Ethics Education in the Field with Clinicians

Ethics issues and consultations often include multiple steps to resolve the issue. In the first article, Kelly Stuart brings attention to an underemphasized process in ethics consultation and education – coaching. Next, Paul Wagle introduces an Ascension Health ethics education initiative focused on behavioral health. Their descriptions of both the coaching mode and behavioral health content (and process) make them easily replicable.

The third and fourth articles detail education piloted to nurses. Jason Lesandrini and David Reis present an ethics program made for nurse managers at Wellstar. Finally, one academic plan has been used by at least four health care systems in different ways and with different professionals. Readers can either use it verbatim or continue to adapt it in ways that serve a system best. For instance, it is short enough that it could be a part of a morning huddle, announcements, or as an extension to a reflection.

Next, Kelly Turner describes an academic plan has been used by at least four health care systems in different ways and with different professionals. Readers can either use it verbatim or continue to adapt it in ways that serve a system best. For instance, it is short enough that it could be a part of a morning huddle, announcements, or as an extension to a reflection. Lastly, Becket Gremmels and Kristine Ehlert describe a virtual ethics education program designed to teach volunteer ethics consultants skills related to mediation and clinical ethics consultation

EXECUTIVE COACHING IN ETHICS CONSULTATION AND EDUCATION

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Current work on developing standards for accreditation of ethics fellowships prompts consideration of what to include and how to provide comprehensive education and development. When I transitioned from clinical work as a neonatologist to full-time ethics work in 2010, I soon realized that understanding and articulating ethical principles and medical standards, as well as leading clinical consultation processes, even after practicing medicine for many years, only took me so far. Most ethical dilemmas do not require consultation; the issues are effectively addressed by patients, caregivers, and clinicians within the therapeutic relationship, as health care professionals generally possess the basic skills, knowledge, and experience to resolve them and move forward.

The cases escalated to ethics consultation are almost never purely ethical and medical at the patient care level; rather, they often include additional complex components related to

resources, health disparities, trust, statutory and regulatory limitations, litigation risk, social circumstances, mental illness, etc., that persist even when the best (or least bad) options that align with patient values are identified. Helping stakeholders to achieve sufficient alignment to move forward is challenging in our evolving American health system, and "teaching" the skills required for this work requires a multimodal approach. Advanced degrees, clinical training, and experience only go so far partly because these cases require many areas of expertise and partly because they raise difficult social questions that ethics consultation cannot "fix." Even identifying and focusing on the ethical question or concern can be a challenge.

That is why I decided to pursue formal studies in negotiation and conflict resolution (NCR), and this course of study introduced me to executive coaching. I decided to learn more through executive coaching certification so I could help health care professionals use their expertise more effectively. Along the way I have discovered that comprehensive ethics services that include coaching methodologies may do more to further ethics education and professional development than simply giving recommendations. In addition, a coaching approach may achieve professional development goals for both teams and individuals.

Executive coaching literature is plentiful in the business realm, but there is less written about coaching in ethics consultation. Kockler and Dirksen translated American Society for Bioethics and Humanities (ASBH) ethics consultation competencies into coaching competencies and applied this work to a case involving informed consent and decisional capacity.[1] Although the competencies the authors created do not all directly correlate to International Coaching Federation (ICF) core competencies, their insightful bridging of ethics consultation competencies and coaching can be applied directly to clinical cases and fellow training, and it supports the notion that ethics education should include professional development using coaching strategies.[2] Benoit (Belgium) and Rose (USA) also affirm that clinicians respond well to coaching aimed at increasing participation in advance care planning, although their coaching strategies are less clear.[3] This makes sense since coaching deliberately acknowledges the skills and knowledge of the person being coached; it is more collegial and less hierarchical than simply advising.

