Philosophy of healthcare ethics practice statements: Quality attestation and beyond

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Conflict of Interest: The author states that she has no conflict of interest.

Acknowledgments

Special thanks to Kevin Reel, Barbara Secker, Jennifer Gibson and the two anonymous reviewers for their helpful comments on an earlier version of this manuscript. I would also like to thank Carolyn Ells and members of the University of Toronto Joint Centre for Bioethics for discussing with me some of the key ideas behind this manuscript.

I also acknowledge the infrastructure funding received from the Victorian State Government through the Operational Infrastructure Support (OIS) Program.

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Abstract

One element of the American Society for Bioethics and Humanities' recently-piloted quality attestation portfolio for clinical ethics consultants is a 'philosophy of clinical ethics consultation statement' describing the candidate's approach to clinical ethics consultation. To date, these statements have been under-explored in the literature, in contrast to philosophy statements in other fields such as academic teaching. In this article, I argue there is merit in expanding the content of these statements beyond clinical ethics consultation alone to describe the author's approach to other important 'domains' of healthcare ethics practice (e.g. organizational policy development/review and ethics teaching). I also claim such statements have at least three additional uses outside quality attestation: (1) as a reflective practice learning tool to increase role clarity among Practicing Healthcare Ethicists and bioethics

Fellows; (2) assisting Practicing Healthcare Ethicists in clarifying role expectations with those they work with; and (3) helping inform developing professional practice standards.

Introduction

In 2013, the Quality Attestation Presidential Task Force (QAPTF) of the American Society for Bioethics and Humanities (ASBH) proposed a two-step ‘quality attestation’ process for individual clinical ethics consultants¹ (Kodish and Fins et al. 2013). Some authors hailed this development as a “milestone” (Magnus and Fishbeyn 2015, p. 1) in the movement towards professionalization of the field of healthcare ethics practice.²

The ASBH QAPTF’s proposed quality attestation process consists of (1) development and submission of a quality attestation portfolio for review and (2) a subsequent oral examination (Fins et al. 2016; Kodish and Fins et al. 2013). The first portfolio step of this quality

¹ In this article, I use the term ‘clinical ethics consultant’ to refer to an individual who performs clinical ethics consultation. I adopt the definition of clinical ethics consultation put forward by Greenberg and colleagues; namely, “the act of conferring with, seeking clarification about, requesting deliberation concerning, asking [for] guidance/advice about ethical issues, relating to, broadly, patient-care and/or staff support from a bioethicist [or clinical ethics committee]. A consultation may involve (but is not necessarily limited to) the bioethicist [or members of the clinical ethics committee] listening, providing information, facilitating communication, advising and/or meeting with one or more persons involved” (Greenberg et al. 2014, p. 138).

² While professionalization of the field of healthcare ethics practice is still contested by some authors, there now appears to be a general consensus within the academic literature that the movement towards professionalization is warranted. Consequently, the discussion seems to have shifted away from *whether or not* there should be professionalization of the field to *how* exactly this professionalization ought to take place. Thus, a discussion of the merits and limitations of professionalization of the field of healthcare ethics practice is beyond the scope of this article and has been addressed elsewhere. See, for example, Cline et al. (2012); d’Agincourt-Canning 2012; Frolic and Practicing Healthcare Ethicists Exploring Professionalization (PHEEP) Steering Committee (2012); Reel (2012); Scofield (2008); and Spike (2009).

attestation process has been piloted and the results were published by the ASBH QAPTF in 2016 (Fins et al. 2016).

One element of the ASBH QAPTF's quality attestation portfolio is a 'philosophy of clinical ethics consultation' statement that describes the candidate's approach to clinical ethics case consultation (Fins et al. 2016; Kodish and Fins et al. 2013). To date, philosophy of clinical ethics consultation statements have been under-explored in the academic literature, in contrast to philosophy statements prepared in other fields such as academic teaching. There is therefore a need for additional discussion about what philosophy of clinical ethics consultation statements should contain and how they should be used in practice. This article seeks to address this gap in the literature.

In the first part of this article, I will provide a brief overview of what has been written to date on philosophy of clinical ethics consultation statements in terms of their content, assessment, and place in the broader ASBH quality attestation portfolio. I will also highlight that these statements have so far only been described in the literature in relation to clinical ethics case consultation and in the context of quality attestation. Following this, I will argue there is merit in expanding the content of these philosophy statements beyond clinical ethics consultation alone so that they describe the author's approach to other important 'domains' of healthcare ethics practice, including the development and/or review of ethics-related organizational policies and guidelines and ethics teaching. Finally, I argue that philosophy statements are not only valuable as one element of a broader quality attestation portfolio, as described by the ASBH QAPTF, but also have tremendous value outside the context of quality attestation. I describe three additional ways philosophy of healthcare ethics practice statements may be used: (1) as a reflective practice learning tool, which may improve role

clarity among bioethics Fellows and Practicing Healthcare Ethicists (PHEs);³ (2) to assist PHEs in clarifying and, if required, aligning role expectations with the various individuals they work with; and (3) to help inform the development of professional practice standards.

Quality Attestation

Quality attestation has been defined by the ASBH as “the review of an individual’s ability to carry out CEC [clinical ethics consultation] practice” (Kodish and Fins et al. 2013, p. 27).

The main goal of quality attestation is to evaluate, certify, and document that an individual clinical ethics consultant is competent to perform clinical ethics consultation, either as a ‘lone ethicist’ or as a leader of a clinical ethics consultation team (Kodish and Fins et al. 2013).

