendations made (i.e., justifications grounded in ethics scholarship and literature, beyond mere group consensus).

The duty to include marginalized voices does not imply that one is to give more weight to such individuals simply due to their marginalized status, but it does recognize that individuals in this category face a higher risk of being unjustly treated, and may need additional assistance from the HCE consultant to have their positions recognized and respected. This should not be confused with patient advocacy, a concept that some survey respondents identified as an HCE consultant’s primary responsibility. The Code views the HCE consultant as obligated to involve all relevant parties in an ethics consultation. Treating individuals fairly does not mean giving equal attention to each or favoring the voice of one stakeholder over another—rather, it involves the HCE consultant tailoring his or her approach as needed to facilitate an inclusive, equitable HCEC process.

The HCE consultant’s obligation to address the injustice affecting HCEC depends on the directness of causal influence of the injustice and the ability of the HCE consultant to affect change. For example if a deaf patient was at the center of an ethics consultation, and an administrator directed the HCE consultant to communicate with the patient in written form rather than through an American Sign Language (ASL) interpreter to save on interpreter fees, the HCE consultant should recognize that (in addition to violating the Americans with Disabilities Act) such a position is unfair to both the patient and

to other members of the Deaf community who communicate most effectively through ASL and who may be deprived of needed interpreter services owing to the facility's practice of limiting access to ASL interpreters. The HCE consultant's obligation, then, is to educate the administration on its legal and ethical obligations to provide ASL interpreter services. However, if the patient asked the HCE consultant to rectify interpreter access issues in other venues (e.g., the patient's church or her child's school), the HCE consultant would neither be professionally obligated nor restricted by this Code to take on such advocacy.

Admittedly, it is difficult to draw bright lines where an HCE consultant's professional obligations to address injustices within HCEC ends, since injustice has deep roots. This Code responsibility establishes a floor rather than a ceiling for an HCE consultant's duty to attempt to rectify social injustices impacting HCEC. The focus here on HCEC should not be interpreted to relieve HCE consultants of any considerations beyond individual ethics consultations at the institution where they practice. For example, an individual case consultation may reveal inconsistencies in an institution's ICU triage policies. The HCE consultant may have no direct control over ICU admission criteria but should be able to provide persuasive arguments supporting fair ICU triage policies.

This Code's interpretation regarding an HCE consultant's professional obligations to address macro-level injustice that influences HCEC at his or her institution is more aspirational than binding. For example, an HCEC involving a severely premature, low birth weight infant may be affected by state resources for severely disabled children. This Code obligates the consultant to ensure that similar cases within the institution are handled alike and according to process- and outcomes-based standards for HCEC. While the HCE consultant may also choose to address macro-level injustice in resource allocation for disabled infants, this code is not designed to render such action obligatory. HCE consultants with expertise and experience that can influence public policy affecting HCEC may choose to engage in advocacy work to attempt to rectify health care injustices at the macro level. Such action is laudable but

not required to meet the Code's obligations. HCE consultants who choose to work on macro-level injustices affecting HCEC are bound by the obligations articulated in Responsibility #6 ("Communicating Responsibly").

IMPLICATIONS & FUTURE DIRECTIONS

This paper describes the transparent, participatory process used to develop a code of ethics for HCE consultants. As has happened with other professions, considering adoption of a code of ethics as a step toward professionalization of HCE consultants has raised concerns. How will the code be interpreted? Who will enforce it? How will professionalization affect diversity in the field? How will practitioners be adequately trained and mentored? How will the cost of professionalization be borne by HCEC practitioners and health care facilities using their services? These questions were asked of other professions when the initial steps toward professionalization were undertaken. Until HCE consultants undergo certification that requires passing an exam, acquiring clinical internship experience, and obtaining a degree from an accredited graduate program, and/or professional licensing, these Code obligations will remain aspirational rather than enforceable. This is the reasoning for keeping "should" rather than "must" language in the Code.

The function of a code is in part to proclaim a profession's commitments to those served by the profession. It also allows professionals to establish working conditions that maximize their ability to fulfill their professional obligations. Thus, while this Code focuses on aspirational obligations of individuals practicing HCEC, it has implications for those who educate, train, mentor, and hire HCE consultants. With these ends in mind, the Code can be seen as a viable document that can serve the interests of HCE consultants, employing institutions, and the public. It certainly is not the last word on the subject, but it is a good start.

