Competencies Required for Clinical Ethics Consultation as Coaching

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Elsewhere we have described our philosophy and practice of clinical ethics consultation as coaching;[1] here, we wish to describe the competencies required for performing ethics consultation in this manner. We define coaching as *a set of activities performed by one person (or more) to assist and support another individual or group striving to achieve excellence in a given field or discipline*.[2] This coaching modality[3] may be distinguished from other modes like one that emphasizes advisement or conflict mediation.[4] To illustrate this mode of ethics consultation, and the competencies necessary to perform it well, we will use a case example. Clinical ethics consultation calls for ethicists to achieve sufficient proficiency of a distinct set of competencies that either differ or further specify the core competencies for health care ethics consultation described by the American Society of Bioethics and Humanities (ASBH).[5]

In our approach, ethics consultation is not limited to answering a focused ethical question as described by others. Ethics consultation (and education) can, and we believe *should*, serve to help transform one's skill or *techné* into the professional application of that skill (*praxis)*. We built our ethics consultation service and (education programming) around the philosophy that ethics consultation (*ethos*) helps to transform clinical skills and applied knowledge (*techné*) into professional care-giving practices or what we also refer to as the therapeutic relationship (*praxis*). By this we mean that a clinician learns not only how to apply the healing arts to obtain clinical benefit, but she is also capable of entering into and managing the challenges and nuances of interpersonal dynamics to create quality therapeutic relationships.

Some of the research on ethics consultation supports the mode of an ethics consult as coaching. First, survey data suggest that physicians who tend not to engage an ethics consult believe it is their responsibility to address the issues and that they may be proficient in ethics already.[6] Although health care providers may have varying degrees of formal training or self-reported confidence in ethics, these data reflect a sense of accountability in the role of health professional for which an ethics consult qua coaching, but not necessarily qua advisement, complements. Second, ethnographic research suggests that ethics consults may tend to occur when there is a disruption in quality patient care or there is an anticipated disruption in patient care.[7] Insofar as ethics consults are about promoting therapeutic relationships (and not, *per se*, giving advice or mediating conflict), an ethics consult should aim to restore patient care through the care providers themselves or to avoid such disruptions in the delivery of quality care by those responsible for it. It is true that giving advice or mediating conflict could help address those disruptions. But those mechanisms may represent two among several 'deliverables' that could be produced in any given consultation. In addition to enhancing professional development, other such 'deliverables' include creating the moral space for dialogue, building shared accountabilities for a care plan, affirming moral sentiments, witnessing moral angst, clarifying or interpreting barriers or norms (be they moral norms or institutional norms), recommending practical solutions, and disclosing ethical thinking and processes.

Case

Mr. Garrison is an 82-year-old resident of a local nursing home. He has developed a benign skin growth, which his primary doctor believes should be removed to prevent more serious problems and for hygiene reasons. He has dementia and is incapable of making his own medical decisions.

He is admitted for the procedure. When the surgeon talks with the patient before the treatment, Mr. Garrison states, "I don't want surgery. Bring me home!"

The surgeon pages the ethicist and asks, "Should I move forward with the procedure? The patient is saying, "No."

In what ways shall the ethicist perform the consultation? The ethicist may advise whether the surgeon may ethically perform the procedure to remove the skin growth. On the other hand, the ethicist may engage in a dialogue with the surgeon to help her think through the ethical issues in a way that enhances the surgeon's ethical competencies. In the latter approach, the ethicist is more intentionally assisting the surgeon to achieve a higher level of excellence in professional practice in the context of her therapeutic relationship with this patient.

What competencies are necessary for consultation as coaching? How does this differ from the emerging dominant paradigm as articulated in ASBH's document, *Core Competencies in Healthcare Ethics Consultation, 2nd Edition*?