Multiple arguments have been put forward in the academic literature in support of implementing a quality attestation process for clinical ethics consultants. These arguments include that such a process (Dudzinski 2016; Fins et al. 2016; Kodish and Fins et al. 2013; Smith et al. 2010):

- helps to increase the accountability of clinical ethics consultants;
- improves the transparency of clinical ethics consultation;
- may help to reassure patients, families, and healthcare providers that clinical ethics consultants are competent in their work;

³ In this article, I employ the definition of ‘Practicing Healthcare Ethicist’ put forward by Simpson (2012), namely an individual with “dedicated work responsibilities within a healthcare organization to provide a *variety* of ethics-related services which include one or more of the following: clinical and/or organizational ethics consultation; policy development and/or review; ethics education for staff; management of ethics programs (including clinical ethics committees); mentoring of staff/learners; and conducting research ethics consultations” (p. 150, emphasis added).

- aligns with the “patient safety movement” and quality improvement practices in healthcare more generally; and
- is consistent with expectations of other healthcare professionals to demonstrate competency in their work.

In short, the ASBH QAPTF has stated, “[g]iven the importance of clinical ethics consultation to patient care, the people doing it should be asked to show that they do it well” (Kodish and Fins et al. 2013, p. 26).

The ASBH QAPTF’s ‘Two-Step Model’ of Quality Attestation

In 2013, the ASBH QAPTF first proposed their ‘two-step model’ of quality attestation, aimed at individual clinical ethics consultants (Kodish and Fins et al. 2013). The first step involves submission and review of a quality attestation portfolio. The second step is an oral examination, which is based in part on the content contained within the candidate’s portfolio and also involves ethical analyses of two hypothetical clinical ethics case consultations. The first portfolio step is a hurdle requirement; candidates must pass this step to proceed to the second oral examination step of the quality attestation process.

The ASBH QAPTF’s quality attestation portfolio consists of the following five key elements (Kodish and Fins et al. 2013; Fins et al. 2016):

- (1) A summary of the candidate’s education, training and experience related to clinical ethics consultation, accompanied by the candidate’s resume and proof of their education and training;

- (2) The candidate's philosophy of clinical ethics consultation practice statement;
- (3) Three letters of recommendation from individuals with knowledge about the candidate's work related to clinical ethics consultation;
- (4) Six in-depth written descriptions of clinical ethics case consultations the candidate has led or co-led; and
- (5) Six shorter, one-page summaries of six additional clinical ethics case consultations the candidate has been involved in, to demonstrate the candidate's experience in conducting consultations regarding various ethical issues in diverse practice settings.

Piloting of the Quality Attestation Portfolio

In 2016, the ASBH QAPTF published the results of their piloting of the portfolio step of their proposed quality attestation process (Fins et al. 2016). Eighty-two clinical ethics consultants submitted letters of intent to submit a quality attestation portfolio for review, of which 32 were selected by the ASBH QAPTF and invited to submit. In total, 23 clinical ethics consultants prepared and submitted a quality attestation portfolio to the ASBH QAPTF for review in this pilot phase.

Each quality attestation portfolio submitted was assessed both independently and as a duo by two members of the ASBH QAPTF from different disciplines. In addition, examiners were asked to refrain from assessing the portfolios of candidates with whom they have had a personal or professional relationship in order to avoid any actual or perceived conflicts of interests. Assessment of the quality attestation portfolios followed a standard marking scheme. The maximum score a candidate could obtain for their portfolio was 100 points, and

the number of maximum points each element of the portfolio was worth is as follows (Fins et al. 2016):

- (1) Summary of the candidate's clinical ethics consultation-related education, training and experience: 15 points.
- (2) Philosophy of clinical ethics consultation statement: 15 points.
- (3) Three letters of recommendation: 10 points.
- (4) Six in-depth clinical ethics case consultation descriptions: 48 points.
- (5) Six shorter one-page summaries of six additional clinical ethics case consultations: 12 points.

The six in-depth written descriptions of clinical ethics case consultations the candidate has led or co-led account for almost half of the total quality attestation portfolio score, with the remaining elements of the portfolio worth approximately the same number of points.

This article will focus on the philosophy of clinical ethics consultation practice statement element of the ASBH QAPTF's quality attestation portfolio. The remaining portfolio elements have been described in detail by the ASBH QAPTF (Kodish and Fins et al. 2013; Fins et al. 2016).

Philosophy of clinical ethics consultation practice statements, as envisaged by the ASBH QAPTF

In their description of their proposed quality attestation process for individual clinical ethics consultants, the ASBH QAPTF further breaks down the philosophy of clinical ethics consultation statement into five key components, as follows (Kodish and Fins et al. 2013):

The statement:

- (1) Aligns with the goals of clinical ethics consultation described in the ASBH's *Core Competencies for Healthcare Ethics Consultation* report;⁴
- (2) Describes how the candidate achieves the above goals in their practice;
- (3) Provides insight into areas of controversy within the field of healthcare ethics consultation, such as whether there is a need to achieve consensus, the role of ethics 'experts', to what extent the patient should be included during the consultation, and the "conflicting commitments" (Fins et al. 2016, p. 17) of the clinical ethics consultant;

⁴ The ultimate goal of healthcare ethics consultation, according to the ASBH, is to "improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns" (ASBH 2011, p. 3). Intermediate goals to be met in order to achieve this ultimate goal are to "identify and analyze the nature of the value uncertainty or conflict that underlies the consultation" and "facilitate resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of all those involved" (ASBH 2011, p. 3). The ASBH also identifies a number of additional goals of healthcare ethics consultation, including: assisting in the promotion of practices that are consistent with ethical standards and norms; informing the organization's attempts to develop policy, implement quality improvement initiatives, and appropriately utilize resources through identifying the underlying causes of ethical concerns; and assisting individuals and the organization in addressing current and potential future ethical problems through providing healthcare ethics education (ASBH 2011). The ASBH's emphasis on *ethical standards and norms* is of particular interest, given the ASBH QAPTF's requirement that philosophy of clinical ethics consultation statements must also provide insight into areas of *controversy* within the field of healthcare ethics consultation. This raises the question of whether there can indeed be norms amid controversy.

