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What is the Minimal Competency for a Clinical Ethics Consult Simulation? Setting a Standard for Use of the Assessing Clinical Ethics Skills (ACES) Tool

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KW and WA conceived and designed the methods for the study. All authors contributed to data collection. KW and WA analyzed the data. KW, KB, AD, MK, MM, KP, and AT comprised the steering committee. KW and WA prepared the initial draft of the article. All authors provided edits and revisions to it and subsequent revisions. All authors approved the final revision.

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Abstract

Background: The field of clinical ethics is examining ways of determining competency. The Assessing Clinical Ethics Skills (ACES) tool offers a new approach that identifies a range of skills necessary in the conduct of clinical ethics consultation and provides a consistent framework for evaluating these skills. Through a training website, users learn to apply the ACES tool to clinical ethics consultants (CECs) in simulated ethics consultation videos. The aim is to recognize competent and incompetent clinical ethics consultation skills by watching and evaluating a videotaped CEC performance. We report how we set a criterion cut-score (i.e., minimally acceptable score) for judging the ability of users of the ACES tool to evaluate simulated CEC performances.

Methods: A modified Angoff standard setting procedure was used to establish the cut-score for an end-of-life case included on the ACES training website. The standard setting committee viewed the Futility Case and estimated the probability that a minimally competent CEC would correctly answer each item on the ACES tool. The committee further adjusted these estimates by reviewing data from 31 pilot users of the Futility Case before determining the cut-score.

Results: Averaging over all 31 items, the proposed proportion correct score for minimal competency was 80% corresponding to a cut-score that is between 24–25 points out of 31 possible points. The standard setting committee subsequently set the minimal competency cut-score to 24 points.

Conclusions: The cut-score for the ACES tool identifies the number of correct responses a user of the ACES tool training website must attain to “pass” and reach minimal competency in recognizing competent and incompetent skills of the CECs in the simulated ethics consultation videos. The application of the cut-score to live training of CECs and other areas of practice requires further investigation.

Keywords

ethics consultation; clinical ethics; cut-score; simulation; ethics training; standard setting

Background

The field of clinical ethics consultation has matured into a multidisciplinary profession, with clinical ethics consultants (CECs) being trained in bioethics, philosophy, theology, law, medicine, nursing, social work, pastoral care and other disciplines. Along with the

development of the field, questions about its nature and what constitutes appropriate knowledge and training have been debated. How to assess the competence of CECs has been discussed by many, including the American Society for Bioethics and Humanities (ASBH) and others (ASBH 1998; ASBH 2011; Kodish et al 2013; Fins et al 2016; Dubler et al 2009; Pearlman et al 2016; Tarzian 2009). Arguments to professionalize the field, set standards, and assess CECs systematically have gained support and momentum from within the field of clinical ethics consultation and been spearheaded by the ASBH. While prior work suggested assessment could include a portfolio of the CEC's training and experience, checklists for CECs in practice, and other evaluation processes (Fins et al., 2016; Dubler et al., 2009; Flicker et al., 2014; Kodish et al 2013; Svantesson et al 2014; Pearlman et al 2016), the leadership of the ASBH decided to develop a standardized means of assessment and certification through a written examination and formed a Certification Commission (<http://asbh.org/professional-development/hcec-certification>, 2017). In November 2018, the examination was offered for the first time. Such an approach tests the knowledge of CECs but is unable to assess completely the analytic and interpersonal skills that are crucial to conducting ethics consultations.