Coaching is substantively different from didactic teaching and clinical training experiences. Coaches assume the basic ability and knowledge to perform are already present and require further cultivation. Coaching swimming is technically different from teaching a person to swim. A person who cannot swim might easily drown - that person is not safe in the water and needs to learn basic skills - but coaching swimming helps the athlete improve their efficiency by increasing awareness of their own form and refining it with intentional adjustments, practice, and strength training. Coaching team sports adds a level of complexity because achieving success requires the team to work as a unit and to trust in each other's abilities.

The same is true in ethics work. Coaching in the ethics realm assumes that health care professionals are already reasonably familiar with basic ethical principles and moral

deliberation, and they have specific clinical skills and good intentions. Clinicians may also have a significant amount of experience and know what works in practice. This acknowledgement of existing ethical and clinical knowledge and experience may enhance an atmosphere of mutual respect and make clinicians more receptive to ethics services.

Coaching is also different from mentoring. A mentor can certainly move into coaching mode in the moment, but mentoring involves a long-term relationship in which a person learns by example and good counsel. Mentors are frequently in the same or similar field of work as the mentee, and their professional position is often aspirational for the mentee. Mentors give direct advice and help to prime professional pathways for advancement through personal recommendations and networking. With coaching, advice is best kept infrequent and based in broad truths rather than specific decisions, and the coach may or may not interact within the client's professional circles. Coaching is focused on specific areas of improvement. Most significantly, executive coaches ask questions and provide tools that invite the person being coached to create their own improvement path. So mentors might take a coaching approach in the moment, but mentoring is a more comprehensive relationship and commitment.

Advantages of incorporating coaching modalities into fellowship training and consultation services include promoting a culture of ethical engagement, supporting clinical teams in addressing ethical concerns independently, and resource stewardship. In circumstances where ethics consultation resources are spread across multiple sites, empowering clinicians to address immediate concerns is important. In addition, in cases where the patient-professional relationship has broken down, introducing another professional may be risky. In non-health-care settings, downstream developmental effects of executive coaching include better leadership abilities, confidence, and work satisfaction - all current focus areas in health care.[4]

Case: A 61-year-old man with cognitive impairment from childhood sustained a traumatic upper extremity fracture requiring open reduction and internal fixation. His guardian would not permit any post-operative pain medications, including acetaminophen or ibuprofen. The clinical team consulted ethics, and the response was timely, collaborative, and ethically thorough, but it was ineffective in that the guardian was permitted to deny the medications for more than two days because of legal constraints. This case caused moral distress for providers, and the patient endured significant pain according to nursing assessment. The clinical team and the ethics consultant felt that the guardian should not have been permitted to deny pain medications and requested a case review.

In addition to pertinent questions related to the guardian's reasons for denying pain medications, some coaching questions for both the ethics consultant and the medical team to answer are:

1. How is pain management different from other surrogate decision making?
2. How is this patient's vulnerability a factor in our response to his pain?
3. What are the standards of care for pain treatment in this clinical circumstance?

4. What are the legal and ethical obligations of a surrogate decision maker, in this case a guardian, to permit pain assessment and treatment?
5. What are the moral, legal, and regulatory requirements of the caregivers?

Further coaching involved organizational change that the ethics consultant could lead:

1. If organizational change is warranted, what is the best vehicle and level for change (e.g., system policy or guidelines; educational case conference)?
2. Who participated in the initial decision making, and what other stakeholders should be included?
3. What evidence will be required to influence leadership that surrogate decision making should be limited in this case?
4. What is our obligation as a ministry of the Catholic Church?
5. How can we minimize organizational risk if we override a guardian's decision?

The questions sometimes seem obvious to experienced ethicists, but it can be difficult for care teams and inexperienced ethics consultants to formulate them in the moment. A disciplined coach will ask the questions and leave the consultant and medical team to provide the answers, and raise additional questions, with support and guidance. This case presented an opportunity to demonstrate to the care team that advocating for patients by raising ethical concerns and collaborating with the ethics consultant can lead to better care for future patients. It also presented an opportunity for the consultant to navigate organizational change with executives and clinical leaders. Following the case, the ethics consultant achieved organizational change in two system policies and collaborated with clinicians in a case conference.