- (4) Demonstrates “thoughtful self-reflection” (Fins et al. 2016, p. 17); and
- (5) Does not conflict with “generally accepted norms” (Fins et al. 2016, p. 17) guiding the conduct of clinical ethics consultation.

The marking scheme followed by members of the ASBH QAPTF when reviewing the philosophy of clinical ethics consultation statement element of the portfolio was a binary scheme. Each of the above five components of the statement could attract a maximum of three points each (adding to a maximum total score of 15 points for the entire philosophy of clinical ethics consultation statement), with the candidate either achieving a score of 0 (unacceptable) or 3 points (acceptable) for each component.

In addition to the above marked components, the ASBH QAPTF has provided additional suggestions for candidates to describe in their philosophy of clinical ethics consultation statement their process of clinical ethics consultation, their accomplishments related to clinical ethics consultation, and the ways in which the candidate recognises and manages organizational and their own personal biases and beliefs when conducting clinical ethics consultation (Kodish and Fins et al. 2013).

The maximum word length for the philosophy of clinical ethics consultation statement element of the ASBH quality attestation portfolio is 500 words (Kodish and Fins et al. 2013). This raises questions about whether it is feasible for quality attestation candidates to successfully meet all of the above criteria in such a brief statement, and whether this word limit is far too short to allow for the production of a philosophy statement that provides meaningful insight into how the PHE works.

Expanding the content of philosophy statements beyond clinical ethics consultation alone

In the bioethics literature, philosophy statements and quality attestation are currently discussed only in the context of clinical ethics case consultation, rather than healthcare ethics practice more broadly. This is in line with the ASBH's focus on clinical ethics case consultation in its *Core Competencies* report (ASBH 2011). The ASBH initially states that the focus of their report is on the core skills and knowledge competencies required to successfully perform *healthcare ethics consultation*, which they define as “a set of services provided by an individual or group in response to questions from patients, families, surrogates, healthcare professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care” (ASBH 2011, p. 2). However, while the ASBH acknowledges the importance of all types of healthcare ethics consultation and all aspects of healthcare ethics practice more broadly, they later specify that their “report focuses predominately on the subspecialty of clinical ethics, and within that subspecialty, the practice of HCEC [healthcare ethics consultation]” (ASBH 2011, p. 3); in other words, clinical ethics case consultation.

The ASBH has justified their focus on clinical ethics case consultation over other types of healthcare ethics consultation and other aspects of healthcare ethics practice by appealing to its high-stakes nature (ASBH 2011; Kodish and Fins et al. 2013). As the ASBH has noted, clinical ethics case consultation has potentially far-reaching consequences for the patients, families, and healthcare providers involved. For example, clinical ethics case consultation may:

- influence decisions regarding patient care;
- entail direct interaction between the clinical ethics consultant and patients and families;
- involve the clinical ethics consultant accessing the patient's private healthcare information as part of the process of preparing for the consultation; and/or
- include the clinical ethics consultant mediating conflict in emotional situations.

For these reasons, the ASBH has claimed that “it is in the clinical subspecialty where unqualified HCE [healthcare ethics] consultants have the *highest potential to directly harm* patients and families (as well as others involved in a consultation). Moreover, the Task Force considers clinical ethics case consultation in which the healthcare ethics consultant interacts with a patient/family and documents healthcare ethics consultation activities in the patient's medical record (‘case consultation’) to be where the stakes are often highest” (ASBH 2011, p. 3, emphasis added).

Clinical ethics case consultation is undoubtedly a high-stakes activity. However, it is important to note that these high stakes are not limited to clinical ethics case consultation, but rather are also applicable in many other domains of healthcare ethics practice (Secker et al. 2014). For example, there are high stakes involved in providing ethics education to students and healthcare staff. In Canada, a common topic currently being taught by many PHEs is ethics in the practice of medical assistance in dying (MAID). There are many aspects to MAID that must be accurately and clearly conveyed, such as the criteria patients must meet in order to be deemed eligible. If the PHE incorrectly teaches these MAID eligibility criteria,

this could lead to confusion among and potential legal liability⁵ for healthcare professionals. Such incorrect teaching may also have negative ramifications for patients. For example, a patient who is experiencing intolerable suffering may indeed meet all of the eligibility criteria for MAID, but the healthcare professional to whom they convey their MAID request may mistakenly deem them ineligible due to misinformation provided by the PHE. Consequently, the healthcare professional may not be willing to discuss MAID with the patient any further, effectively withholding a legitimate option the patient wishes to pursue.

Another example of where stakes are high in bioethics education relates to the teaching of healthcare legislation that is relevant to clinical ethics case consultation. For example, many PHEs in the Canadian province of Ontario regularly provide healthcare professionals with an overview of Ontario's *Health Care Consent Act* (1996), which includes a definition of decision-making capacity and a hierarchy of legally authorised substitute decision makers. If the PHE were to incorrectly represent the substitute decision maker hierarchy, for example, and the healthcare professionals they were teaching this to relied on this information and did not read the *Health Care Consent Act*, this could potentially lead to negative consequences if the healthcare professionals were to seek and obtain consent to treatment from a person who was not legally authorized to provide it.