Comparisons and Contrasts

The first comparison we would like to make is to differentiate the goals and objectives of the ASBH ethics facilitation approach and coaching. The *Core Competencies* document

states that the goal of ethics consultation is to improve the quality of health care. Intermediary goals (or objectives) are (1) to identify and analyze the nature of the value uncertainty or conflict and (2) to facilitate resolution of the conflicts in a respectful atmosphere.[8]

In contrast, the primary goal of ethics consultation as coaching is to demonstrate integrity in the context of a therapeutic relationship. This does a few things. At a minimum, it shifts ethics consults away from situations where there is disagreement or conflict. More fundamentally, this goal emphasizes a discerning attitude toward the ethical tensions in a case, so that the ethicist aims to guide perception and thinking-through issues so that stakeholders can align their decision-making with who they aspire to be in the given circumstances.[9] As Richard Gula, SS, Ph.D., professor of moral theology at Franciscan School of Theology, says,

> "Discernment," as we generally use the term, refers to the quality of perception and the capacity to discriminate degrees of importance among various features before making a judgment. The ability to discern involves keenness of perception, sensitivities, affectivities, and capacities for empathy, subtlety, and imagination.[10]

We believe these are the things an ethicist should do in a consult. Renowned moral theologian Richard McCormick's ten recommendations for physicians include not thinking of ethics as a threat (#2), not principally expecting ethics to provide answers (#3), and not identifying ethics "with dilemma ethics" (#4).[11] Lastly, this goal also sets up the notion that the ethicist helps stakeholders demonstrate integrity in the therapeutic relationship by (1) eliciting practical wisdom and avoiding default decisions, (2) maximizing stakeholders' moral freedom to choose or act conscientiously and manage any concomitant moral distress,[12] and (3) managing the moral hazards[13] that may disrupt (or are disrupting) delivery of quality patient care.[14]

In the case example, the ethicist may help Mr. Garrison's surgeon avoid defaulting to a decision not do the surgery merely because the patient says "No." Alternatively, a default could be doing the procedure simply because it is medically indicated. It may be ethically appropriate to perform the surgery, but 'defaulting' to this decision suggests it was arrived at in an unreflective, non-deliberative way. In the latter default decision, the surgeon runs the risk of not respecting the dignity of the patient; whereas in the former, the surgeon runs the risk of patient abandonment. How can the ethicist help the surgeon be prudent about this decision?

The ethicist may further help the surgeon by addressing sources of moral distress. For example, the surgeon may feel frustrated at being unable to help the patient because the patient is behaving in a way that interferes with recommended care. The surgeon may not feel free to be the best caregiver for this patient.

Lastly, the ethicist may aid the surgeon by identifying the moral hazards operating in this case. These could include addressing ambiguity over who makes decisions on behalf of Mr. Garrison, strategizing over Mr. Garrison's resistant behavior, assessing whether the professional obligation to benefit

the patient is no longer binding on the surgeon or whether proceeding with the treatment is ethically problematic.

The next comparison we would like to make is to compare select competencies articulated by ASBH and translate these as coaching competencies (see table below). ASBH categorizes the skills-based core competencies into assessment or analysis skills ("A"), process skills ("P"), and interpersonal skills ("I").[15] For purposes of this paper, we will focus on the select competencies from ASBH in the table.

In contrasting the competencies required for coaching with those from ASBH's *Core Competencies* document, we observe competencies for consultation as coaching further specify the ASBH competencies. One, we describe competencies as concrete, embodied actions undertaken in relationship with stakeholders in a therapeutic context. The purpose of these actions is to help stakeholders address moral controversy or ambiguity which jeopardizes integrity. That is, we imagine these competencies as embodied performances in relationships with those persons (stakeholders) who are embedded in therapeutic relationships as they experience moral controversy and/or ambiguity in the present circumstances.[16] In other words, the competencies for consultation as coaching is in the context of an ethicist encountering others whose integrity is somehow at risk in the therapeutic relationship.

In the case example, this is the encounter with the surgeon; the surgeon's integrity is at risk because she feels she is unable to be the best surgeon she can be. Or, perhaps more accurately, she has in mind only one care plan that would demonstrate the excellence becoming of a good surgeon, the care plan seems to be ethically problematic.