Four of the authors (KW, MK, MM, KP) were part of the original study team and steering committee that developed a tool to evaluate the interpersonal skills of CECs in 2014 – the Assessing Clinical Ethics Skills (ACES) tool (Wasson et al. 2016). The ACES tool drew on the ASBH Core Competencies (2011) and the Veterans Affairs Integrated Ethics® Program's Ethics Consultant Proficiency Assessment Tool (ECPAT) (US Department of Veterans Affairs 2014). The ACES tool is designed to be used in an educational setting with simulated ethics consultation cases. It includes 11 main constructs that assess a range of interpersonal skills, including specific behaviors that the CEC should demonstrate to facilitate an ethics consultation (Table 1). Currently, the ACES tool has two primary purposes: first, it is used in real time to evaluate graduate bioethics students performing as CECs in "live" simulated cases where each item is scored by a trained rater as *Done*, *Not Done*, or *Done Incorrectly*; second, the ACES website provides training on how to use the tool to assess the performance of a CEC in a variety of videotaped ethics consultations (For a sample see <https://lucapps.luc.edu/clinicaethicsdemo/>). Users of the website can work through four different cases and evaluate different CECs as they demonstrate the skills included on the ACES tool. One goal is that by learning to identify competent ethics consultation skills in the videos, the user will also be able to reflect on their own skills and competency in ethics consultation. After each scene, users submit their answers and, for each ACES item, receive feedback on their response to the simulated CEC's performance in the ethics consultation video, including how their answers align with those determined by the ACES steering committee. This feedback appears in written form showing the user's responses compared with the correct responses and a pre-recorded video explaining the correct responses.

The purpose of the ACES tool as presented on the website is to provide training in the recognition of competent and incompetent simulated CEC performances. In so doing, the ACES tool offers users the opportunity to evaluate simulated ethics consultation cases. It gives trainees a first look at their clinical ethics evaluation skills. The ACES tool also offers other stakeholders, such as mentors, an opportunity to identify trainees who need more preparation before performing live consultations. While recognizing appropriate and

inappropriate clinical ethics consultation skills in a simulated environment on the ACES training website does not necessarily generalize to personal competency in the clinical setting, those who are unable to differentiate competent and incompetent *simulated* CEC performances are unlikely to be successful CECs in the clinical setting. Having developed the ACES training website, in this paper we report how we set a criterion cut-score (i.e., minimally acceptable score) for judging the ability of users of the ACES tool to evaluate one simulated CEC performance.

Methods

Standard Setting Method

The ACES Futility Case was used to set the criterion cut-score for identifying users who can and cannot successfully recognize competent and incompetent simulated CEC performances. The Futility Case narrates the end-of-life decisions a daughter must make on behalf of her dying mother. This case was selected as the framework for the standard setting exercise because it comprises a range of items ($k = 31$ in total) that measure interpersonal skills, from managing the length, purpose, and structure of the ethics consult to facilitating discussion about the next steps participants may take at the end of the meeting (Table 1). Each item was assessed as correct or incorrect by selecting from three options for each item/question on the ACES tool: *Done*, *Not Done*, or *Done Incorrectly*. This case was also selected due to its comparability in content and difficulty with other ACES cases developed for the website.

A modified Angoff standard setting procedure was used to establish the cut-score for the Futility Case as described by Cizek (2006). The Angoff standard setting procedure was selected because of its simplicity (Ricker, 2006), and because it is the most widely used and researched method for establishing a cut-score to identify minimal competency. Developed by William Angoff in 1971, he describes the method in his seminal chapter as

...keeping the hypothetical 'minimally acceptable person' in mind, one could go through the test item by item and decide whether such a person could answer correctly each item under consideration. If a score of one is given for each item answered correctly by the hypothetical person and a score of zero is given for each item answered incorrectly by the person, the sum of the item scores will equal the raw score earned by the 'minimally acceptable person' (pp. 514–515).

Later, a slight variation of the Angoff procedure (i.e., the Modified Angoff procedure) was introduced. Here, a judge

...would think of a number of minimally acceptable persons, instead of only one such person, and would estimate the proportion of minimally acceptable persons who would answer each item correctly. The sum of these probabilities would then represent the (judge's) minimally acceptable score (p. 515).

In our study, the standard setting committee comprised four internal (KW, MK, MM, KP) and four external (KB, MD, AD, AT) content experts familiar with the Futility Case and its assessment. Internal experts were those who developed the ACES tool and external experts were from different institutions and selected based on their knowledge of and expertise in

clinical ethics consultation. As noted by Ricker (2006), calibrating raters on what defines minimal competency is one of the main assumptions of the Angoff method. Before participating in the standard setting exercise, we asked the raters to review the ASBH Core Competencies for Health Care Ethics Consultations (2011) and the Department of Veteran Affairs IntegratedEthics® Program's ECPAT (2014). They were also asked to review the Futility Case scoring rubric (<https://lucapps.luc.edu/clinicaethics>) and complete an evaluation of the Futility Case themselves via the ACES website. As recommended by Cizek (2006), this process was meant to calibrate the standard setting participants in the content standards, skills, and abilities expected of a minimally competent CEC. Afterward, the committee participated in two rounds of the standard setting exercise to arrive at a proposed cut-score for passing the case. The internal experts completed the standard setting exercises prior to the external experts and each group followed the same process.