The stakes are also high in many organizational ethics activities. As McDonald and colleagues (McDonald et al. 2008) have highlighted, an ethics-related organizational policy or guideline may not only impact a particular patient, family member, or healthcare provider,

⁵ For example, if a physician misunderstood the legal MAID eligibility criteria and incorrectly deemed a patient eligible.

but may also affect additional stakeholders in important ways. These additional stakeholders include:

- *all* patients and families within the healthcare organization that the policy or guideline relates to;
- *all* of the staff, trainees and volunteers working within the organization for whom the policy or guideline is relevant;
- the healthcare organization itself – is the policy or guideline in alignment with the organization’s espoused values?
- healthcare providers in other healthcare organizations – for example, if the organizational policy or guideline was such that it moved a ‘burden of care’ elsewhere, as may be the case if a hospital introduced a new policy requiring rapid transfer of increasing numbers of alternate level of care patients to community-based long-term care facilities (Affleck et al. 2013);
- members of the surrounding community who rely on the organization for healthcare; and
- related external services the policy/guideline refers to, such as a community care agency or other community-based health and social services and supports.

Given the above reasons, some authors have called for developing professional practice standards for PHEs’ organizational ethics activities, in addition to standards for clinical ethics case consultation (Frolic et al. 2012). This is partly due to the fact that, in the Canadian context especially, PHEs are often involved in multiple ethics activities and not just clinical ethics case consultation. This suite of responsibilities has been reflected in Chidwick and colleagues’ ‘model role description’ for PHEs in Canada (Chidwick et al. 2010). This description includes reference to the PHE:

- providing ethics education to students, healthcare professionals, patients and families;
- participating in various organizational ethics initiatives, such as the development and review of ethics-related organizational policies or guidelines;
- conducting other forms of ethics consultation, including consultation about ethical issues that are organizational or research-related in nature;
- conducting and disseminating academic bioethics research; and
- conducting research ethics review.

A similar argument should also apply to philosophy of healthcare ethics practice statements.

If one agrees with the premise that a philosophy of healthcare ethics practice statement should describe the PHE's approach to healthcare ethics practice more broadly, and agrees with the premise that there is more to healthcare ethics practice than clinical ethics case consultation, the conclusion is that a philosophy of healthcare ethics practice statement should also describe the PHE's approach to other domains of healthcare ethics practice. For example, when describing their approach to the development and review of ethics-related organizational policies or guidelines, the PHE could describe various facets, including (Cline et al. 2012; Frolic and Practicing Healthcare Ethicists Exploring Professionalization (PHEEP) Steering Committee 2012; McDonald et al. 2008):

- who do they consult with during this process?
- how do they decide who to consult with?
- how do they mediate any conflicts that may arise between different individuals during this process?
- what informs their ethical analysis and/or recommendations they provide in the policy/guideline?

- in what ways do they assist the organization with implementing the policy/guideline once it is complete?
- how do they help to evaluate the policy/guideline and its impact on the healthcare organization over time?

In addition to describing the author's approach to each of the different domains of healthcare ethics practice, it would also be beneficial for philosophy of healthcare ethics practice statements to describe the author's views on how each 'domain' of healthcare ethics practice informs the other. For example, relevant ethics-related organizational policies/guidelines and academic bioethics research should ideally inform a PHE's approach to clinical ethics case consultation. Conversely, a clinical ethics case consultation may identify ethical issues that warrant greater exploration in the form of organizational policy/guideline development (McDonald et al. 2008; Smith and Weise 2007) or academic bioethics research (McDougall et al. 2015).

The need to include information about one's approach to other domains of healthcare ethics practice, and not simply clinical ethics case consultation, has also been identified by some of the clinical ethics consultants who participated in the ASBH QAPTF's piloting of the quality attestation portfolio. As part of the pilot, the ASBH QAPTF surveyed 16 of the 23 quality attestation candidates regarding their experiences with preparing and submitting their portfolios for review. One of the suggestions offered by candidates was for future candidates to be asked to include evidence of their participation in various organizational ethics activities within their quality attestation portfolios (Fins et al. 2016).

The ASBH QAPTF also obtained feedback from the individuals who examined the submitted quality attestation portfolios. The examiners made comments similar to the candidates in that they also criticized the portfolio's narrow focus on clinical ethics case consultation, and recommended that additional core competencies related to providing ethics education, participating in organizational ethics activities, and conducting research ethics review be included and assessed in future quality attestation portfolios. Examiners also highlighted the need for including clearer information about what information the philosophy of clinical ethics consultation statement should contain, and stated that their ability to ascertain whether or not candidates' philosophy statements aligned with agreed-on standards for clinical ethics case consultation was limited, as the instructions provided to the candidates did not explain the content they should include in their philosophy statements (Fins et al. 2016).

To summarise, there are many reasons in support of broadening philosophy statements to explain how the PHE approaches other important domains of healthcare ethics practice, including ethics education, research ethics review, conducting and disseminating academic bioethics research, and the development and review of ethics-related organizational policies and guidelines. If this recommendation is adopted, such statements would then become *philosophy of healthcare ethics practice* statements, rather than *philosophy of clinical ethics consultation* statements.