There are limitations in coaching. First, not everyone is coachable. Accepting coaching requires maturity and openness to change. Second, "there is an important distinction between providing general education or coaching about communication principles and giving specific advice about a particular patient that may lead to important decisions about that patient's medical care."[5] Although there can usually be coaching components to consultation, it is important to complete the consultation process, including documentation, when specific recommendations and follow up are warranted. Some may be concerned that ethics consultation numbers may fall off if coaching is an accepted modality, but that seems unlikely since consultant engagement usually increases consult numbers overall, and few consults can be satisfied with coaching alone.

Incorporating coaching modalities into ethics training and consultation is a simple strategy for developing and engaging clinicians and consultants. It has potential for great benefit in both clinical and organizational ethics work. For more information about executive coaching training, see the Center for Executive Coaching.[6]

BRIDGING THE GAP: BEHAVIORAL HEALTH ETHICS EDUCATION IN CATHOLIC HEALTHCARE

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Why Ethics Education in Behavioral Health Matters Now

In 2023, the nonprofit Mental Health America ranked my home state of Kansas dead last—51st out of 51 states and territories—for both mental health and access to care.[7] While the state rose to 22nd in the 2024 report, the statistics remain sobering: nearly one in four Kansas adults reported a mental illness, and over 30,000 children disclosed serious suicidal thoughts.[8] Nationally, more than 3 million children in 2024 alone went without needed mental health treatment.[9]
For Catholic healthcare, called to serve the most vulnerable, these numbers are not just statistics—they are a call to action. Behavioral health is ethically complex terrain where neurochemical imbalances meet structural injustice, stigma, and profound human suffering. These situations demand careful moral discernment.

Recognizing this gap, Ascension launched an ethics education initiative focused on behavioral health. What began as a response to pressing clinical concerns has grown into an interdisciplinary, Mission-driven model equipping providers across specialties to serve patients with behavioral health complexities. Here is how it came to be, how it functions, and how it is shaping both our care for vulnerable patients and our growth as clinicians and ethicists.

Recognizing the Ethical Gaps

This program aimed to equip all clinicians—not just those in behavioral health units—to navigate daunting ethical challenges and extend the compassion of our faith-based Mission to patients who suffer from a behavioral health diagnosis. Grounded in Directive 3 in the Ethical and Religious Directives (ERDs), which calls Catholic healthcare to distinguish itself by care for people with mental and physical disabilities, this initiative addresses a population historically marginalized. These moments ask: What do we owe our patients, especially those whose struggles defy easy understanding?

Beyond individual cases, systemic challenges have historically neglected behavioral health care. From underfunded institutions to societal stigma that isolates patients, those with mental illness have too often been treated in ways that fail to honor their dignity—such as being denied the resources and care they deserve. Catholic social teaching calls us to solidarity with these marginalized groups, affirming their inherent worth and demanding systemic reform. This initiative responds directly to these structural injustices, striving to cultivate an ethical culture that resists discrimination and advances justice.

What It Looks Like in Practice

The behavioral health ethics initiative was designed as a quarterly, system-wide webinar series, co-led by behavioral health and ethics leaders and open to all Ascension associates across the county. Each session was offered live, then recorded and made available as an enduring continuing education module through our Interprofessional Continuing

Education (IPCE) platform. While some attendees registered for CE credit, many more accessed the sessions without formal registration—highlighting the widespread hunger for support in this area.

Our steering committee—social workers, counselors, nurse leaders—began not with preaching but with listening. The first sessions were grounded in real consultations I had encountered, which I brought to the committee to compare against their lived experiences. Rather than starting with textbook ethics cases, we drew on the lived experiences of clinicians facing these challenges daily—spanning inpatient, outpatient, emergency and critical care settings.

To gather broader input, we created a Google form that was disseminated throughout the healthcare system. The form provided background framing and asked clinicians what ethical topics were most relevant to them when caring for patients with behavioral health and substance needs. The open-ended responses gave us a rich understanding of the ethical pressure points clinicians experience, and shaped both content and delivery.

