

Professional Clinical Bioethics: The Next Generation

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Volume 7, numéro 1, 2024

Dialogue with Future Bioethicists
Dialogue avec la prochaine génération en bioéthique

URI : <https://id.erudit.org/iderudit/1110322ar>

DOI : <https://doi.org/10.7202/1110322ar>

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Éditeur(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (numérique)

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Citer ce document

Potter, J. (2024). Professional Clinical Bioethics: The Next Generation. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, 7(1), 16–18.
<https://doi.org/10.7202/1110322ar>

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TÉMOIGNAGE / PERSPECTIVE

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Jordan Potter^{a,b}

Résumé

Ce commentaire détaille les lacunes du modèle traditionnel du comité d'éthique des soins de santé dans les soins de santé modernes et plaide en faveur de la nécessité de bioéthiciens cliniques professionnels pour mieux répondre aux besoins éthiques des soins de santé modernes.

Mots-clés

bioéthique, clinique, comité, éthique, expertise, soins de santé, professionnel, qualité

Abstract

This commentary details the shortcomings of the traditional healthcare ethics committee model in modern healthcare and argues for the necessity of professional clinical bioethicists to better meet modern healthcare's ethics needs.

Keywords

bioethics, clinical, committee, ethics, expertise, healthcare, professional, quality

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Practical bioethics in clinical settings has long been associated with healthcare ethics committees (HECs), which traditionally have been tasked with three main ethics functions within the institution: ethics consultation, education, and policy development. Comprising a multidisciplinary group of volunteers from both hospital personnel (e.g., physicians, nurses, social workers, chaplains, etc.) as well as occasionally community members, HECs were established as a practical mechanism to address the inevitable ethical dilemmas and value conflicts that arise in healthcare (1). For the past several decades, HECs have been the primary resource for virtually all ethics-related needs within hospitals and healthcare institutions, particularly in North America.

However, as Bob Dylan famously sang – “the times they are a-changing.” Whether it be the Covid-19 pandemic or the constant emergence of novel, complex medical technologies, the past few years have demonstrated that modern healthcare is rife with convoluted ethical issues, and these ethical issues are likely to become even more frequent and complex as novel medical technologies continue to be developed. Given this changing ethical landscape in healthcare, as a field we must also adapt our strategies in addressing new and ongoing bioethical issues that arise in the clinical environment. I argue that the traditional HEC is no longer best suited to meeting the ethics-related needs of modern healthcare, or at least not alone. Rather, moving forward, hospitals and healthcare institutions must prioritize the attainment of clinical bioethics expertise in the form of professional clinical bioethicists, i.e., professionals with advanced bioethics training who are hired to work solely on ethics-related issues within the institution. Professional clinical bioethicists can then take over the ethics-related work of the healthcare institution or take leadership roles and work with HECs to better meet the healthcare institution's ethics-related needs in a quality manner. There are two main reasons supporting such a shift to prioritizing in-house professional clinical bioethicists.

First, professional clinical bioethicists are generally better trained in ethics than HEC members, and they are more likely to deliver high quality clinical bioethics services than traditional HECs composed of volunteers. Several empirical studies in recent years have highlighted significant concerns surrounding the training of HEC members and subsequently the quality of ethics services they provide. A recent scoping review by Ong et al. (2) found significant variations in the existing literature regarding training of HEC members, with most curricula not meeting ethics consultation standards set forth by the American Society for Bioethics and Humanities (ASBH), i.e., ASBH's Core Competencies for Healthcare Ethics Consultation, which are the dominant professional practice standards for clinical bioethics consultation in the US.

Recent studies on ethics consultation in the US also seem to support these concerns, with over 56% of ethics program respondents indicating that they had not read the Core Competencies, including over 47% of respondents indicating they were not at all familiar with these practice standards (3). Further, this same study found that most ethics program respondents did not believe ethics consultation required graduate-level coursework or certification, with most respondents stating that less than 20 hours of training is needed to practice ethics consultation at the basic level, and less than 40 hours of training is needed to practice ethics consultation at the advanced level. These are “strikingly low” assessments of ethics consultation training needs, especially considering that most clinical ethics fellowships meant to develop competency in clinical bioethics consultation are full-time, intensive post-doctoral fellowships that last between one to two years (3).

It should then not be surprising that this same study found that approximately only 2% of those practicing ethics consultation in the responding ethics programs were described as “ethicists/bioethicists” – presumably those being professional clinical bioethicists – and only 8% had completed a fellowship or graduate degree program in bioethics, with over 41% having “learned [ethics consultation] independently, without formal, direct supervision by an experienced member of an [ethics consultation service].” Further solidifying this apparent connection between lack of training and questionable quality, smaller hospitals and non-teaching hospitals were much less likely to employ professional clinical bioethicists to practice ethics consultation in their

hospitals, thus meaning more HEC members practicing ethics consultation in these hospitals without advanced fellowship- or graduate-level bioethics training (4). And this likely contributed to this demographic of ethics programs in smaller hospitals and non-teaching hospitals also being much more likely both to be unfamiliar with the ASBH Core Competencies and to rate ethics consultation training needs at the “strikingly low” levels described above (3).

While concerning, these data should not be unexpected. Almost by definition, professional clinical bioethicists are bound to be better trained than volunteer members on a HEC. This is especially true given what was highlighted above regarding the variability of HEC training curricula as compared to most professional clinical bioethicist positions, which usually require some combination of formal training and/or experience in clinical bioethics, whether through a graduate-level or fellowship program.