It is important to note that it is not only PHEs who are involved in these ethics activities. For example, medical educators are also involved in providing ethics education to healthcare professionals, and others (e.g. members of hospital administration) may be involved in developing or revising ethics-related organizational policies. While medical educators are generally required to undergo a formal quality assurance process (Adkoli 2015; MacCarrick

2013),⁶ non-PHEs involved in policy development/review may not be. It could be argued that it is unfair to require PHEs to undergo a formal quality assurance process (in the form of quality attestation) while others involved in the same ethics-related activities do not need to meet this requirement. However, as described earlier, ethics education and ethics-related policies can have an important impact on patients, healthcare professionals and the entire healthcare organization. Given the high stakes involved with these activities, requiring *all* individuals (not just PHEs) involved in these activities to undergo some form of quality assurance seems prudent. A complete description of what this quality assurance process may look like for non-PHEs is beyond the scope of this article. However, a quality assurance process for non-PHEs involved in policy development/review would likely involve similar steps as the suggested process for PHEs involved in these same activities, such as requiring a written description of their approach to this activity (the possible features of which were described earlier).

Employing the use of philosophy of healthcare ethics statements beyond quality attestation

To date, philosophy of clinical ethics consultation statements have been discussed in the literature only in relation to quality attestation, as an element of a broader quality attestation portfolio. Although philosophy of *healthcare ethics practice* statements have not yet been described in the literature, I will focus on this expanded version (rather than philosophy of clinical ethics consultation statements) in the remainder of this article.

⁶ A description of the quality assurance process for medical educators is beyond the scope of this article and has occurred elsewhere (e.g. Adkoli 2015; MacCarrick 2013).

It is worth considering the myriad of uses philosophy of healthcare ethics practice statements may have beyond quality attestation. In what follows, I will discuss three different additional uses of philosophy healthcare ethics practice statements. These uses include (1) to help add to role clarity among bioethics Fellows and PHEs through being used as a reflective practice learning tool; (2) to assist PHEs in clarifying and, if required, aligning role expectations with the various individuals they work with; and (3) to help inform the development of professional practice standards.

Use of healthcare ethics practice statements as a reflective practice learning tool to add to role clarity

The exercise of preparing a philosophy of healthcare ethics practice statement can be a useful reflective practice learning tool. *Reflective practice* refers to the process of reflection, which has been defined as an “[a]ctive, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends” (Dewey 1933, p. 8). In the clinical context, reflective practice may involve reflecting on various foci, including a particular experience or clinical case, one’s feelings, thoughts and actions in a given situation, the nature of one’s overall practice, or team functioning (Ménard and Ratnapalan 2013). Reflective practice has numerous benefits. For example, it may help to inform future learning by identifying individual learning needs, contribute to quality improvement initiatives by identifying ‘lessons learned’ and barriers which need to be addressed in future similar cases, and contribute to professional competence (Ménard and Ratnapalan 2013). Different approaches to reflective practice, at

both the individual and team level, have been described in the literature (Mann et al. 2009; Ménard and Ratnapalan 2013). One exercise that aims to encourage reflection is writing a reflective essay or reflective practice statement (Ménard and Ratnapalan 2013). The emphasis and primary value of this exercise is less on the production of the reflective practice statement itself, and more on the process of reflection that is required in order to write this statement (Ménard and Ratnapalan 2013). In this way, the reflective practice statement is one *facilitator* of reflective practice.

Reflective practice statements have been described in other fields, including nursing (Bulman 2013; Johns 2013), professional development (Bolton 2010), and education (Schon 1995). It is important, however, to note the differences between philosophy of healthcare ethics practice statements (or, more narrowly, philosophy of clinical ethics consultation statements) as they are currently described in the literature and reflective practice statements in other fields. For example, in nursing and medicine more generally, reflective practice statements generally involve the healthcare professional reflecting on a particular clinical case, rather than their approach or philosophy to their practice more broadly (Ménard and Ratnapalan 2013). Conversely, philosophy of clinical ethics consultation statements or, as I am proposing, philosophy of healthcare ethics practice statements, focus on the author's approach to their *overall* practice.

Nevertheless, the process of reflection required in order to write one's philosophy of healthcare ethics practice statement can be immensely useful. Some Fellowships that train individuals to become PHEs, such as the [name of Fellowship] at the [name of institution],⁷ have recognized this and have included preparation of a written philosophy statement as a

⁷ This Fellowship has been described in detail elsewhere – for example, see [references]

requirement for completion ([name of document year, unpublished]). Unlike the ASBH, the statement in the [name of Fellowship] program, for example, is a philosophy of *healthcare ethics practice* statement, rather than a philosophy of *clinical ethics consultation* statement. The philosophy statement within the [name of Fellowship] is also a standalone piece, rather than an element of a broader quality attestation portfolio. [Name of institution] Fellows are asked to write a draft version of the statement before the end of their first Fellowship year (the midpoint of the two-year Fellowship) and submit a final, revised version of the statement by the end of their Fellowship. [Name of institution] Fellows receive written and verbal feedback on their philosophy of healthcare ethics practice statements from the Fellowship Director and [name of institution] Director, and also have the opportunity to receive additional feedback from their rotation supervisors, all of whom are PHEs. Philosophy of healthcare ethics practice statements within the [name of institution] Fellowship program are informed by the discussions that occur between Fellows during their monthly, shared, self-directed reflective practice sessions. During these sessions, Fellows have the opportunity to reflect on and clarify their own approach to healthcare ethics practice and beliefs regarding the proper roles of a PHE. Fellows also have the chance to discuss the differences they have observed in the approaches of the supervising PHEs they have worked with in different practice settings (e.g. community vs. academic hospitals, general vs. specialty hospitals, hospital vs. community care agency). In addition, Fellows undergo repeated evaluations by their rotation supervisors at specific time points (at the beginning, mid-point, and end of a rotation), having already met Fellowship admission criteria for completion of significant graduate level education in bioethics.