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REFERENCES

- American Society for Bioethics and Humanities' Core Competencies Update Task Force (2011). *Core competencies for health care ethics consultation: The report of the American Society for Bioethics and Humanities* (2nd Ed.). Glenview, IL: American Society for Bioethics and Humanities.
- Baker, R., Pearlman, R., Taylor, H., Kipnis, K. 2006. *Report and recommendations of the American Society for Bioethics and Humanities' advisory committee on ethics standards*. Glenview, IL: American Society for Bioethics and Humanities. Available at <http://www.asbh.org>
- Baker, R. 2005. A draft model aggregated code of ethics for bioethicists. *American Journal of Bioethics* 5(5): 33-41.
- Campbell, A.T. 2012. Bioethics in the public square: Reflections on the how. *Journal of Medical Ethics* 38(7): 439-41.
- Fox E., Berkowitz K.A., Chanko B.L., Powell T. 2006. *Ethics consultation: Responding to ethics questions in health care*. Washington, DC: Veterans Health Administration. Available at http://www.ethics.va.gov/docs/integratedethics/Ethics_Consultation_Responding_to_Ethics_Questions_in_Health_Care_20070808.pdf (last accessed September 30, 2014).
- Fox, E., Myers, S. and Pearlman, R.A. 2007. Ethics consultation in United States hospitals: A national survey. *The American Journal of Bioethics* 7(2): 13-25.
- Frankena, W.K. 1973. *Ethics* (2nd ed.). New Jersey: Prentice-Hall.
- Jonsen, A. 1993. The birth of bioethics. *The Hastings Center Report* 23(6): S1-4.
- Kant, I. 1785. *Groundwork of the Metaphysics of Morals*. New York: Cambridge University Press.
- Kipnis, K. 2005. The elements of code development. *American Journal of Bioethics* 5(5): 48-50.
- Kodish, E., Fins, J.J., et al. 2013. Quality attestation for clinical ethics consultants: A two-step model from the American Society for Bioethics and Humanities. *The Hastings Center Report* 43(5): 26-36.

Loewy, E. and Loewy, R.S. 2005. Use and abuse of bioethics: Integrity and professional standing. *Health Care Analysis* 13(1): 73-86.

MacDonald, C. (n.d.) *Model code of ethics for bioethics*. Available at <http://www.bioethics.ca/resources/PDF%20documents/draftcode.pdf> (last accessed August 21, 2014).

Ross, W. D. 1930. *The right and the good*. Oxford: Oxford University Press.

Scofield, G. R. 2008. What is medical ethics consultation? *Journal of Law, Medicine & Ethics* 36(1): 95-118.

Society for Health and Human Values–Society for Bioethics Consultation 1998. *Core competencies for health care ethics consultation: The report of the American Society for Bioethics and Humanities*. Glenview, IL: American Society for Bioethics & Humanities.

Stohlberg, S.G. "Bioethicists Find Themselves the Ones Being Scrutinized," *The New York Times*, August 2, 2001. available at <http://www.nytimes.com/2001/08/02/us/bioethicists-find-themselves-the-ones-being-scrutinized.html> (last accessed September 30, 2014).

Tarzian, A.J. & the ASBH Core Competencies Update Task Force 2013. Health care ethics consultation: An update on core competencies and emerging standards. *American Journal of Bioethics* 13(2): 3-13.

Tervalon, M. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved* 9(2): 117–125.

APPENDIX 1

CODE OF ETHICS AND PROFESSIONAL RESPONSIBILITIES FOR HEALTH CARE ETHICS CONSULTANTS

[Note to editor: We will have to negotiate copyright of Code which is open access on the ASBH website]

PREFACE

This statement sets out the core ethical responsibilities of individuals performing health care ethics consultation (HCEC)—specifically, clinical ethics consultation, a subset of HCEC. It does not explicitly address the ethical obligations for the range of additional ethics services that health care ethics (HCE) consultants may provide for an organization. Clinical ethics consultation (CEC) represents a subset of the activities performed by HCE consultants.