This program's scope was intentionally wide. While many assumed it was only for psychiatric units, we emphasized that behavioral health touches every clinical setting—from med-surge and ICU to ambulatory clinics and social services. For example, the session on Scarce Resources explored moral obligations when community mental health resources are scarce, invoking the Catholic principles of stewardship and just distribution.

Each session included polls, moderated chat, and interactive segments to invite participation. Presenter selection was key: we sought individuals with lived expertise who could speak to complexity, nuance and Mission. These voices became ethical witnesses, drawing others into deeper discernment.

Topics to date have included:

- Understanding Suicide and Suicidal Ideation
- Addressing the Stigma Surrounding Mental Health and Substance Use
- Decision-Making Capacity - Increasing Awareness and Improving Evaluation
- Legal, Clinical, Risk and Ethical Dimensions of Involuntary Committals and Holds
- Safe Discharge Planning and Scarce Resources

What We've Learned Data and Transformation

Over 1,000 clinicians have engaged with these sessions, half attending live and half completing enduring modules. The results are compelling:

- **High satisfaction:** 70–80% of participants rated sessions as "Excellent," with nearly 100% saying objectives were met and content was free of bias.
- **Commitment to change:** Over 80% pledged concrete practice changes. The top areas include:
  - Clinical communication (20–22%)
  - Safety (25%)
  - Teamwork and roles (16%)
  - Diagnosis and screening improvements (up to 15% in live sessions)
- **Confidence:** Participants reported average confidence scores of 8–9/10, with over 40% rating 10/10 in their ability to implement

changes.

- **Knowledge sharing:** ~50% shared learnings with teams, influencing entire care units.
- **Barriers:** 50–70% reported no barriers to applying changes; others cited organizational constraints, time, or resource limitations.

Qualitative feedback tells the human story:

"I changed my discharge planning to honor patient self-determination."

"I finally understand the difference between capacity and competency—it's transforming our assessments."

This is not abstract ethics; it is incarnational. It forms clinicians who navigate foggy, high-stakes decisions with courage and compassion.

A Model for Vulnerability-Informed Ethics Education

Though this webinar series sunsets in 2025, the model it established endures as both relevant and replicable. The recorded sessions remain available through IPCE, offering ongoing education well beyond the original events. More importantly, the principles it embodied provide a roadmap for similar efforts elsewhere. The initiative was built on four key strategies:

1. **Listen to front-line associates** – Ethics education must begin with the real questions clinicians are wrestling with. By asking rather than assuming, we built relevance, trust, and genuine engagement.
2. **Balance legal realities with ethical education** – While behavioral health laws very by jurisdiction, core Catholic commitments—human dignity, subsidiarity, and common good—transcend these boundaries. We framed sessions in a way that respected compliance while also cultivating moral understanding.
3. **Empower passionate leaders** – This initiative thrived because we entrusted clinicians to co-lead. Their credibility and energy gave the content life and sustained participation.
4. **Position the ethicist as guide on side** – The most powerful moments arose from clinicians' lived experiences. The ethicist's task was not to dominate but to frame those stories through ethical lenses, making intentional connections that highlighted their deeper moral dimensions.

This model reflects a spirituality of accompaniment: we do not merely educate about ethics—we walk with clinicians in the ambiguity of care. Done well, this work does more than shape decisions; it forms consciences, cultivates virtue, and reshapes the culture of caring.

Conclusion

This did not start with strategy decks. It started with a moral wound that could no longer be ignored.

Directive 3 in the ERDs and Ascension's Mission call us to accompany the marginalized. As I reflected on Luke 10:25–37—the Sunday gospel reading shortly after I was invited to write this piece—I was reminded of the Good Samaritan's call to be a neighbor to those on the margins. Behavioral health ethics education is one small step toward living out that call in shared solidarity.