The process of reflection required in order to write a philosophy of healthcare ethics practice statement may add to role clarity. While additional role clarity is arguably useful for all

PHEs, it may be particularly so for bioethics Fellows and PHEs in the early stages of their careers. One variation of writing a philosophy of healthcare ethics practice statement that may further add to role clarity is including a requirement that candidates include a section within their broader philosophy statement that describes at least one common misperception of the role of a PHE. This could be helpful, as clarity about what PHEs are *not* may add further clarity about what PHEs *are*. Common misperceptions of the PHE role have been described elsewhere in the bioethics literature and are beyond the scope of this article. However, they include notions of a PHE as a member of the ‘ethics police’; ‘moral expert’; ‘ultimate decision maker’; and automatic ‘rubber stamp’ of ethics-related activities and documents (ASBH 2011; Chidwick et al. 2004; Cline et al. 2013; McDonald et al. 2008; Moreno 1991; Smith and Weise 2007). This section identifying common misperceptions of the role of a PHE within the broader philosophy of healthcare ethics practice statement could also describe the various ways in which the PHE attempts to identify and address these misperceptions in their practice. For example, the PHE could describe how they clarify their role with others at the beginning of an ethics consultation or a meeting to review a draft organizational ethics-related policy/guideline.

The use of philosophy of healthcare ethics practice statements as a reflective practice exercise may mean that such statements are revisited and revised by PHEs on a regular (e.g. annual) basis, rather than the one-time event that occurs as part of the ASBH QAPTF’s proposed one-off quality attestation process. Such an approach would be broadly in alignment with expectations of reflective practice statements in other clinical fields; for example, nurses in Ontario are required by their professional college to write a reflective practice statement annually in order to renew their professional licence to practice (College of Nurses of Ontario 2013).

Writing a philosophy of healthcare ethics practice statement as part of one's reflective practice could be a valuable exercise, for reasons I have described above. However, it is important to note that this particular use of healthcare ethics practice statements may come into tension with the use of philosophy of healthcare ethics practice (or clinical ethics consultation) statements as part of the ASBH QAPTF's proposed quality attestation process. This is due to (1) the current rubric used by the ASBH QAPTF to evaluate philosophy of clinical ethics consultation statements and (2) the very evaluation of such reflective practice statements. I describe each of these causes of this tension below, and propose options for addressing it.

As noted earlier, the ASBH QAPTF has proposed that philosophy of clinical ethics consultation statements be evaluated as part of the quality attestation process (Fins et al. 2016; Kodish and Fins et al. 2013). Two of the evaluation criteria for the philosophy statement are that the statement must align with the goals of clinical ethics consultation described in the ASBH's *Core Competencies for Healthcare Ethics Consultation* report (ASBH 2011) and must not conflict with "generally accepted norms" (Fins et al. 2016, p. 17) guiding the conduct of clinical ethics consultation. One concerning aspect of the ASBH QAPTF's current rubric is that it may lead to candidates merely paraphrasing the ASBH's core competencies in their philosophy statements, without critical reflection, if candidates believe that this approach will increase the likelihood of them passing the portfolio stage. In other words, there is a risk that quality attestation candidates may 'play it safe' and simply write a philosophy statement that they believe the ASBH QAPTF wants to read, rather than a statement that accurately describes their actual philosophy of and approach to clinical ethics consultation. For example, under the current rubric, there is a lack of clarity as to whether

certain practices (or lack thereof), such as never consulting directly with patients or substitute decision makers, would automatically disqualify a candidate from the quality attestation process (Dudzinski 2016). Given this lack of clarity, some candidates may err on the side of caution and omit any practices from their philosophy statement that they believe may conflict with the approaches described in the *Core Competencies*. This risk depends on candidates being made aware of what the evaluation criteria are before they prepare their philosophy statements, which did not occur in the pilot (Dudzinski 2016; Fins et al. 2016). However, as this was identified as a key limitation by at least one quality attestation candidate (Dudzinski 2016) and by the ASBH QAPTF itself (Fins et al. 2016), there is reason to believe that future candidates will be provided with the evaluation criteria before submission. In any case, the evaluation criteria used in the pilot have been published (Fins et al. 2016) and may inform the approach used by future candidates when preparing their philosophy statements.

Another concern for healthcare ethics practice raised by evaluating philosophy statements as part of quality attestation is that the very act of evaluating such statements may lead to homogeneity within the field. If candidates believe that being innovative in their practice may penalize them in the quality attestation process, this could act as a deterrent and the quality of healthcare ethics practice may decline if such innovation is lost. The ASBH QAPTF has acknowledged this, stating that they “recognized that the process of developing quality standards was accompanied by some concern in the ethics consultation community that respect for diverse, reasonable differences in philosophies and approaches to ethics consultation might be lost” (Fins et al. 2016, p. 22). To address this concern, the ASBH QAPTF claimed that the criteria they developed to evaluate the philosophy statements “took into account that there are a number of reasonable and respected approaches to consultation” (Fins et al. 2016, p. 22). However, as noted earlier, candidates participating in the ASBH

QAPTF's pilot were not provided with the evaluation criteria before preparing their philosophy statements. Hence, candidates were not made aware of this apparent flexibility and may have had a different understanding of which philosophy statements would be deemed acceptable. Furthermore, the two specific aspects of the evaluation criteria noted above - that the statement must align with the goals of clinical ethics consultation described in the ASBH's *Core Competencies* and must not conflict with "generally accepted norms" guiding the conduct of clinical ethics consultation – leave less room for interpretation.

To better understand this tension between the reflective and evaluative purposes of philosophy of practice statements and propose ways of addressing it, lessons can be learned from how such statements are drafted, evaluated and conceived of in other disciplines, such as academic teaching, nursing and allied health professions (e.g. occupational therapy and physiotherapy).