During the first round, the committee members were instructed to imagine a large number of minimally competent CECs completing the case, i.e., viewing the Futility Case on the ACES website and using the ACES tool to score the performance of the CEC in the video. For each item on the ACES tool, they were asked to estimate the probability that these minimally competent individuals would correctly assess the CEC's performance in the video, i.e., correctly answer the ACES item. After providing their answers, the first round concluded by alerting each member of the standard setting committee that, "Next week, you will be asked to repeat this exercise one more time. However, before you do so, additional information on how easy or difficult each item is based on a pilot sample of all individuals who completed the case through July 2016 will be provided to you."

Operational case data were available for 31 users, meaning 31 individuals had completed the Futility Case via the ACES website as of July 2016. Approximately half of these individuals were under age 55 with the remaining half identifying as older than 55 (range 25 – 65). More than half were female (61%), and the clear majority identified as White (90%); only three individuals identified as non-White including one as Asian, one as Black, and one as Hispanic. Nearly all (84%) held a graduate degree while 10% held only a Bachelor's degree. Two individuals additionally identified as registered nurses. Regarding their profession, 35% identified as clinical ethicists, 16% as administrators, 16% as chaplains, and 16% as physicians. The remainder did not report a profession (17%). Finally, 61% reported that they supervise clinical ethicists.

Classical test theory statistics for each item were provided to the standard setting committee between the two standard setting rounds (Table 3). These statistics included an estimate of each item's difficulty (using proportion correct scores) as well as each item's ability to separate high scoring performers from low scoring performers using discrimination statistics, including point biserial correlation coefficients as described by Cody and Smith (2014). The Kuder-Richardson 20 (KR-20) formula, also described by Cody and Smith (2014), was further used to estimate the case's reliability or internal consistency for the committee. Each member was asked to review these results as well as the results of his/her colleagues from the first round. More specifically, they were asked to compare the probabilities they listed in the first round to their peers' responses as well as to the item difficulty parameters provided in the interim results report. The purpose of providing this

information was to reduce group variability and engender a consensus on the proposed cut-score (Cizek, 2006). After reviewing this information, each committee member was asked to complete the standard setting exercise one final time. As before, they were instructed to imagine a large *new* group of minimally competent CECs who completed the Futility Case on the website. For each item the committee was asked to estimate the probability that these minimally competent individuals would provide the correct answer.

Once the second round concluded, those responses were used to estimate the proposed cut-score. The median probability estimate among the eight committee members was recorded for all 31 items and yielded an estimate of the proposed proportion correct for minimal competency. Importantly, we used the median (rather than mean) probability estimate in this study, because there were only eight raters available and the median was a more accurate estimate of the center of their judgements. Finally, we used an exact version of the Conover (1999) non-parametric test for equal variances to compare the variability in raters' scores between internal and external raters. These estimates along with the classical test theory estimates described above were calculated using SAS version 9.4 (Cary, NC).

This study was approved by the Institutional Review Board at Loyola University Chicago Health Sciences Division.

Results

Table 1 displays the ACES items and constructs. Results from the standard setting committee's first round of responses are displayed in Table 2. With most estimates exceeding a 70% probability of a correct response, the committee generally believed that minimally competent CECs would have a high probability of correctly answering each item in the Futility Case. However, the committee clearly believed that minimally competent CECs would struggle with three items (i.e., items 11, 23 and 28) where the committee believed such individuals would have only a 50% probability of providing a correct response.