These concerning data should also be expected given how much of an outlier the HEC model is among other healthcare consult services and disciplines. No other healthcare consult service is staffed by a group of volunteers that is minimally trained and questionably qualified to perform the work. Rather, healthcare consult services are provided by expert medical personnel with advanced training in the discipline. For example, when an intensivist has a question about how to manage antibiotics for a chronic wound, they do not consult an “infectious disease committee”; they consult an infectious disease physician, an expert specifically trained in treating infectious diseases. So it is unclear then why an intensivist should consult a minimally trained and questionably qualified HEC volunteer for a complex ethical dilemma, rather than an expert in clinical bioethics and ethics consultation. If as a field we are truly committed to moving towards professionalization and ensuring quality in clinical bioethics practice, addressing this outdated approach to our practice is imperative to achieving the same status and stature as other healthcare professionals, let alone the subsequent quality benefits associated with such a transition.

Second, the ethics-related needs of modern healthcare have expanded beyond the scope, capacity, and capabilities of the traditional HEC. In addition to significantly increased ethics consultation volumes over the past two decades, especially at medium to large hospitals (4), many ethics programs have significantly broadened their outreach and the so-called “non-consult ethics activities” they participate in across the healthcare institution. For example, before transitioning to my new role where I am creating a new ethics program in a large health system that has not employed the services of a dedicated, professional bioethicist for several years, I was previously a member of a large ethics program staffed with six professional clinical bioethicists and two clinical bioethics fellows among other full-time ethics staff. In this ethics program, we regularly participated in the two other traditional functions of the HEC, that is ethics education and policy development, including facilitating over 115 internal ethics education sessions and creating or revising 11 ethics-related institutional policies in fiscal year 2020. But even beyond the three traditional HEC functions, our program was extensively integrated in numerous other non-consult ethics activities across the healthcare institution. These included unit rounding and hospital committees/taskforces like mortality committees, complex case committees, the institutional review board, etc., as well as non-consult ethics activities external to the institution, such as ethics scholarship and publications and external education sessions like grand rounds or conference presentations. Further, in fiscal year 2020, our ethics program participated in 181 hospital committees and taskforces, completed 115 multidisciplinary rounds in intensive care units and with other hospital units and care teams, published 26 ethics texts, and facilitated nearly 40 external education sessions (5). And these non-consult ethics activities were completed in conjunction with an ethics consultation service that receives over 800 ethics consults per year.

The reason the ethics program was able to meet the healthcare institution’s ethics needs and be so well-integrated is because they have multiple individuals that are both (1) experts in clinical bioethics, and (2) dedicated full time to clinical bioethics work within the healthcare institution. It is unreasonable to expect a group of volunteers with primary, full-time healthcare roles elsewhere within the institution to complete all this necessary ethics-related work, as it is both time-consuming and labor-intensive. For example, in my new health system where I am the only dedicated professional bioethicist, this amount of integration and volume of ethics-related work would be unreasonable to expect, even with substantial volunteer assistance. This is especially true given the major shortages in healthcare workers that North America is currently experiencing. Without the substantial time and energy dedicated solely to clinical bioethics activities, much of this work goes undone and unrecognized, which is concerning given the likely consequences of unmet ethics needs for patient care, outcomes, and satisfaction, let alone the detrimental effects on caregivers and staff in terms of moral distress and moral injury. In fact, the US ethics consultation study mentioned above actually found a significant association between the presence of full-time professional clinical bioethicists in an ethics program and a significantly higher number of reported ethics consults on average (6). Logically, as well as anecdotally based on my own experiences, one can additionally infer from these data that the associations are likely to also hold when it comes to non-consult ethics activities, given that a full-time professional clinical bioethicist can dedicate much more time, energy, and expertise to ethics-related work than several volunteers with full-time roles and responsibilities elsewhere in the healthcare institution.

Now, this is not to suggest that every hospital or healthcare institution regardless of their size, location, or context should aim for an extensive and robust team of professional clinical bioethicists. Obviously, such an approach may not be practical or necessary everywhere, and many hospitals and healthcare institutions would likely find it difficult to retain more than one full-time professional clinical bioethicist. The concept of the professional clinical bioethicist is still relatively new to many areas of North America, particularly in smaller healthcare institutions where the need and value of clinical bioethics services is not well-known. However, looking ahead, hospitals and healthcare institutions should still strive to have at least some sort of access to this kind of clinical bioethics expertise. The specific ethics-related needs of each institution should determine the required level and extent of this access and expertise. Ideally, the supply of and demand for professional clinical bioethicists will eventually reach a level such that each hospital and healthcare institution can have their ethics-related needs met via sufficient

professional clinical bioethicist staffing. This would pave the way for the development of alternative structures designed to better educate and train former HEC members, enabling them to actively participate in various ethics initiatives within the healthcare institution, such as an ethics champion training program or ethics grand rounds. Meanwhile, professional clinical bioethicists can then focus on completing the more skilled and complex ethics-related work, like ethics consultation or leading ethics education and policy development. But before this ideal state is reached, hospitals and healthcare institutions should strive to augment their current ethics programs and HECs with the addition of professional clinical bioethicists, who at the very least are better situated to lead HECs and facilitate quality ethics work alongside HECs within hospitals and healthcare institutions.

Changes of this magnitude are often challenging, and they are rarely quick. However, progress requires change, and in the context of the next generation of clinical bioethics, this change is critical and necessary. To riff off one of my favorite television programs – Star Trek: The Next Generation, which clearly inspired the title of this piece – to progress, the next generation of bioethicists must “boldly go where no one has gone before!”

Reçu/Received: 17/07/2023

Conflits d'intérêts

Aucun à déclarer

Publié/Published: 18/03/2024

Conflicts of Interest

None to declare

Édition/Editors: Hazar Haidar & Aliya Affdal

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