HCEC is “a set of services provided by an individual or group in response to questions from patients, families, surrogates, health care professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care” (ASBH, 2011). Ethics consultation seeks to identify and support the appropriate decision-maker(s) and ethically sound decision-making by facilitating communication among key stakeholders, fostering understanding, clarifying and analyzing ethical issues, and including justifications when recommendations are provided. It addresses the ethical concerns of persons involved in health care decision-making and health care delivery including patients, family members, health care providers, institutional leaders, and those who set guidelines and create policies.

PROFESSIONAL RESPONSIBILITIES

1. Be Competent. HCE consultants should practice in a manner consistent with professional HCEC standards.

Competency requires education and experiential training to acquire the knowledge, skills, and attributes needed to do HCEC effectively. Continuing education and training is essential to maintain these competencies and to foster professional development. Competency also requires a commitment to

subject one's work to peer review and quality improvement. The core competencies for performing ethics consultation are evolving. HCE consultants should meet competency standards that have achieved field-wide acceptance, including the American Society for Bioethics and Humanities' Core Competencies for Health Care Ethics Consultation (2011).

2. Preserve integrity. HCE consultants should consistently act with integrity in the performance of their HCEC role.

HCE consultants should strive to be worthy of the trust placed in them by patients, family members/caregivers, health care staff, and the institutional leaders who seek their help in addressing ethical questions and problems. Personal integrity involves acting in a manner that is consistent with one's core beliefs and values. Professional integrity involves commitment to the core values underlying the practice of HCEC. This requires an ongoing commitment to cultivating attributes, attitudes, and behaviors that enable one to perform HCEC well, such as self-awareness, fair-mindedness, humility, and moral courage.

Consultants should strive to safeguard the process of moral deliberation in the institutions where they provide ethics consultation. They should foster learning and facilitate respectful interactions among involved parties in the ethically complex, emotionally fraught, high-stakes situations they often face. Consultants should preserve professional integrity by not engaging in activities that involve giving an ethical justification or stamp of approval to practices they believe are inconsistent with agreed-upon ethical standards. If a conflict involving the consultant's personal core beliefs or values arises in the course of performing HCEC, the consultant should recuse him/herself from the case after securing the services of a replacement. For example, HCE consultants who have a strong moral objection to artificial reproductive technologies (ART) should recuse themselves in consultations involving ART, and should not agree to provide HCEC in a setting where this routinely arises. If no replacement is available, the primary obligation of the HCE consultant is to maintain professional integrity.

HCE consultants promote integrity when they are transparent about the conditions under which they perform HCEC, such as who they report to, who funds their HCEC work, and the boundaries of their responsibilities. (See also Code Responsibility #3: Manage conflicts of interest and obligation.)

3. Manage conflicts of interest and obligation. HCE consultants should anticipate and identify conflicts of interest and obligation and manage them appropriately.

Conflicts of interest involve situations in which the professional judgment of a HCE consultant is, or may appear to be, affected or compromised by competing interests such as personal, professional, or financial interests. For example, consultants employed by an institution may be reluctant to disagree with someone of authority and influence within the institution. This demonstrates competing interests in preserving one's employment and competently performing consultation. Conflicts of obligation involve situations in which HCE consultants' work is or may appear to be affected or compromised by competing professional and/or personal responsibilities. For example, a consultant who is also a social worker or director of an intensive care unit may experience pressure as part of that role to limit a patient's length of stay, which may not be in the patient's best interests. Personal and professional obligations may also be in conflict, when, for example, one has a duty to keep other work-related or personal commitments and a competing duty to complete an ethics consultation in a timely manner.

HCE consultants should minimize the likelihood that conflicts will interfere with their duties toward those who seek their advice and support through HCEC. Principal strategies include avoidance, recusal, and disclosure. An Ethics Consultation Service with multiple consultants can, for example, assign cases with attention to avoiding conflicts. Consultants may recuse themselves from the consultation when another qualified consultant is available, or disclose the conflict. For example, some HCE consultants who are employed or paid by the facility where the ethics consultation request occurs disclose this potential conflict of interest to patients or family members at the onset of a case consultation. Consultants should make efforts to negotiate terms of service that minimize the occurrence

of conflicts of interest and obligation and allow them to be managed appropriately.

In addition to their role as HCE consultants, some individuals are members of other professions and may be accountable to different codes of ethics. While engaging in ethics consultation, individuals should adhere to the Code of Ethics for HCE consultants.

4. Respect privacy and maintain confidentiality. HCE consultants should protect private information obtained during HCEC, handling such information in accordance with standards of ethics, law, and organizational policy.