Their concerns were partially supported by the item difficulty statistics, which are displayed in Table 3. Looking down the difficulty column (where lower values indicate greater difficulty), item 11 ("Express a supportive statement early in the consult") was the most difficult for the 31 pilot users completing the Futility Case on the ACES website, where no users correctly answered the item. Other items that were scored incorrectly at least 50% of the time were: Item 7 ("Health professionals and administrators should distinguish their clinical roles from their ethics role as needed"); 17 ("Ask clarifying questions"); 26 ("Identify Areas of Disagreement"); and 27 ("Elicit or Propose Compromise Options"). Conversely, the items that were the easiest and had all 31 pilot users answer them correctly were: (1) "Identify yourself and your role as the ethics consultant"; (2) "Have each party introduce themselves"; (12) "Avoid distracting behaviors"; (29) "Offer other appropriate ancillary services"; and (31) "Facilitate discussion about options including ways forward." The reliability of the case was also very good with an estimated KR-20 coefficient exceeding 0.80 (KR-20 = 0.88) (Table 3).

Seeing these item statistics as well as their peers' responses had a moderate effect on the second round of ratings (Table 4). In fact, there was a severe decline in the probability responses for item 7 ("Health professionals and administrators should distinguish their clinical roles from their ethics role as needed") (*Median* = 75% on round 1 versus *Median* = 57.5% on round 2), for item 26 ("Identify areas of disagreement") (*Median* = 82.5% on round 1 versus *Median* = 50% on round 2), and for item 27 ("Elicit or propose potential compromise options") (*Median* = 80% on round 1 versus *Median* = 67.5% on round 2). Averaging over all 31 items, the proposed proportion correct score for minimal competency was 80% corresponding to a cut-score, or pass/fail score, that is between 24–25 points out of 31 possible points. The standard setting committee subsequently set the minimal competency cut-score to 24 points.

Regarding variability in raters' scores, at the end of round 1 the internal raters had less variability on item 2 ("Have each party introduce themselves"; range: 100–100) than the external raters (range: 95–100; exact $p = .03$). This was also true for item 12 ("Avoid distracting behaviors"), where the internal raters had less variability (range: 100–100) than the external raters (range: 95–100; exact $p = .03$), and on item 28 ("Identify relevant legal issues") where the internal raters had less variability (range: 50–50) than the external raters (range: 20–100; exact $p = .03$). Finally, at the end of round 1 the internal raters demonstrated less variability on item 29 ("Offer other appropriate ancillary services", range: 90–100) than the external raters (range: 40–100; exact $p = .03$).

On round 2, the internal raters had less variability on item 1 ("Identify yourself and your role as the ethics consultant", range: 100–100) than the external raters (range: 95–100; exact $p = .03$), but this conclusion flipped for item 2 ("Have each party introduce themselves") where the internal raters' scores were more variable (range: 80–100) than the external raters' scores (range: 95–100; exact $p = .03$). Finally, for item 9 ("Maintain eye contact"), the internal raters' scores were also more variable (range: 50–100) than the external raters' scores (range: 95–95; exact $p = .03$).

Discussion

A modified Angoff standard setting procedure as described by Cizek (2006) was used to establish the cut-score for the ACES tool Futility Case. The eight experts on the standard setting committee determined that individuals scoring 24 or more points (out of 31 points or 80%) would be minimally competent and capable of evaluating the performance of the CEC in this case.

The items deemed easiest for a minimally competent CEC to answer correctly, as determined by the 100% scores noted in Table 3 were: (1) "Identify yourself and your role as the ethics consultant"; (2) "Have each party introduce themselves"; (12) "Avoid distracting behaviors"; (29) "Offer other appropriate ancillary services"; and (31) "Facilitate discussion about options (pros/cons) including ways forward. One explanation is that these skills are linked to clear behaviors that make it more straightforward for the individual viewing the case to easily determine if the CEC in the video did (or did not) demonstrate them. Further,

some items (particularly “Have each party introduce themselves”), may have been observed or learned in other contexts.

In the pilot data from the ACES tool, one particular item stood out as the most difficult for the 31 website users to answer correctly. Everyone incorrectly answered item 11, “Express a Supportive Statement Early in the Consult”. The difficulty of this item may have arisen because the creators of the ACES tool determined that the CEC must offer a supportive statement within the first five minutes of the consult to receive a *Done*. This requirement is specified in the scoring rubric on the website and the videos display the time as the case progresses. In the Futility Case video on the ACES website, the CEC does not make such a statement within this time frame. Instead, she makes a vague supportive statement about difficult decisions that need to be made later in the consult. This, coupled with an inappropriate lag time, is insufficient to count clearly as *Done* according to the scoring rubric. For this reason, the correct answer is *Done Incorrectly*. The nuance of the supportive statement is a likely reason this item was challenging for the pilot users viewing the video.