Ethics education in Catholic healthcare must be more than theoretical. It must ask: Are we walking by the wounded traveler, or are we stopping to serve? This initiative shows what can happen when we choose to stop and serve: clinicians are equipped, patients are safer, and our shared Mission is brought to life—with courage, competence, and compassion.

BUILDING ETHICAL COMPETENCE: WHY NURSING LEADERS NEED TAILORED ETHICS EDUCATION

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In today's complex healthcare environment, nursing leaders face unique ethical challenges that require specialized knowledge and skills. The intersection of clinical care, leadership responsibilities, and organizational dynamics creates a distinct ethical landscape that traditional ethics training often fails to address adequately.

At Wellstar Health System, we recognized this gap and developed a targeted ethics education program specifically for nursing leaders. Our approach was shaped by two key insights: the ethical patterns we saw in our consultation data and the absence of others we expected to find. In clinical ethics, absence is not necessarily a good thing. A former mentor of one of the authors, once shared the idea that "the lack of data can mean a lot of things," e.g., that there are not really ethics issues present or that there may be other challenges: normalization of acceptance of ethical challenges, barriers to speaking up, or general lack of moral awareness.

Learning from What We See and What We Do Not

Ethics consultation services provide valuable windows into the ethical challenges that reach a critical threshold within healthcare organizations. Our analysis of ethics consultation patterns helped identify prevalent ethical issues encountered by nursing leadership teams, from surrogate decision-making to navigating complex discharge scenarios.

However, equally revealing were the ethical issues that rarely or never appeared in our consultation data. This absence does not indicate these challenges do not exist—rather, it suggests they may be normalized, unrecognized, or addressed through other channels. It is often what we do not see in the ethics consultation service that should worry us most. These blind spots might include subtle power dynamics, slow ethical drift in organizational culture, or systemic inequities that become invisible through familiarity. Our program was designed to address both the visible ethical challenges and these hidden dimensions of ethical leadership.

To address these visible and hidden issues, we created a 6-week program for assistant nurse managers and above to bring awareness to key ethical issues. Unlike ethics education for frontline nurses, which often focuses

primarily on patient care dilemmas, our nursing leadership curriculum incorporated elements of ethical culture and ethical leadership. For example, the program includes sessions on moral distress, ethical leadership, obligations to ourselves, and bedside clinical ethics topics of forced treatment and combative patients, end-of-life care, surrogate decision-making, and against medical advice (AMA) discharges. Our hope is that after this initial roll out we can take the education system wide and involve all nurse leaders.

Addressing Moral Injury and Professional Suffering

One of the most urgent drivers for specialized ethics education is the widespread experience of moral distress among healthcare professionals. Further complicating this issue is that nursing leaders must not only navigate their own moral distress but also support team members experiencing ethical challenges.

Our program equipped nursing leaders with core knowledge to improve understanding and identification of ethical issues either they or their teams may encounter.

Furthermore, we provided specific education on the impact these ethical challenges have on individuals and the unit with a focus on creating psychologically safe environments where team members can voice ethical questions. Understanding the time constraints facing nursing leaders, we designed our program to integrate into existing team meetings rather than adding additional commitments. Each 45-minute session is focused on practical application rather than abstract theory, making ethics education accessible and immediately relevant.

From Individual Skills to System-Wide Culture

Ultimately, our goal is not just to enhance individual ethical competence, but to build "a system-wide culture of ethical practice." By equipping nursing leaders with both ethical awareness capabilities and methods for resolution, we aimed to create a ripple effect throughout the organization. As healthcare continues to face unprecedented challenges, investing in the ethical formation of nursing leaders represents a vital strategy for supporting clinical teams, improving patient care, and building resilient, values-driven organizations.

DEVELOPING AND DELIVERING STAT EDUCATION FOR SSM NURSES

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While working as an Ethics Graduate Assistant in the Mission Integration department at SSM Health, I took an existing design for hospital ethics education (STAT from CHRISTUS Health), developed modules for SSM, and then piloted one at a community hospital for my practicum project. The long-term goal of this project is to implement STAT modules as an available ethics education format for SSM Mission leaders and Ethics Committee members; however, I will focus on the justification for, process of, and experience with developing a pilot STAT at SSM here.

