# Jacks and Jills of All Trades, Experts of Some: Process Skills Training for Ethics Programs

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## CASE REFLECTION

**Case 1:** One of the first ethics consultations I (Steven) witnessed as a novice left me confused. An attending physician had me observe a family-provider ethics consultation meeting. The patient was a woman in her thirties who was hit by a car while walking. Multiple opportunistic infections from advanced AIDS exacerbated her injuries. She was quite ill but not actively dying yet and she lacked decision-making capacity. Providers wanted to meet with her sister, who was the patient's statutory, default surrogate decision-maker, to suggest palliative care rather than aggressive treatment for her sister. Three chairs were in the middle of a medium-sized institutional room with half-filled bookcases on the sides. The patient's sister arrived with the patient's two children, who looked to be approximately seven and nine years old. They gingerly sat down. The attending physician, who had been standing at the doorway, left and returned with some resident physicians, all of whom were White and wore white lab coats. They filed in and stood surrounding the seated Black family. The rest was a worsening nightmare, from providers talking to — not with — family members to doctors younger than the children's mother making an abrupt and unabridged disclosure, far too blunt for little ears, as the children's eyes widened and welled with tears.

**Case 2:** Many years later, ethics consultation team members asked for my (Steven) help in a provider-family ethics consultation meeting. I was requested because of my ethics expertise after a provider-family ethics consultation meeting had already occurred. The patient's husband and children asked to have a second ethics consultation with an expanded group after concerns about providers' advocacy of their and the patient's interests in the wake of the first ethics consultation. I entered the meeting room where chairs were arranged in a large circle. Something seemed off when just over a dozen participants found their chairs. My thoughts periodically drifted to a former consult (Case 1), but I was confused why. Discussion reached a crescendo. As voices raised, the back-and-forth between the care team and family resembled a tennis

volley. Only then did it occur to me that the patient's family members, all of whom were Black, were seated on one side of a huge circle. The caregiver and provider team, all of whom were white, were seated on the opposite side of the circle. Chairs arranged in a circle were meant to create closeness, be therapeutic, and remove barriers such as tables. Yet the participants' seating choices made it an oppositional cross-examination. I sought a place in the conversation to mention this, but someone else did first. A family member rightly called attention to the seating choices, so then everyone switched seats.

**Reflection:** Hindsight is 20/20. During Case 2, I didn't understand why I thought about Case 1, because the consults' topics and substance bore no semblance to one another. My reflections shortly after Case 2 clarified the cases' similarities. Too many caregivers were present at the consults. Family members were clearly overwhelmed. Participants' choices for placement and arrangement, seated or standing, aligned with ethnic differences and differences in relationship to the patient (care providers vs. family). The care team and I, failed to notice and call attention to arrangements early in the meeting. Failure to do so likely elevated us-vs.-them tensions.

It was much later, after supervising chaplains and understanding pastoral care, that I better realized why it took me years of working with health care professionals from different fields to understand my role and the facets or layers in these cases. On one level, I reflected on my and other consultants' proficiency in addressing diversity and inclusion. On another level, my reflection was about recognizing and managing my own thoughts and emotions while actively listening to others. I didn't reflect until years after these cases, so I pondered how to foster intentionality around reflection and make connections among cases and myself. Perhaps on the deepest level, it was about my and others' education and training in ethics, which didn't include these skill sets that are basic to other fields.

## OPPORTUNITIES FOR PROCESS SKILLS DEVELOPMENT IN ETHICS

The American Society for Bioethics and Humanities (ASBH) has emphasized process and knowledge as core competencies for clinical ethics consultants.[1] ASBH recently launched a credentialing program, and thwe requirements are currently limited to an exam. The launch of this program has received criticism for its lack of attention to the process dimension of ethics consultation.[2] Knowledge of theory pertaining to process skills for ethics consultation is necessary but not sufficient. Although these efforts are a good start, we need to augment our existing knowledge-oriented training programs with process learning. Specifically, we need process learning tools oriented toward effective facilitation when emotions are high and power dynamics related to social identities (e.g., race, gender, immigration status, religion, or culture) are magnified. We need the skill to address these power dynamics in real time while managing our own emotions. This is essential for building trust and eliciting honest responses from participants, which are both core competencies for ethics consultants according to ASBH.