In academic teaching, there is evidence to support concerns that the evaluation of philosophy of practice statements leads to a non-reflective, homogenous approach to the writing of such statements. For example, Kaplan et al. (2008) surveyed the chairs of search committees of American universities regarding their experiences with evaluating applicants' philosophy of teaching statements. According to the chairs, some statements were "generic", "full of boilerplate language", "cliché", and/or included too much "jargon" or "buzzwords" (Kaplan et al. 2008, p. 249), leading chairs to question the sincerity of these statements.⁸ Some authors have attributed this homogeneity across different philosophy of teaching statements to applicants deciding to 'play it safe', given the high stakes involved for their career; "if a

⁸ Similar observations have been made by others in the field – see, for example, Brinthaupt et al. (2014); Haggerty (2010); Pratt (2005).

candidate's file is otherwise acceptable, why court disaster by straying from the teaching-philosophy script?" (Haggerty 2010, unpaginated). As philosophy of healthcare ethics practice statements become more common, it is possible that a similar conservative 'script' may emerge.

Concerns have also been raised in academic teaching regarding how the evaluation of philosophy of teaching statements may lead to loss of innovation within the field. For example, Pratt (2005) has expressed concern that:

"Across North America and increasingly elsewhere, there is a move toward a single, dominant philosophy of teaching, usually labeled 'learner centered'...I fear we are building an overly narrow view of what counts as effective teaching and falsely promising that personal philosophies of teaching will receive serious consideration in faculty evaluations. My hope is that we will not naively yield to those who believe there is but a single viable perspective on good teaching. I wish to honor those teachers who have been memorable but different—those whose teaching was instrumental to our learning and our professional path without necessarily fitting within yet another orthodoxy of teaching...I want to see a plurality of acceptable philosophies of teaching acknowledged. If we are to recognize and respect differing views of teaching, we must avoid extremes of 'anything goes' or its opposite, 'one size fits all'" (pp. 34-35).

To reduce the likelihood that these undesirable outcomes will also arise in the context of healthcare ethics practice, it seems prudent to keep in mind that "reflective practice [is] much more about a process than a product" (Stewart and Richardson 2000, p. 373). If too much

emphasis is placed on the product (here, the resulting philosophy of healthcare ethics practice statement), this may detract from the important reflective purpose the process of writing this statement serves. Placing greater emphasis on the process of reflective practice rather than the product appears consistent with what already happens in other disciplines, such as nursing. For example, Cangelosi (2008) describes including an “experiential learning reflection paper” as one element of a broader learning portfolio for student nurses. While this paper is assessed, emphasis is placed on “thoughtful discussion [which] must be the focus” (p. 126). The assessment criteria provided to each student regarding the task also emphasise the importance of “creativity and thoughtful discourse” (Cangelosi 2008, p. 127).

Moving forward, there are at least three different options concerning the role (if any) of philosophy of healthcare ethics practice statements in quality attestation. The first is to not include philosophy of healthcare ethics practice statements as a component of quality attestation, reserving the use of such statements for other purposes such as reflective practice. As demonstrated in other disciplines such as occupational therapy and physiotherapy, the writing of philosophy of practice statements may be a more effective reflective practice exercise if such statements are not evaluated (Stewart and Richardson 2000). The second option would be to retain the philosophy statement as an element of the quality attestation portfolio, but not evaluate it. The inclusion of a philosophy statement could be classified as a mandatory (but unmarked) ‘prerequisite’, as is the case with the candidate’s resume (Fins et al. 2016). The philosophy statement could also serve as a talking point for the subsequent oral examination, if the candidate passes the portfolio stage. For example, when describing the various approaches they apply to healthcare ethics practice, the candidate could also describe how these approaches align with their philosophy of healthcare ethics practice more broadly to give better context. The third option would be to continue to evaluate philosophy

statements as part of quality attestation, but revise the current evaluation rubric to make it more flexible and hopefully encourage greater creativity from candidates (similar to the approach used in nursing, described above). At minimum, this option would involve removing the two criteria requiring the philosophy statement to align with the ASBH *Core Competencies* and “generally accepted norms” for clinical ethics consultation and replacing these with more open-ended guiding questions, such as ‘What do you think are the proper goals of healthcare ethics practice?’. If philosophy statements continue to be evaluated as part of the quality attestation process, it would also be advisable to abandon the current word limit (500 words), which may constrain the candidate’s ability to engage in meaningful reflective practice.

Use of healthcare ethics practice statements to clarify and align role expectations

A philosophy of healthcare ethics practice statement may also be a useful document for PHEs to discuss, review and potentially revise with the various individuals they work with. This would allow the PHE to explore, clarify and, if necessary, align the expectations of their role with others.

For example, a PHE may wish to discuss their philosophy of healthcare ethics practice statement with their current employer as part of regular performance reviews or with their potential future employer as part of the job application process. Submitting a philosophy statement as part of a job application would be broadly consistent with what occurs in other fields such as academic teaching, where teachers often include their philosophy of teaching statements as part of their job and promotion applications (Eierman 2008; Meizlish and

Kaplan 2008). Given that one's philosophy statement may be appropriately tailored to the particular context the PHE works in, it may be necessary for the PHE to review and possibly revise their philosophy statement if taking up a PHE role in a different healthcare organization. For example, if a PHE worked in healthcare organization A where direct interaction with patients and families was a rare part of the role, and the PHE is moving to healthcare organization B, where hospital management expects the PHE to speak with patients and families as a part of every consultation, it would be worthwhile for the PHE to discuss this with their employer, preferably early on. Philosophy of healthcare ethics statements may facilitate such important discussions.