Choice of STAT for Ethics Education at SSM

The idea for this project began with identifying a general gap within SSM Health's ethics educational programs. Little, if any, in-person, on-location (hospital floors) ethics education occurs for healthcare providers at SSM hospitals who are not Ethics Committee members.

Thus, there is a need for it, which would also increase the visibility of our ethics committees, the ethics consultation process, and existing ethics educational resources for interested SSM clinicians. Fortunately, the SSM SVP of Mission & Ethics shared a recent presentation he had seen at the Catholic Healthcare Innovation in Ethics Forum (CHIEF) conference, delivered by Steven Squires: a short, 5–10-minute ethics education called STAT (Short, Timely, Applicable, Team-based) that had been piloted at nursing huddles.

STAT is intended to be delivered verbally, in small teams, and cover a very narrow topic or situation relevant to ethics or commonly encountered in ethics consults. The format is simple: (1) three to five most important points about a topic, (2) a short, typically paragraph length, case study that sets up a related problem, (3) three to five questions that facilitate case discussion and underscore the points to remember, and (4) three to five resources available to participants for further learning on the topic (e.g. publicly available or accessible educational resources, such as organizational policies). The content fits onto one page, is easily adaptable for a range of topics, and non-experts can deliver it with minimal training (at CHRISTUS Health, chaplains frequently delivered STAT on the hospital floors).

These features of accessibility, adaptability, and brevity made the STAT method particularly appealing for on-the-ground education and optimal for frontline healthcare workers. Steven developed STAT in response to feedback from clinicians. He had found that his colleagues responded positively to a) concrete ethics problems they encountered in their daily work and b) case discussions. Clinicians tended to learn better when content was brief and in their own setting. Since STAT seemed suitable for SSM's ethics education needs, I developed STAT modules for SSM (with permission), based on the skeleton template.

Creation of STAT modules for SSM

I chose the topic of surrogate decision-making for a pilot STAT module, based on frequently occurring ethics issues in ethics consults at the selected hospitals. Nurses frequently encounter this topic, and clinicians often have misconceptions about it. For instance, some believe that Missouri has a surrogate decision-making hierarchy of family members like other states. Moreover, the applicable policy would pertain to any of SSM's Missouri-based hospitals ("Missouri-Advance Directive"), including the three hospitals identified for the pilot.

With the chosen topic, I drafted the first STAT after reviewing the recent ethics consult logs for these cases and trying to anticipate frequent questions or points of confusion on this topic from providers. The most common iteration was when multiple family members were involved in a patient's care and disagreed about the treatment plan. A common situation involved one or two family members disagreeing about transitioning to

comfort care or stabilizing a patient in critical condition, often with significant neurological damage. I crafted the module after deciding on the specific scenario ("surrogate disagreements about patient care decisions") and the paradigm case of three adult children debating tracheostomy and PEG tube placement for their mother after her stroke.

I worked backwards to determine the three to five specific points that the nurses would need to know for approaching similar cases:

- The name and significance of the legal document designating a specific surrogate (dHPOA document or advance directive),
- The preference for mediation and, ideally, gaining consensus from all the surrogates,
- That close friends of the patient can be involved in decision-making, which may be preferable over distant relatives if they know the patient's treatment preferences better, and
- The clinical team could designate a surrogate based on assessing the person who knows the patient's wishes best as a last resort, should the decision-makers' conflict be truly intractable.

My case study questions encouraged participants to directly apply any of the four points to reinforce the material:

- 'What would be your first step to address the conflict?' - was aimed at addressing the first and second points (appropriate responses would be to look for an advance directive and/or to attempt to gain consensus among the patient's adult children)
- 'What questions would you ask the adult children?' and 'When family members are making decisions on behalf of patients, what considerations should guide those decisions?' - were aimed at addressing the 'substituted judgment standard' considerations embedded in my third and fourth points to remember.