While the scoring rubric provides the instructions on how the original steering committee determined what behaviors count as *Done*, *Not Done*, or *Done Incorrectly* for each item on the ACES tool, new users of the tool may not have reviewed it in detail before watching the case and rating the CEC’s skills. In addition, the standard setting committee may have overestimated the ability of a minimally competent CEC to answer some of the items correctly. These items may seem obvious to experts in the field with a great deal of experience. However, it may be difficult to view the Futility Case and CEC’s performance through the eyes of a new minimally acceptable or competent CEC.

Other items that were scored incorrectly at least 50% of the time by these pilot users were: Item 7 (“Health professionals and administrators should distinguish their clinical roles from their ethics role as needed”); 17 (“Ask clarifying questions”); 26 (“Identify Areas of Disagreement”); and 27 (“Elicit or Propose Compromise Options”). For Item 7, 65% of users thought that the CEC stating she was a physician and clinical ethicist was sufficient to count as *Done* whereas the correct answer was *Not Done*. The CEC needed to clarify that she was functioning *solely* as the clinical ethicist in this case. For item 17, 57% of users incorrectly selected *Not Done* or *Done Incorrectly*. The CEC asked clarifying questions to both parties and appropriately facilitated the discussion. It may be that users thought the CEC did not ask enough clarifying questions to count as *Done* and were looking for a performance that went beyond minimal competence. For Item 26, 58% of users answered incorrectly. The scoring rubric indicates parties other than the CEC may make their disagreements obvious during the discussion or state them clearly and, if so, the CEC receives a score of *Done* for this item by default. This nuance may have been misunderstood by users. For item 27, 58% of users answered incorrectly. The CEC does elicit or propose potential compromise options, most notably a “Do Not Resuscitate Order.” Again, users may have viewed one compromise option as insufficient and wanted the CEC to perform above minimal competence to receive a *Done* score.

More broadly, examining the importance of this standard setting process, the field of clinical ethics consultation now has an innovative and practical method to assess one measure of

competency of CECs in a reliable and standardized way. The cut-score set in this exercise is meant to identify whether a user of the ACES tool who views the Futility Case on the website can correctly identify (in)competent practices and skills of the CEC in the video. While it is not intended to indicate competency of the user as a CEC in practice, we propose that the opposite has merit: if a user of the ACES website is unable to correctly answer 80% of the 31 Futility Case items, that person is unlikely to be competent when performing in the clinical setting because he/she is unable to recognize basic competencies when viewing the performance of another CEC.

The cut-score determines whether that user is minimally competent to evaluate others. As for generalizability, the hope is that through the ACES training, users will increase their awareness of the core skills needed to conduct ethics consultation and that this increased awareness will be applied to the user in their own ethics consultation skills. Whether and how the ACES training translates into developing more effective CECs in practice is an area for future investigation.

Limitations of this method and exercise are the small pilot sample for the Futility Case. We observed heterogeneity in rater judgments between our internal and external raters. Where such variability was significant, it was associated with the items that were the least difficult. This limitation may relate to the few raters available for this analysis, and we are hesitant to draw conclusions about the distribution of internal versus external rater scores based on this small sample size. With more users who complete this case on the ACES website, the results might change and the difficulty estimates may change. The first two ACES cases both had a similar difficulty level and addressed end-of-life issues. By inference, the cut-score of 24/31 should be appropriate for both, but this needs to be tested and is a direction of future research. Subsequent cases involve different ethical issues including pediatric decision making, and a case that tests an additional item (Recognize and Address Barriers to Communication), which focuses on informed consent and using trained interpreters. The current proposed cut-core may not apply to these cases given they may have different difficulty estimates. Finally, the link between the website training and the generalizability of the cut-score in its application to practice (i.e., training CECs) has not been demonstrated. Finally, a single case study does not necessarily support competence and further research and dialogue is needed to define the components of what is considered “minimal competency.”