This gap can be filled by engaging a phenomenological approach to ethics consultation. In a 2011 issue of *Bioethics*, Andrea Frolic shared an analysis of her qualitative research on the profession of bioethics.[3] She observed that most ethics consultants did not consider their own embodiment in their interactions during consultation, suggesting to her a lack of reflection on the micro-politics involved in ethics consultations. They regarded themselves as "talking heads," oblivious to the emotional, social, and political work they did with their embodied presence. Building on Frolic's observations, Ellen Bernal recognized a deficiency in self-awareness when considering the way bioethicists discuss moral distress.[4] She argues that we fail to acknowledge our own moral distress in difficult cases. Both Bernal and Frolic recommend the work of Richard Zaner as particularly helpful for considering how the ethics consultant affects (and is effected by) an ethics consultation. We agree that too little attention is given to the personal formation required for an embodied practice of ethics consultation that respects the dignity of the people involved in a case consultation. We recommend ongoing process learning for ethics consultants that includes self-reflective tools.

The field of bioethics is inherently interdisciplinary, assimilating knowledge from medicine, philosophy, law, theology, and more. Bioethicists already draw on multiple disciplines for methods of analysis. For example, a key resource for ethics consultants is *Bioethics Mediation: A Guide to Shaping Shared Solutions* by Nancy Dubler and Carol Liebman. Their chapter on techniques for mediating bioethics disputes in the revised and expanded edition includes reality testing, reversing roles, allowing silence, and stroking. These are basic counseling techniques found in texts such as *Counseling Strategies and Interventions* by Sherry Cormier and Harold Hackney.[5]

We can continue to draw on other disciplines for tools to implement in process learning. Such learning would not only help ethics consultants build process skills for consultation but would also provide an opportunity for ethics consultants to process their own emotions about their work. As we develop a credentialing program in ethics consultation, we should look to the tools of other professions that achieve similar learning goals. Frolic and Bernal recognize the need for reflective tools that engage ethics consultants in self-reflective processes. An example of this kind of training can be found in Clinical Pastoral Education (CPE). Although pastoral care interventions are directed to different goals than ethics consultation, the process skills of building trust and values solicitation are necessary to both professions. CPE provides a model of the kind of training ethics consultants need.

CPE arose out of a need to complement knowledge training in the seminary with skills training in ministry.[6] The early CPE movement was driven by a belief that ministers learned plenty about doctrine in school; what they still needed to learn to be effective ministers was how to work with people. One of the founders of CPE, Richard C. Cabot, was a physician who had taken the chair of ethics at Harvard University. In 1925, he wrote a plea for ministers to have a clinical training year. Decades later, clinicians sought out philosophers to help them answer difficult

questions about morality in clinical decision-making.[7] Over time, pastoral care has become the realm for addressing patients' feelings, and ethics has been the realm for analysis of values.[8] This divide isn't exact, nor is it sufficient to our work. Good spiritual care and good ethics consultation require integration of head and heart; we need collaboration to help each other grow more effective in our roles. Pastoral Care is an older profession than ethics consultation and thus has had more time to cultivate and implement tools for process learning. The plea for a clinical year that Cabot made one hundred years ago has been resonating for ethics consultation training in recent decades, and the call sounds even louder as ASBH has begun credentialing ethicists with an exam.

Rather than starting from scratch in developing tools for process learning, ethics consultants should build variations on existing tools that have proved effective in pastoral care. One such tool is the verbatim. A verbatim includes a transcript of a consult (from memory) with notes on context, nonverbal communication, the consultant's mood, the consultant's read on the interlocutor(s)' mood(s), and interpersonal dynamics. The verbatim allows for reflection on one's own performance, including the micro-politics and emotional factors that influence analysis and communication. These reflections are not simply private writing experiences; they are presented before a group of peers for discussion and evaluation. They invite others to broaden the consultant's self-awareness, bringing attention to habits or styles of communication that may not serve the goals of the consultation. Implementing the verbatim in the training of ethics consultants will address the gaps in process learning that the profession currently experiences to improve ethics quality.

Having an experience without considering or processing emotions, sensitivities, motivations, or character misses the mark.[9] This illustration may assist: ASBH mentions knowing a clinical context with "awareness of the grieving process and psychological responses to illness" in *Core Competencies for Healthcare Ethics Consultation,* second edition. One can know Elisabeth Kübler-Ross' stages of grief, but identifying what stage someone is in is a different matter. Supporting someone is another matter still. Guidance about what to do and what to avoid in response to grief requires much more skill and precision.