I provided the following resources for the participants:

- A webpage on 'Advance Directives and Surrogate Decision Making' from the Missouri University School of Medicine, which provided detailed advance directive and surrogate decision-making standards (known wishes, substituted judgment, best interests) information in accessible language
- The publicly available State of Missouri health care power of attorney, or dHPOA, document template, which I chose for two reasons: to show nurses what these documents looked like, and because they were likely to come across one of these completed documents
- SSM's regional policy on Advance Directives, to provide a policy reference for nurses should they need it when either interacting with other clinicians or with family members.

Once this first STAT was drafted, I wrote more two modules to showcase a few different topics and prove that the format was adaptable to different scenarios.

Partnering with SSM Stakeholders and Piloting the Education

With the modules complete, I decided which of SSM's three community hospitals would be

best for piloting STAT, based on the hospitals in which there was access to nursing huddles, interest in ethics education, and investment in continuing the education. A nursing director at St. Joseph's-Lake St. Louis (SJ-LSL), who also chairs the ethics committees at SJ-LSL and SJ-SC, volunteered to help locally. She loved the idea of STAT, and we decided that SJ-LSL was a particularly good hospital at which to pilot STAT given her position there and the fact that many of their ethics consults are placed by nurses.

Before the nursing director and I planned the pilot SJ-LSL, we ironed out a few logistical details. We wanted to make sure that the nurses would have access to the STAT module handout after we did the education, but worried that handing out pieces of paper was not the most effective way to do this. Thus, we designed a QR code that would be on the back of the 1-page handout used to conduct the module, which would link to a SharePoint site that had both the handout information and the links to the additional resources. The paper handout could then be pinned to huddle boards and nursing breakroom boards with the QR code side facing out, so nurses would be able to scan it and access the information if/when they needed it.

I conducted the STAT pilot (using the "Surrogate Disagreements about Patient Care Decisions" topic) on April 19th, 2024, with about 8 nurses at SJ-LSL. We first explained the purpose of the education. I used the handout to verbally talk through the four points, read the case, and then worked our way through the three questions following the case. The participants responded well to the interactive portion (the 3-5 questions after the case). Once I asked the first question, we were able to facilitate a productive dialogue that demonstrated their awareness of the points I'd intended to cover with the second and third questions. I thus nixed these last two questions in the pilot.

After the session, I collected verbal feedback from participants to see whether they found the information useful and preferred this mode of ethics education to more traditional education formats. The feedback was overwhelmingly positive. A few participants shared that they had learned new things from the session. Everyone stated that they enjoyed this format more than longer, traditional mode of ethics education ("short and sweet," in the words of one participant). Moreover, despite the fact that the participants had expressed some hesitancy before the session when I stated that I would be asking them a few questions during the module (one nurse asked, "Do I have to say anything? Are you going to quiz me afterwards?"), most participants mentioned that they enjoyed the interactive portion. When I asked the participants which features of STAT they liked the most or found the most useful, they stated that they found the case discussion helpful given its similarity to recent situations of surrogate disagreement they had encountered.

Plan for Long Term Implementation and Future Directions

I reported back to the SVP of Mission & Ethics and presented this education at our next Ethics Committee chairs meeting. We posted the STAT template and examples to both the Mission Integration and Ethics Committee Teams sites, so that both Mission leaders,

committee chairs, and committee members can access existing modules and make their own. Eventually, I envision a bank of available STAT modules on the bread-and-butter basic clinical ethics topics (e.g. different facets of decision-making capacity, treatment refusals, potentially inappropriate treatment, etc.), though we will need to make sure these modules are tailored to particular ministry contexts. Finally, while Steven Squires originally created STAT for nurses, I think the format would also be well-suited for residents and medical students (for example, before or after convening for morning rounds).

For more on STAT Ethics, go to Bioethics for the People at: https://www.bioethicsforthepeople.com/episodes/stat-ethics-education-with-steven-squires

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