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'Quality Attestation' and the Risk of the False Positive

Abstract
The Quality Attestation Presidential Task Force's recent proposal for "quality attestation" (QA) of clinical ethics consultants was advanced on the premise that, "[g]iven the importance of clinical ethics consultation, the people doing it should be asked to show that they do it well." To this end, the task force attempted to develop "a standardized system for proactively assessing the knowledge, skills, and practice of clinical ethicists." But can this proposed method deliver? If the proposed QA process is flawed, it will label clinical ethicists as qualified to do clinical ethics consultations (CECs) when they are not. The result will be the creation of a new, likely intractable, problem of CEC "false positives:" consultants who have passed QA without actually possessing the requisite knowledge and skills to perform CECs.

To avoid the risk of false positives, the QAPTF needs to conduct a rigorous analysis of the skills that the QA process will be positioned to judge and those that are simply beyond the scope of its current metrics. Rather than "attesting" to overall CEC "quality," QA needs to be precise about the skill inventory it can confirm yet honest about the skills it has no basis to assess. I will argue here that QA has strong prospects for accurately assessing consultants' competence in ethical analysis but very weak prospects for determining competence in two other skills listed as essential by the QAPTF: value-neutrality and conflict resolution.

Keywords
bioethics, clinical ethics, medical ethics

Disciplines
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Comments
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'Quality Attestation' and the Risk of the False Positive

The recent proposal for "quality attestation" (QA) of clinical ethics consultants was advanced on the premise that, "[g]iven the importance of clinical ethics consultation, the people doing it should be asked to show that they do it well."[1] To this end, the Quality Attestation Presidential Task Force (QAPTF) attempted to develop "a standardized system for proactively assessing the knowledge, skills, and practice of clinical ethicists."[2] But can this proposed method of QA deliver on the promise of a discriminating assessment of clinical ethics consultants? Assessing the assessment method *before* the program launches is of paramount importance because, if the proposed QA process is flawed, it will have the adverse effect of labeling clinical ethicists as qualified to do clinical ethics consultations (CECs) when they are not. The result will be the creation of a new, likely intractable, problem of CEC "false positives:" consultants who have passed QA without actually possessing the requisite knowledge and skills to perform CEC. Coming from the American Society for Bioethics and Humanities (ASBH) – the national bioethics organization – the QA imprimatur will be seen as having effectively weeded out the incompetent and untrained. Therefore, false positives in QA would do more harm than good by replacing the prevalent uncertainty about the quality of consultants with a specious confidence and reassurance about their qualifications.

To avoid the risk of false-positives, the QAPTF needs to conduct a rigorous analysis of the skills that the QA process will be positioned to judge and those that are simply beyond the scope of its current metrics. Rather than "attesting" to overall CEC "quality," QA needs to be precise about the skill-inventory it can confirm, while being upfront about the skills it has no

[1] E. Kodish and J. Fins, et al., "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics and Humanities," *Hastings Center* Report 43, no. 5 (2013): 26-36.
[2] Ibid.

basis to assess. In the service of beginning that review, I will argue here that QA has strong prospects for accurately assessing consultants' competence in ethical analysis, but very weak prospects for determining competence in two other skills listed as essential by the QAPTF: 1) value-neutrality: i.e., "avoid[ing] the risk of imposing…values and judgments;"[3] and 2) conflict resolution: i.e., "facilitating, and, when appropriate, mediating solutions."[4] If I am correct, the examples stand as evidence that the QAPTF needs to be more restrained and explicit about which qualifications QA can verify.

An Inconsistent Litany of CEC Skills

The first obstacle to a systematic evaluation of what the proposed QA will cover is the moving target in the QAPTF document of what they take the necessary CEC skill set to be. While the QA process is designed to "identify individuals who are qualified to perform this role,"[5] the QAPTF conception of the CEC role appears to vary at different points throughout manuscript – often in substance, but certainly in emphasis. For example, they make a passing reference to the 1998 ASBH *Core Competencies for Health Care Ethics Consultation*, stating: "That document forms the basis of the assessment process envisioned by the quality attestation process,"[6] but they offer no catalogue of the core competencies their QA process will measure. At three separate points in the document,[7] they lay out various criteria for good CEC, but these three sets of skills don't entirely overlap.