Future directions for the ACES project include collecting data on how graduate students and CEC-trainees perform when the cut-score is applied to live ethics simulations. This type of controlled environment allows each student to experience the same case and ethical issues while using the same evaluation tool. It also allows trained raters and experts to evaluate students and trainees versus the real world where observing ethics consultations may be challenging and, even if possible, done by a variety of colleagues or supervisors who may not use the same criteria. Other areas for future research include examining how users of the ACES website perform in relation to the original steering committee for each of the cases presented; whether repeating the cases increases the percentage of correct responses; and whether determination of “correct/incorrect” answers for a particular ACES case may need to be revised based on website users’ performance and feedback.

Conclusion

A modified Anghoff method was used to set a cut-score for users accessing the ACES Tool. The cut-score evaluates the ability of those viewing one simulated ethics consultations on the training website to identify minimal competency for a single simulated ethics consultation. We believe that training people to recognize competent and incompetent CEC skills will aid that individual's ability to recognize his/her own ability to perform ethics consultations – at the least in a simulated environment. This cut-score is novel and demonstrates promise for training clinical ethics consultants as we move toward determining minimal competency for CECs in practice.

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Table 1:

ACES Tool Items (© 2016 Loyola University Chicago Used with permission. All rights reserved)

Manage the Formal Meeting	
1. Identify yourself and your role as the ethics consultant	
2. Have each party introduce themselves	
3. Explain the purpose of the consult	
Gather the Relevant Data	
4. Elicit the relevant medical facts in the case	
5. Confirm the appropriate decision maker	
6. Clarify when needed	
Express and Stay within the Limits of the Ethics Consultant's Role During Meetings or Encounters	
7. Health professionals and administrators should distinguish their clinical roles from their ethics role as needed	
8. Correct errant expectations of participants as needed.	
Listen Well, and Communicate Interest, Respect, and Empathy to Participants	
9. Maintain eye contact	
10. Use engaged body language	
11. Express supportive statements early in the consult	
12. Avoid distracting behaviors	
Elicit the Moral Views of the Participants in a Non-Threatening Way	
13. Establish the moral views and/or values of participants	
14. Establish the wishes and/or expectations of participants	
15. Clarify when needed	
Enable Participants to Communicate Effectively and Be Heard by Other Participants	
16. Give each participant an opportunity to share his or her views	
17. Ask clarifying questions	
18. Redirect conversation when needed	
Accurately and Respectively Represent the Views of Participants to Others	
19. Summarize the conversation reflecting back the views of each party	
20. Allow participants to confirm or clarify	
Educate Participants Regarding the Ethical Dimensions of the Case	
21. Identify the ethical issues	
22. Identify the range of ethically (in)appropriate options	
23. Explain the rationale for the ethically (in)appropriate options	
24. Use plain/simple language	
Mediate Among Competing Moral Views	
25. Identify common goals including areas of agreement	
26. Identify areas of disagreement	
27. Elicit or propose potential compromise options	
Distinguish Ethical Dimensions of the Consultation from Other, often Overlapping, Dimensions	
28. Identify relevant legal issues	

29. Offer other appropriate ancillary services
Identify and Explain a Range of Ethically Justifiable Options and Their Consequences
30. Summarize potential options/choices already discussed
31. Facilitate discussion about options (pros/cons) including ways forward