In some cases, the PHE may choose to review and revise their philosophy of healthcare ethics practice statement in situations where they find the organization's expectations of the role do not align with their own practice or philosophy. In other cases, if the PHE feels very strongly about their particular approach to healthcare ethics practice, they may wish to reflect on whether or not they wish to continue to remain in or pursue work with the organization. Alternatively, the PHE may try to reconcile the organization's expectations of their role with their philosophy of healthcare ethics practice in other ways, such as by making attempts to change the way the organization views the role of the PHE.

Using healthcare ethics practice statements to help inform the development of professional practice standards

A third potential use of healthcare ethics practice statements outside of the context of quality attestation is using these statements to inform the development of professional practice

standards⁹ for PHEs. As Kon (2016) notes, “in today’s health care environment, clinical ethics consultants may be the only individuals with direct access to patients and medical records that lack any certification or other credentials that attest to their competence” (p. 31). Healthcare ethics practice is not yet a regulated profession, and does not have any accepted professional practice standards (Kon 2016; Reel 2012). Although the ASBH’s *Core Competencies* report has set some standards for aspects of ethics consultation, the ASBH has not yet “provided an overarching conceptual framework that helps define and elucidate the construct of ethics consultation quality” (Pearlman et al. 2016, p. 4). As Agich (2016) correctly points out, in order to evaluate and attest to the quality of ethics consultation (and arguably healthcare ethics practice more broadly), “one needs to [first] establish some normative standard for what defines acceptable or unacceptable features of an ethics consultation [or other aspect of healthcare ethics practice]” (p. 25).

The development of professional practice standards for the field may follow a ‘ground-up’ approach and be informed by the content of philosophy of healthcare ethics practice statements. A worthwhile future study would be to conduct a qualitative, inductive analysis of the content of submitted philosophy of healthcare ethics practice statements. These statements may include but ideally would not be limited to the 23 philosophy of clinical ethics consultation statements that were submitted by clinical ethics consultants as part of the ASBH’s pilot of the quality attestation portfolios. Expanding the sample to philosophy of healthcare ethics practice statements submitted voluntarily by a range of PHEs (not just those

⁹ I have adopted the definition of “practice standards” put forward by Reel (2012), namely: “Authoritative statements that describe minimum practice performance expectations of a healthcare ethicist in any relevant vocational role or setting for which practitioners are accountable, reflect the values and priorities of the field, and provide direction for professional practice and a guideline for the evaluation of practice” (p. 205).

applying for quality attestation) would be more useful, as it would increase the likelihood of including statements written by PHEs who come from different backgrounds and who work in a variety of practice settings. Such an analysis would presumably capture and reflect the breadth and diversity among PHEs in terms of how they view and approach the process of clinical ethics case consultation and other activities (e.g. ethics education and policy development/review) related to their healthcare ethics practice. This analysis could then be used as a starting point to help inform the development of some shared professional practice standards that reflect this diversity in the field.

This development could also be informed by analysing the philosophy of healthcare ethics practice statements submitted by bioethics Fellows participating in the [name of Fellowship] and other bioethics Fellowship programs. The 2015-2017 cohort of the [name of Fellowship] was the first time a philosophy of healthcare practice statement was included as a Fellowship requirement,¹⁰ following a comprehensive evaluation of the Fellowship in 2014 to ensure the Fellowship aligned with recent developments (including the ASBH's quality attestation process) in the professionalization of PHEs.¹¹ Comparing and contrasting different philosophy of healthcare ethics practice statements submitted by bioethics Fellows participating in this and other bioethics Fellowship programs may identify common themes and explore if and how these themes evolve over time.

Conclusion

¹⁰ Personal communication with [name of Fellowship] Director.

¹¹ [identifying reference].

In this article, I have made two main arguments in relation to philosophy of healthcare ethics practice statements. Firstly, I argued that a philosophy statement written by a PHE would ideally describe their approach to *all* domains of healthcare ethics practice, and not simply their approach to clinical ethics case consultation. I acknowledge that it may be challenging in practice to move the focus of philosophy statements and quality attestation more broadly away from clinical ethics case consultation alone and on to all elements of the role of a PHE. It is possible that the ASBH QAPTF may expand the focus of its quality attestation in the future. However, it is important to note that such continued narrow focus on clinical ethics case consultation may potentially carry the risk of unintentionally downplaying the importance of the other domains of healthcare ethics practice that PHEs are routinely engaged in as part of their roles.

Secondly, I have argued that philosophy of healthcare ethics practice statements are valuable in multiple ways. Such statements may be valuable as one element of a broader quality attestation portfolio, as has been proposed and described by the ASBH QAPTF. However, such statements also have at least three additional potential uses outside of the quality attestation context. Firstly, the process of writing a philosophy of healthcare ethics practice statement can be a useful reflective practice exercise for bioethics Fellows and PHEs that helps add to role clarity. Secondly, the PHE may choose to review their resulting philosophy of healthcare ethics practice statement with the various individuals they work with in order to clarify and, if necessary, align others' expectations of their role. Finally, reviewing the content of philosophy of healthcare ethics statements submitted voluntarily by PHEs and bioethics Fellows may provide a 'ground-up' approach to the development of professional practice standards for PHEs that represents the diversity and commonalities of those who

work in the field. It will be important for these additional uses of philosophy healthcare ethics practice statements to be further explored and implemented moving forward.

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Title:

Philosophy of Healthcare Ethics Practice Statements: Quality Attestation and Beyond

Date:

2018-12-01

Citation:

Notini, L. (2018). Philosophy of Healthcare Ethics Practice Statements: Quality Attestation and Beyond. HEC FORUM, 30 (4), pp.341-360. <https://doi.org/10.1007/s10730-018-9354-7>.

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