As a first example: early in the document the QAPTF says of consultants, "They must be trained to avoid the risk of imposing their values and judgments," harkening back to the *Core*

[3] Ibid.
[4] N. Dubler, et al, "Charting the Future," *Hastings Center Report* 39(6) (2009): 29-33, cited in Kodish and Fins, 29.
[5] Kodish and Fins.
[6] Ibid.
[7] Ibid., at 27, 29, 32.

Competencies' admonition, "Ethics consultants need to be sensitive to their personal moral values and should take care not to impose their own values on other parties."[8] While the concern about value imposition undergirds the *Core Competencies*' central distinction between the "authoritarian approach" they deride and the "ethics facilitation approach" they embrace, this neutrality criterion does not appear in the QAPTF's next two lists of benchmark skills.

One of the few proficiencies emphasized in all three lists is mediation, which, interestingly, is relegated to the 11th – and last – skill mentioned in the *Core Competencies*' "ethics facilitation approach": "apply mediation or other conflict resolution techniques, if relevant."[9] In the QA document, the authors first mention this skill in their overview of CEC: "In order to perform their activities, clinical ethics consultants have access to families and the medical record, and they are often called upon to mediate conflict and provide assistance at times of great stress and emotional need."[10] In their second and third lists of skills and attributes, they write, respectively: "Clinical ethics consultants must 'be trained to engage in…explaining, facilitating, and when appropriate, mediating solutions"[11] and, then, "examiners reviewing the portfolio will be able to distinguish whether the candidate followed established guidelines for CEC:…using reason, facilitation, negotiation, or mediation to seek a common judgment about a plan of care moving forward…"[12]

Throughout the QA document, the QAPTF names a hodge-podge of other CEC skills they may intend to scrutinize and evaluate, but at no point do they chart with any precision or transparency the exact set of skills that are to be appraised. Without such a skills-rubric, it is

[8] American Society for Bioethics and Humanities. 2011. *Core Competencies for Healthcare Ethics Consultation*, 2nd edition. Glenview, IL.
[9] Ibid.
[10] Kodish and Fins.
[11] Dubler et al, quoted in Kodish and Fins, 29.
[12] Kodish and Fins, 32.

impossible to judge how many false positives there will be given the proposed assessment model. While they painstakingly describe the elements of the two-step evaluation – the portfolio and oral exam – they have not yet provided an equally meticulous articulation of both the skills under review and the corresponding metrics for testing each of them.

Below I offer a cursory look at the prospects for making meaningful judgments about three skills named in the QA report: ethical analysis, value neutrality, and conflict resolution. While I am optimistic about the probability that the proposed QA will be able to evaluate the first, I am skeptical about the likelihood of avoiding false positives with regard to the latter two.

Ethical Analysis

With the significant number of clinical ethics case discussions woven into the QA process, assessing the candidate's ability to do ethical analysis should be a fairly straightforward task. The required portfolio includes 6 lengthy cases analyses and an additional 6 others that are more briefly dissected and summarized. If candidates pass this first step, an oral exam will be given that will ask candidates to perform extemporaneous case-analysis, demonstrating that they can "think on their feet"[13] about the ethical dimensions and considerations involved in cases.