Ethics colleagues express a range of difficult experiences from the coronavirus pandemic: These include moral distress, moral injury, and burnout. Many ethics consultants *are* frontline health care professionals although their services are classified as ancillary. The same ethics consultants who experience moral distress and injury may also facilitate moral distress and moral injury interventions for their colleagues. Practicing the services that we provide to others and modeling self-care can be difficult for ethicists.[10] Ethics consultants need help processing our own experiences in the clinic. Chaplains have tools to help, and they have cultivated a culture of emotional processing by encouraging activities such as journaling, making notes, taking quiet time, and spending time with family and friends.[11] We can borrow these tools and adapt them to our work to help us practice better self-care.

## OTHER OPPORTUNITIES INCLUDE EQUITY, DIVERSITY, AND INCLUSION TRAINING

Other fields also have transferrable skills and tools for bioethics. The following true story highlights the need for equity, diversity, and inclusion training for ethics consultants:

> Susan Moore, the patient, said the White doctor at the suburban Indianapolis hospital where she was being treated for COVID-19 had downplayed her complaints of pain. The doctor told her that he felt uncomfortable giving her more narcotic and suggested that she be discharged. "I was crushed," Moore said in a video posted on Facebook. "He made me feel like I was a drug addict." In her post, which has since circulated widely on social media, she showed a command of complicated medical terminology and an intricate knowledge of treatment protocols as she detailed the ways in which she had advocated for herself with the medical staff. She knew what to ask for because she, too, was a medical doctor. But that was not enough to get her the treatment and respect she said she deserved. "I put forth and I maintain if I was White," she said in the video, "I wouldn't have to go through that." After Dr. Moore, 52, complained about her treatment, she received care that she said "adequately treated" her pain. She was eventually sent home, and on Sunday, less than three weeks after posting the video, Dr. Moore died of complications from COVID-19, said her son, Henry Muhammed.[12]

As a hypothetical, assume that Dr. Moore requested an ethics consult when she first experienced a care disparity. The on-call consultant would need recognition, skill, and comfort working with the patient and providers on this overt discrimination that is intensely uncomfortable to discuss.

Not all diversity and inclusion issues in ethics are as overt. Some are subtext within other discussions. Consider the patient who moved to the United States, could not access appropriate health care, and then once accessed, the level of care appears … *different* … than care received by others. These narratives may not have occurred in the current setting, but they impact current perceptions and plans, nonetheless. Physician ethicist Kelly Stuart's simple and helpful rubric is that less has always been less for people who have experienced health disparities.[13] In other words, clinicians and ethics consultants often express the view that less invasive treatment is better for the person.

Responding to overt or implicit care disparities in a consult can be awkward for White ethicists. These situations bear a remarkable resemblance to addressing adverse events, such as medical errors, especially for clinicians, lawyers, and risk managers. The fairness of disclosure (or delving into disparities, in our case) to respect autonomy hangs in the balance with worries about organizational nonmaleficence after the disclosure (discussing disparities). Do ethics consultants have the tools and training to effectively navigate situations? What are the ways the organization helps consultants process their anxieties and fears around these tough topics? Professionals in health equity, diversity and inclusion (HEDI) have the skills and training to help.

## ETHICS CONSULTANT CONTINUING TRAINING AT CHRISTUS HEALTH

Ethics consultants appreciate and invite periodic skills retraining, especially if consultants are the point person for only a couple to a half-dozen consultations a year (i.e., they experience long intervals between consults). After reformatting initial ethics consultation training, a small planning team's attention focused on skills retraining for consultants who have taken the initial, which focuses mainly on process and basic skills. Two key questions emerged: 1) Can content, methods, and skills from other fields and professions benefit CHRISTUS Health ethics consultants, and 2) can involving experienced, talented professionals and leaders from those fields and professions benefit CHRISTUS Health ethics consultants by their involvement in ethics consultant training? The answer to both questions was yes.

The planning team considered when and how health care and ethics consultations can go wrong. A litmus test for technological and treatment appropriateness developed by neurologist Bryan Jennett was used in a different manner to sort issues: Anything inappropriate may be unnecessary, unsuccessful, unsafe, unkind, or unwise.[14] Although safety issues are usually referred to other departments, ethics consultants are frequently called into situations where these five issues arise.