Table 2

Modified Angoff standard setting results for round 1

	Internal Raters				External Raters				Median (range)
	A	B	C	D	E	F	G	H	
1 Identify yourself and your role as the ethics consultant	100	100	100	100	100	90	95	95	100 (90–100)
2 Have each party introduce themselves	100	100	100	100	100	100	95	100	100 (95–100)
3 Explain the purpose of the consult	80	100	100	100	85	80	95	85	90 (80–100)
4 Elicit the relevant medical facts in the case	80	100	100	80	50	75	95	90	85 (50–100)
5 Confirm the appropriate decision maker	50	80	65	70	90	50	85	75	72.5 (50–90)
6 Clarify when needed	50	100	85	65	90	85	85	65	85 (50–100)
7 Health professionals and administrators should distinguish their clinical roles from their ethics role as needed	60	80	75	50	90	50	80	75	75 (50–90)
8 Correct errant expectations of participants as needed.	50	100	75	60	90	50	80	75	75 (50–100)
9 Maintain eye contact	100	100	100	90	95	90	95	85	95 (85–100)
10 Use engaged body language	80	100	100	90	95	90	95	90	92.5 (80–100)
11 Express supportive statements early in the consult	50	80	50	50	50	80	35	75	50 (35–80)
12 Avoid distracting behaviors	100	100	100	100	100	100	95	100	100 (95–100)
13 Establish the moral views and/or values of participants	90	100	85	90	75	75	90	95	90 (75–100)
14 Establish the wishes and/or expectations of participants	90	100	100	80	90	75	90	95	90 (75–100)
15 Clarify when needed	90	100	100	70	90	60	90	90	90 (60–100)
16 Give each participant an opportunity to share his or her views	100	100	100	90	95	70	95	90	95 (70–100)
17 Ask clarifying questions	80	100	90	90	90	65	95	75	90 (65–100)
18 Redirect conversation when needed	70	80	95	60	95	50	75	80	77.5 (50–95)
19 Summarize the conversation reflecting back the views of each party	80	80	85	80	95	70	80	75	80 (70–95)
20 Allow participants to confirm or clarify	70	80	100	80	95	65	80	60	80 (60–100)
21 Identify the ethical issues	90	100	100	90	75	65	85	80	87.5 (65–100)
22 Identify the range of ethically (in)appropriate options	70	80	60	80	20	50	85	85	75 (20–85)
23 Explain the rationale for the ethically (in)appropriate options	50	80	50	70	20	50	50	80	50 (20–80)
24 Use plain/simple language	100	100	100	90	75	85	95	90	92.5 (75–100)
25 Identify common goals including areas of agreement	70	80	90	90	50	60	95	85	82.5 (50–95)
26 Identify areas of disagreement	50	100	85	80	25	45	90	85	82.5 (25–100)
27 Elicit or propose potential compromise options	70	100	85	70	75	30	95	85	80 (30–100)
28 Identify relevant legal issues	50	50	50	50	100	20	85	85	50 (20–100)
29 Offer other appropriate ancillary services	100	100	100	90	100	40	95	100	100 (40–100)
30 Summarize potential options/choices already discussed	100	100	100	80	75	55	95	90	92.5 (55–100)
31 Facilitate discussion about options (pros/cons) including ways forward	100	80	100	80	95	65	95	90	92.5 (65–100)
Proposed Cut %									87.5%
Proposed Cut Score									27–28 points

Table 3

Performance of the pilot users for the Futility Case

	Choices			Difficulty
	DONE	NOT DONE	DONE INCORRECTLY	
	%	%	%	
1 Identify yourself and your role as the ethics consultant	100	.	.	100%
2 Have each party introduce themselves	100	.	.	100%
3 Explain the purpose of the consult	94	.	6	94%
4 Elicit the relevant medical facts in the case	68	3	29	68%
5 Confirm the appropriate decision maker	16	81	3	81%
6 Clarify when needed	35	58	6	58%
7 Health professionals and administrators should distinguish their clinical roles from their ethics role as needed	65	26	10	26%
8 Correct errant expectations of participants as needed.	19	77	3	77%
9 Maintain eye contact	96	.	4	96%
10 Use engaged body language	96	4	.	96%
11 Express supportive statements early in the consult	89	11	.	0%
12 Avoid distracting behaviors	100	.	.	100%
13 Establish the moral views and/or values of participants	79	14	7	79%
14 Establish the wishes and/or expectations of participants	89	4	7	89%
15 Clarify when needed	54	43	4	54%
16 Give each participant an opportunity to share his or her views	86	4	11	86%
17 Ask clarifying questions	43	50	7	43%
18 Redirect conversation when needed	14	82	4	82%
19 Summarize the conversation reflecting back the views of each party	14	82	4	82%
20 Allow participants to confirm or clarify	32	64	4	64%
21 Identify the ethical issues	88	.	13	88%
22 Identify the range of ethically (in)appropriate options	63	21	17	63%
23 Explain the rationale for the ethically (in)appropriate options	75	13	13	75%
24 Use plain/simple language	79	13	8	79%
25 Identify common goals including areas of agreement	71	29	.	71%
26 Identify areas of disagreement	42	50	8	42%
27 Elicit or propose potential compromise options	42	50	8	42%
28 Identify relevant legal issues	21	71	8	71%
29 Offer other appropriate ancillary services	100	.	.	100%
30 Summarize potential options/choices already discussed	96	.	4	96%
31 Facilitate discussion about options (pros/cons) including ways forward	100	.	.	100%