The chosen modes of assessment (i.e., the portfolio and oral exam) can hardly fail to highlight the candidate's proficiency in ethical analysis because the genres selected deliver precisely that type of data. Borrowing an insight from Tod Chambers' *The Fiction of Bioethics,*[14] both the case write-up and its oral correlate are constructs that lend themselves to sleuthing out competence in principle-detection. Chambers writes, "[T]he genre of the medical ethics case has adopted distinct narrative attributes – distinct ways of portraying characters,

[13] Ibid.
[14] T. Chambers, *The Fiction of Bioethics* (New York: Routledge, 1999).

plotting events, presenting scenes – which determine the kind of questions that can be raised as relevant…"[15] Cases are "constructed to provide a particular moral viewpoint,"[16] and that framework is principlist. If "ethical analysis" is defined – as it typically is in the field of bioethics – as applying a principle-based template to an ethical conflict, then the QA process will surely determine competence in this activity. The genre is built for this type of scrutiny, i.e., for detecting the pertinent ethical considerations from the set of bioethical concepts and principles commonly employed in bioethical discourse.

Of course, as Chambers convincingly argued, the moral reasoning and moral argumentation that candidates will be able to demonstrate in these genres will be largely "principlist" in nature (rather than, say, virtue ethics or feminist ethics of care). Evaluators will not be able to assess casuistical skill, at least not what I think of as "moral archeology,"[17] that mines cases for novel perspectives, weakly articulated moral claims, or nascent principles. What evaluators will be able to see is the candidate's application of standard, well-established principles and concepts that comprise the field's dominant "principlist paradigm."[18]

Value Neutrality

If candidates' ability to do conventional ethical analysis will be readily apparent in the proposed QA process, their ability to avoid the authoritarian imposition of their values on stakeholders will be much more difficult to detect. To think otherwise is to underestimate the insidious nature of values-bias.

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[15] T. Chambers, "The Fiction of Bioethics: A Précis," *American Journal of Bioethics* vol. 1, no. 1 (2001): 40-43**,** at 41.
[16] Chambers, *The Fiction of Bioethics*, 9.
[17] A. Fiester, "Mediation and Recommendation," *American Journal of Bioethics* (2013):13(2): 23-24
[18] A. Fiester, "Why the Clinical Ethics We Teach Fails Patients," *Academic Medicine* 82(7): 684-689.

The assumption that seems to underlie both the QA document and the *Core Competencies* is that reflective adults are cognizant of their explicit and implicit normative biases and have them well in hand. The view seems to be that merely being mindful and attentive to the issue of values-bias is all that is needed to avoid inserting one's own particular moral views of right and wrong or good and bad into the consultation process. Therefore, in the QA process, candidates will simply need to note those instances when they were vigilant about moral or religious difference in the CECs they have conducted. The authors write, "Candidates, knowing that they will be preparing their work for the assessment, will offer individual best practice,"[19] presumably highlighting the ways in which they remained neutral in various consultations. But this view of bias and value-partiality is strikingly naïve.[20]

The core problem is our difficulty in perceiving our own values and biases, explicit or implicit. We do not routinely conduct a "values-inventory" of our central beliefs, what John Rawls famously called our personal "conception of the good."[21] And even fewer of us have diagnosed our implicit biases.[22] Consider moral bias as an example: when I impose my normative or religious values on someone else, I actually perceive myself as articulating what is morally or spiritually *right*, not expressing one particular view of a situation that legitimately admits of possibly many other morally supportable views.[23] Values-imposition masquerades as moral righteousness and objectivity. With the exception of the familiar bioethical differences

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[19] Ibid.
[20] For more general research on implicit bias see, for example, https://implicit.harvard.edu/implicit/. For a compelling example of how implicit bias effects clinical care, see the work on Curtis JR, Park DR, Krone MR, Pearlman RA. "Use of The Medical Futility Rationale in Do-Not-Attempt-Resuscitation Orders," JAMA 1995 Jan 11; 273(2):124-8; and, Ehlenbach WJ, Barnato AE, Curtis JR, Kreuter W, Koepsell TD, Deyo RA, Stapleton RD. "Epidemiologic Study of In-Hospital Cardiopulmonary Resuscitation in the Elderly," N Engl J Med. 2009 Jul 2;361(1):22-31.
[21] J. Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press), 11.
[22] See, for example, https://implicit.harvard.edu/implicit/takeatest.html.
[23] Fiester, A. "Mediation and Advocacy," *American Journal of Bioethics*, Volume 12, No. 8, August 2012, 10-11; Fiester, A. "A Dubious Export: The Moral Perils of American-Style Ethics Consultation," *Bioethics*, 2013, Volume 27, No. 1, ii-iii.