Bryan Jennett's definition of unwise involves justice, which is another area where healthcare delivery and ethics consults may fail. Dr. Martin Luther King Jr. inherently linked injustice with unkindness during a press conference outside the second convention of the Medical Committee for Human Rights in 1966 with, "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman." Chaplains and HEDI professionals have unique skills and resources to bolster ethics responses to what is unkind and unwise. Opening conversations with an acknowledgement of historical and social injustice is a helpful way to respond in situations when a patient experiences care disparities. An approach resonating with HEDI professionals was introduced by Kelly Stuart during Awkward Moments in Ethics Consultation training in 2019 at a different organization. She recommends inviting a patient or their family members to the table with something such as, "We know healthcare doesn't always meet everyone's needs. Please share any concerns if you have any. It helps us meet your needs better."[15] This short script addresses the needs of individuals while still being comfortable for the organization. The focus is on problem-solving for all stakeholders.

A mid-sized workgroup of chaplain leaders, HEDI professionals, and ethicists are currently designing the training and the workgroup will also be involved in the rollout. Involving human resources, the experts said, in the training's construction and practice increases the chances of identifying and attending to root problems rather masking their signs and symptoms. An observant Ph.D. ethicist, for instance, could assess whether training participants use the five R's of effective listening — repeating, restating, reflecting, responding, and respecting.[16] Seasoned chaplains, chaplain leaders, or CPE supervisors are more likely to evaluate the totality of active

listening and engage why a participant is not listening.

We are also leveraging the rarest of healthcare professionals — those who have expertise in two professions, such as this article's co-author Andrea Thornton, who has extensive training in ethics and pastoral care. CHRISTUS Health has an exemplary chaplain ethicist, Jeff Matsler, who was the only uniformed ethicist in the Department of Defense for approximately 15 years. Some HEDI professionals have experience with ethics and are uniquely suited for this work. Social worker ethicists also have knowledge and experience with diversity and inclusion issues in addition to their ethics expertise. Those with feet in two professional worlds have insights that can only be seen at the intersection of two disciplines.

The pastoral skills component of ethics consultant training at CHRISTUS Health focuses on three things:

1) **Emotional awareness:** Chaplains and care ministers should be adept at knowing how they are before entering a visit. This applies to ethics consults as well. Emotional checks include: "How do I feel today? How do I feel about going in this visit? Do I have any strong feelings about something else that might preoccupy me today?"[17] Ethics consultants may want to add or adapt questions: "How might the case context or characteristics remind me of my emotions from similar cases? How does this situation mimic illness narratives and family dynamics with my own friends and family members? What are my feelings when someone already reminds me of an acquaintance?" This is called countertransference, and we should be more attentive to it in ethics consultation.

2) **Being pastoral:** Ethicists should be cautious about rubrics and formulas without practice and expert engagement. The devil is in the details and attempts to help can quickly become vapid, armchair "how-to" lists or, even worse, inadvertent techniques for manipulation and intimidation. Appearing to actively listen and actual active listening are light-years apart. Looking present, interested, and engaged is different than being present, interested, and engaged.[18] Other skills include an appreciation for the toll of pain and illness on the mind, body, and spirit and how to accompany those who suffer:[19]

> People in pain don't need to hear: "It can't be that bad, can it?" "Don't worry, everything will work out." "I know what you are going through." "I had that operation once, too." "I've had a really bad day." When working with people in pain, remember: Don't touch without permission. Don't lecture. Don't back away. Don't try to make it all better.[20]

3) **Debriefing with others:** A pastoral skill discussed previously is processing encounters for content, process, and feedback. Emotions and communication are not accessory to a debrief; they are central. Inviting others to share in this reflection helps us see our blind spots. The verbatim provides a template for debriefing ethics consults with others.