Note: Valid N = 31. Test Reliability KR-20 = 0.877. Choices = The proportion of individuals out of 31 marking each choice for the item. Difficulty = The proportion of individuals out of 31 correctly answering the item; lower difficulty values reflect more challenging items.

Table 4

Modified Angoff standard setting results for round 2

	Internal Raters				External Raters				Median
	A	B	C	D	E	F	G	H	
1 Identify yourself and your role as the ethics consultant	100	100	100	100	100	100	95	100	100 (95–100)
2 Have each party introduce themselves	100	100	100	80	100	100	95	100	100 (80–100)
3 Explain the purpose of the consult	90	100	100	80	85	90	90	90	90 (80–100)
4 Elicit the relevant medical facts in the case	80	100	80	60	50	75	70	70	72.5 (50–100)
5 Confirm the appropriate decision maker	70	75	80	70	90	75	80	80	77.5 (70–90)
6 Clarify when needed	70	80	70	70	90	60	65	65	70 (60–90)
7 Health professionals and administrators should distinguish their clinical roles from their ethics role as needed	50	75	50	90	90	40	65	25	57.5 (25–90)
8 Correct errant expectations of participants as needed.	70	75	75	100	90	70	75	75	75 (70–100)
9 Maintain eye contact	100	100	100	50	95	95	95	95	95 (50–100)
10 Use engaged body language	95	100	100	100	95	95	95	90	95 (90–100)
11 Express supportive statements early in the consult	50	70	50	85	50	20	25	20	50 (20–85)
12 Avoid distracting behaviors	100	100	100	90	100	100	95	100	100 (90–100)
13 Establish the moral views and/or values of participants	80	90	85	70	75	80	80	80	80 (70–90)
14 Establish the wishes and/or expectations of participants	90	100	90	90	75	90	85	90	90 (75–100)
15 Clarify when needed	70	100	70	60	90	65	75	60	70 (60–100)
16 Give each participant an opportunity to share his or her views	90	90	90	80	95	90	85	85	90 (80–85)
17 Ask clarifying questions	70	90	60	85	90	70	75	50	72.5 (50–90)
18 Redirect conversation when needed	80	90	90	70	95	75	75	80	80 (70–90)
19 Summarize the conversation reflecting back the views of each party	80	80	90	90	95	80	80	80	80 (80–95)
20 Allow participants to confirm or clarify	80	80	70	70	95	70	65	65	70 (65–95)
21 Identify the ethical issues	90	100	90	70	75	90	85	85	87.5 (70–100)
22 Identify the range of ethically (in)appropriate options	70	80	60	90	20	75	60	70	70 (20–90)
23 Explain the rationale for the ethically (in)appropriate options	70	80	70	80	20	70	50	75	70 (20–80)
24 Use plain/simple language	90	100	90	70	75	85	85	85	85 (70–100)
25 Identify common goals including areas of agreement	75	80	70	50	50	75	75	75	75 (50–80)
26 Identify areas of disagreement	50	90	60	50	25	60	50	50	50 (25–90)
27 Elicit or propose potential compromise options	70	90	60	50	75	65	75	50	67.5 (50–90)
28 Identify relevant legal issues	50	50	50	90	100	60	65	75	62.5 (50–100)
29 Offer other appropriate ancillary services	100	100	100	90	100	100	95	100	100 (90–100)
30 Summarize potential options/choices already discussed	90	100	100	90	75	95	95	95	95 (75–100)
31 Facilitate discussion about options (pros/cons) including ways forward	90	80	100	90	95	90	95	95	92.5 (80–100)
Proposed Cut %									80.0%
Proposed Cut Score									24–25 points