standardly taken to be part of legitimate American pluralism – e.g., views on abortion, religious objections to blood products, etc. – most clinical ethics disputes involve deeply held beliefs that seem objectively and universally true to the beholder. Our moral certitude blinds us to how our own core convictions drive the CEC agenda, steer the conversation, and find their way into the recommendations we make. Maintaining value-neutrality against the backdrop of an extreme plurality of values in the contemporary U.S. – on axes as far-ranging as class, education, ethnicity, race, gender, religion, etc. – requires more than simple mindfulness.

The QA process significantly underestimates the difficulty of the task of identifying and relaying moral and religious bias. Evidenced by the single prompt: "How do you recognize and handle your personal beliefs and biases when conducting CEC with others who may or may not share those beliefs?,"[24] the QA portfolio treats the matter as a straightforward question that will generate accurate and serviceable data needed to assess competency in this area. There are compelling reasons to worry that the QA process will fail to detect CEC values-bias.

Conflict Resolution Skills

If distilling CEC-bias through the medium of self-authored case write-ups will be a daunting – maybe even hopeless – task, then using this same means to assess candidates' skills in mediation and conflict resolution is downright baffling. Mediation is a practical skill and can only be assessed *in practice*. A candidate's self-reflection on his or her ability to mediate conflicts may be a helpful exercise in the *teaching* of mediation, but it is meaningless as a way of *evaluating* mediation. It's pure "hearsay," parallel to replacing third-party judges in a sporting event with an athlete's own self-assessment. Reflecting on one's own performance can, again,

[24] Kodish and Fins, 31.

be a useful learning experience – one often employed in mediation training – but it has no place in a process intended to verify competence and mastery.

Consider the various elements of mediation and conflict resolution that candidates are supposed to display in CECs, according to the QA proposal: "elicits the positions and interests of the agents and actors," "acknowledges all stakeholders in choosing among available options," "reaching consensus," "amplifying the voices of the patients and family," and "explaining, facilitating, and, when appropriate, mediating solutions."[25] The candidate is not a reliable witness about whether s/he performs these tasks well. Only the stakeholders in the conflict can attest to whether: their positions and interests were well understood; a resolution reached that was truly consensual and not coercive; their voices heard and, if needed, amplified; the situation suitably explained; the conversation neutrally facilitated; and the broiling conflicts de-escalated and mediated to a resolution shared by all parties.

For the QA process to include an assessment of mediation and conflict resolution is to bite off more than they can chew and runs the most serious risk of generating a false positive with regard to an important skill set needed in CEC.

Conclusion

In an arena of high-stakes practice that currently has no regulation and oversight, the proposed QA has the potential to do substantial good in establishing minimum competence for those who perform clinical ethics consults. But at this early stage, it is imperative that the QA process not claim to establish more than the proposed metrics can assess, or it will risk deeming consultants qualified in competencies they may not possess. In reviewing the full laundry list of possible CEC skills and knowledge, the QAPTF confidently claims, "In sum, examiners

[25] Dubler et al, quoted in Kodish and Fins, 29.

reviewing the portfolio will be able to distinguish whether the candidate followed established guidelines for CEC."[26] This confidence may be warranted with regard to some of the essential elements of CEC, but, as I have tried to show, not in regard to as many as they claim. As an important step in the evolution of CEC credentialing, the QA process needs a rigorous evaluation of what its metrics will be able to verify and more measured claims about what it can actually attest.

[26] Kodish and Fins, 32.