Confidentiality is the duty to respect others' right to control access to their private information.

In the consultation process, HCE consultants are entrusted with private information about patients, families, providers, and institutions. Respecting privacy and maintaining confidentiality is a high priority. HCE consultants are subject to laws, such as HIPAA in the U.S., and institutional policies regarding the handling of private information.

There are, however, times when HCE consultants should divulge confidential information. When it is necessary to provide significant benefit, e.g., protect life or prevent serious harms, HCE consultants may be obliged to share relevant private information with others, including health care leaders and staff, agents appointed in an advance directive, child/adult protective services agencies and/or law enforcement personnel. The information should be communicated discreetly, only to those who need to know and sharing only the minimum amount of information necessary. When appropriate, HCE consultants should prospectively communicate the limits of confidentiality protection.

Information obtained during HCEC may legitimately be used for a variety of other purposes, including peer review, quality improvement, education, and scholarship. Management strategies for maintaining confidentiality vary among these purposes. For example, one may seek to maintain confidentiality by removing identifiers, using pseudonyms, and/or altering inconsequential information. In some situations, consent should be obtained from those whose identity may be revealed to others not

involved in the consultation.

5. Contribute to the field. HCE consultants should participate in the advancement of HCEC.

To be a member of a profession means, in part, to foster the collective good of that profession and the constituencies it serves. Toward that end, in addition to maintaining their competency as described in Code Responsibility #1, HCE consultants should advance the quality and effectiveness of HCEC by supporting activities that contribute to the field. This involves activities such as conducting and participating in research, publishing in the field, mentoring other ethics consultants, teaching others about HCEC, conducting community outreach related to HCEC, and participating in professional organizations. These contributions may be institutional, regional, national, or international in scope.

6. Communicate Responsibly. When communicating in the public arena (including social media), HCE consultants should clarify whether they are acting in their HCEC role, and should communicate in a manner consistent with the norms and obligations of the profession.

Communicating responsibly obliges HCE consultants to be sufficiently informed about issues on which they communicate publicly, including an understanding of facts and scholarship relating to the topic. If HCE consultants do not have sufficient knowledge in a particular area, they should decline to comment and consider referring to others. Public comments should acknowledge uncertainty about norms or lack of consensus where it exists. Consultants should recognize that the topics upon which they are asked to comment can generate strong reactions. Communicating responsibly should promote reflection in others and an opportunity to consider different points of view. HCE consultants should demonstrate cultural humility and sensitivity to differing values when communicating about HCEC-related issues in the public arena.

7. Promote just health care within HCEC. HCE consultants should work with other health care professionals to reduce disparities, discrimination and inequities when providing consultations.

When doing ethics consultation, consultants need to be attentive to the role that health care

disparities, discrimination and inequities play. Consultants should ensure that all stakeholders have access to the HCEC process, and that the process is fair. Issues of power, privilege, and organizational culture may make the process of ethics consultation more challenging, and may complicate efforts to promote just and equitable recommendations and outcomes. Consultants have a responsibility to identify and include relevant voices in the discourse, particularly marginalized voices. Recommendations of the consultation should not reinforce injustice. When possible, consultants should identify systemic issues constraining fair outcomes in HCEC and bring these issues to the attention of individuals or groups in a position to address them.

Table 1. First Draft of the Code of Ethics and Professional Responsibilities for Health Care Ethics Consultants

Preface

This statement of professional responsibilities is designed to identify and communicate publicly the core ethical responsibilities of anyone engaged in health care ethics consultation (HCEC).

The goals of HCE consultation include: to identify and analyze the nature of the value uncertainty or conflict that underlies the ethics consultation request; and to facilitate resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of all those involved (ASBH, 2011). HCE consultation provides assistance both to individuals involved in “bedside” clinical decision making, as well as to those involved in broader institutional issues, guidelines or policies that raise ethical concerns.

Any individual serving as an HCE consultant incurs a series of responsibilities. Consultants come from various professional disciplines, and so may be held accountable to different codes of ethics standards. However, while engaging in HCE consultation and other HCE activities, consultants should regard this statement of responsibilities as authoritative.