The CHRISTUS Health team looks forward to piloting the program and receiving participants' feedback for refining and improving this training. It is our hope to report back about this intervention's effectiveness. We also look forward to hearing about different cross-disciplinary and interdisciplinary ethics trainings that others develop. ✠

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## ENDNOTES

1. Materials on ASBH certification are taken from two documents, The Core Competencies and the HCEC Certification Commission's document on the HEC-C exam. Anita Tarzian et al., "Core Competencies for Healthcare Ethics Consultation" (American Society for Bioethics and Humanities, 2011), https://asbh.org/. The documents are available at ASBH.org. For additional information on the credentialing effort, see also Eric Kodish et al., "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model From the American Society for Bioethics and Humanities." *Hastings Center Report* 43, no. 5 (September 2013): 26–36, https://doi.org/10.1002/hast.198.
2. Claire Horner, Andrew Childress, Sophia Fantus, Janet Malek. "What the HEC-C? An Analysis of the Healthcare Ethics Consultant-Certified Program: One Year In." *American Journal of Bioethics* 20, no. 3 (March 2020): 9–18. https://doi.org/10.1080/15265161.2020.1714794.
3. Andrea Frolic. "Who Are We When We Are Doing What We Are Doing? The Case For Mindful Embodiment in Ethics Case Consultation." *Bioethics* 25, no. 7 (September 2011): 370–82. https://doi.org/10.1111/j.1467-8519.2011.01913.x.
4. Ellen Bernal. "Health Care Ethics Consultation: Personal Knowledge and Apprenticeship." *Tradition & Discovery* 42, no. 4 (October 2016): 34–54.
5. Many mediation and dispute resolution techniques appear in the sections on responses to cognitive content and responses to affective content in: Sherry Cormier, Harold Hackney, *Counseling Strategies and Interventions*, fifth edition (Boston, MA: Allyn and Bacon, 1999), 80–84, 99–104.
6. For more on the history of CPE, see Edward Thornton. *Professional Education for Ministry; a History of Clinical Pastoral Education* (Abingdon Press, 1970).
7. Richard Zaner tells this history in *Ethics and the Clinical Encounter* (Prentice Hall, 1988).
8. For a critique of how modern pastoral care has drifted from the moral and religious dimensions of spirituality, see H. Tristram Engelhardt Jr., "The Dechristianization of Christian Hospital Chaplaincy: Some Bioethics Reflections on Professionalization, Ecumenization, and Secularization," *Christian Bioethics: Non-Ecumenical Studies in Medical Morality* 9, no. 1 (April 2003): 139–60.

9. Kelly Morton et al., "Defining Features of Moral Sensitivity and Moral Motivation: Pathways to Moral Reasoning in Medical Education," *Journal of Moral Education* 35, no. 3 (2006); Elena Mustakova-Possart, "Education for Critical Moral Consciousness," *Journal of Moral Education* 33, no. 3 (2004).
10. Jonathan Friday, "Education in Moral Theology and Improvement of Moral Thought," *Journal of Moral Education* 33, no. 1 (2004): 23–33.
11. Glen, Kofler, O'Connor, *Handbook for Ministers*, 42–43.
12. John Eligon, "Black Doctor Dies of COVID-19 After Complaining of Racist Treatment," *New York Times*, December 23, 2020, https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html (accessed August 15, 2022).
13. Kelly Stuart, personal communication, August 16, 2022.
14. Bryan Jennett, *High Technology Medicine, Benefits and Burdens* (London, England: The Neuffield Provincial Hospitals Trust, 1984).
15. Steven Squires, Kelly Stuart, Awkward Moments in Ethics Consultation (Bon Secours Mercy Health, ethics consultant training, 2019); Kelly Stuart, personal communication, August 16, 2022.
16. Glen, Kofler, O'Connor, *Handbook for Ministers*, 17–20.
17. Genevieve Glen, Marilyn Kofler, Kevin O'Connor, *Handbook for Ministers of Care*, second edition (Chicago, IL: Liturgy Training Publications, 1997), 21, 39.
18. A chaplain colleague illustrates this with a TEDx talk by Celeste Headlee titled "10 Ways to Have a Better Conversation" for teaching active listening, conversational competence, and respectful disagreement. Although the title seems hypocritical (a rubric), Headlee's modes are for being and doing, not for look or appearance. Additionally, they are about setting parameters and boundaries rather than regimented prescriptions and methodological edicts. Headlee advises entering every conversation as a continuous learner, assuming that you have something to learn and that you can set yourself aside, in the words of M. Scott Peck. Celeste Headlee, "10 Ways to Have a Better Conversation" (TEDxCreativeCoast presentation, Savannah, GA, May 2015), https://www.ted.com/talks/celeste_headlee_10_ways_to_have_a_better_conversation?language=en.
19. Glen, Kofler, O'Connor, *Handbook for Ministers*, 56–57.
20. Ibid, 57–59.