Professional Responsibilities of Health Care Ethics Consultants

- 1. Be Competent.** HCE consultants should practice in a competent manner.
- 2. Avoid Conflicts of Interest.** HCE consultants should identify and avoid, when possible, actual and perceived conflicts of interest. If it is not possible to avoid such a conflict, then it should be managed using ethically supportable strategies.
- 3. Manage Conflicts of Obligation.** HCE consultants should clarify and manage potential conflicting obligations when they perform multiple roles within an organization.
- 4. Protect Confidentiality.** HCE consultants should identify information that is confidential and ensure that such information is respected and shared in accordance with standards of ethics, law, and hospital policy.
- 5. Preserve Integrity.** HCE consultants should preserve professional integrity by not engaging in activities that compromise their ability to fulfill the obligations of their role as HCE consultants, and by not accepting terms of employment that will prevent them from performing responsibilities with integrity. HCE consultants should avoid conflating expertise with authority or abusing power.
- 6. Make Responsible Public Statements.** When addressing the lay public about HCE issues, HCE consultants should speak responsibly, and not make public statements outside of their area of expertise.
- 7. Contribute to the Field.** HCE consultants should participate in the advancement of the profession through contributions to practice, education, administration, knowledge, and skill development.
- 8. Promote Just Health Care.** HCE consultants should collaborate with other professionals and lay persons to promote a more just health care system.

Table 2. Survey responses from 2011-2012. Respondents were provided the Code Preface and the eight responsibilities and asked to identify if they felt the element should “remain as is,” undergo “minor revision” or “major revision” and given space to comment. Elements were rated on a scale from 1 (keep as is) to 4 (omit entirely). There were 295 respondents, however some respondents skipped questions.

Code element	“as is”	%	“omit entirely”	%	Minor revision	%	Major revision	%	Rating Average	Comment
Preface	162	55.0	7	2.4	86	29.2	39	13.2	2.0	128
1	187	63.4	19	6.4	49	16.5	40	13.6	1.8	122
2	202	68.5	3	1.0	61	20.7	23	7.8	1.7	95
3	208	70.5	15	5.1	53	18.0	14	4.7	1.5	88
4	238	80.7	2	0.6	40	13.6	13	4.4	1.4	62
5	177	60.0	14	4.7	65	22.0	37	12.5	1.8	118
6	211	71.5	24	8.1	41	13.9	16	5.4	1.5	77
7	234	79.3	15	5.1	37	12.5	5	1.7	1.4	57
8	168	56.9	49	16.6	40	13.6	27	9.2	1.7	115

1) Be Competent, 2) Avoid conflicts of Interest, 3) Manage Conflict of Obligation, 4) Maintain Confidentiality, 5) Preserve Integrity, 6) Make Responsible Public Statements, 7) Contribute to the Field, 8) Promote Just Health Care

Table 3. Survey responses from 2013. Respondents were asked to reply to the statement “I endorse this portion of the code.” The categories “Strongly Agree” and “Agree” were collapsed as were the categories “Strongly Disagree” and “Disagree.” There were 396 respondents, however some respondents skipped questions.

Code Element	Agree	%	Disagree	(%)	Comments
Preface	356	89.9	40	10.1	85
1. Be Competent	371	94.2	23	5.8	69
2. Preserve Integrity	362	91.4	34	8.6	76
3. Manage Conflicts	370	94.4	22	5.6	67
4. Maintain Confidentiality	372	93.9	24	6.1	53
5. Contribute to the Field	374	95.2	19	4.8	33
6. Communicate Responsibly	377	95.2	19	4.8	48
7. Promote Just Health Care	373	94.4	22	5.6	38
8. Open comments about the Code					99

Figure 1. SELECT MILESTONES LEADING UP TO DEVELOPMENT OF CODE OF ETHICS FOR HCE CONSULTANTS



*Jonsen A.R. 1993. The birth of bioethics. *Hastings Center Report* 23(6): S1-4. This report summarized proceedings of "The Birth of Bioethics" conference, held at the University of Washington, Seattle in September, 1992. The conference proceedings and Hastings Center Report publication evolved into Albert R. Jonsen's book, *The Birth of Bioethics*, published by Oxford University Press in 1998.

** Baker R. 2005. A draft model aggregated code of ethics for bioethicists. *American Journal of Bioethics* 5(5): 33-41.

*** <http://www.bioethics.ca/resources/PDF%20documents/draftcode.pdf>