Two, we acknowledge explicitly both cognitive and affective dimensions of the moral life. Thus, "Listen well and communicate interest" becomes active listening, emotional attunement, and the practice of engaged curiosity, which reflect specific behaviors the ethicist performs precisely to address the interpersonal dynamics at play (e.g., frustration) with ethical principles (e.g., beneficence, respect for autonomy).

In the case, it may be difficult for the ethicist to assess adequately the affective components to the surgeon's ethical inquiry. This is especially the case if the ethicist responds to the page over the phone and the surgeon adopts the perspective "detached concern"[17]and displays minimal emotional expression. The ethicist, merely by listening, may hear tones of voice or words with particular connotations ("he's a difficult patient" or "he's noncompliant") that could be indicative of emotional attitudes.

Three, we further specify certain skills of the ethicist with a reference to the core formational concept of integrity. For example, ASBH Interpersonal Skill #3 suggests consultants, "Elicit the moral views of the involved parties to others."[18]"Moral views" can be enormous and sprawling; by leveraging the concept of integrity, the ethicist-coach can remain neutral with respect to each stakeholder's subjective moral commitments but offer a common framework for the case. A task of the ethicist then is to elicit intentionally a stakeholder's concept of

integrity and to reflect back precisely how that notion is at risk in a given case. The ethicist can in turn reflect back what moral hazards are most relevant to the risk to integrity.

Thus, in the case example, the ethicist may probe the surgeon's moral worries. This means explicitly acknowledging them. Even asking, "What worries you?" can be enlightening to the ethicist and surgeon alike. "I'm worried about causing the patient more harm. I'm not sure how he's going to react, and I just don't want to bulldoze right over him," she might say. "I'm also worried because it doesn't seem like he has any social support; I don't know how he would cope with all of this." Exploring the surgeon's worries can also be an exercise of prudential judgment: whether the recommended care plan would be safe and feasible relative to the invasiveness or risks of the plan, whether it would have an impact on the patient's overall well-being, etc.[19] Such an exploration will require a juggling of relevant facts, applicable principles, and moral hazards as well as a stratification of clinical and ethical risks.

	SELECT ASBH/ETHICS FACILITATION COMPETENCIES	CORRELATIVE COACHING COMPETENCIES	APPLICATIONS TO THE CASE (adopting a coaching modality to consultation)
A-1	Identify the nature of the value uncertainty or conflict that underlies the need for Health Care Ethics Consultation	Describe the clinical conditions or actions that lead to an ethically relevant disruption in care delivery	Stating, in conversation or in documentation, that care delivery is interrupted because (a) the patient's expressions of his will departs from what is medically indicated or recommended; and (b) the appropriate decision-making mechanism is ambiguous.
P-4	Facilitate formal meetings	Facilitate "Socratic dialogue" – Use questions and statements designed to elicit values and core moral commitments as well as identification of moral hazards	Interviewing the surgeon in a semi-structured (cf. ethnographic methodology) way by asking questions like (but not limited to) the following: "If the patient was capable of making his own decisions, what would you recommend? What do you think is in his best

			interests?" Probing further, "What worries you about performing the procedure for Mr. Garrison?"[20]
I-1	Listen well and communicate interest, respect, support, and empathy to involved parties	Actively listen, attune emotionally, and practice engaged curiosity	Engaging in a form of clinical empathy or empathic communication with stakeholders.[21] Bearing witness to the moral angst of stakeholders by maintaining a listening presence.[22]
I-3	Elicit the moral views of the involved parties to others	Help the individual(s) discover and articulate meaning of integrity	This follows facilitating and active listening as described above, but includes setting the 'structure' or the 'arc' and goal of the dialogue. This includes asking probing questions or 'playing softball' by asking simpler or more concrete questions as an entry into a more morally significant discussion.
I-5	Enable the involved parties to communicate effectively and be heard by other parties	Enable, encourage, and/or empower involved parties to demonstrate integrity in words and deeds	Clarifying viable options, affirming moral sentiments ("This is a tough case"), and offering an ethical explanation for a clinical decision that is within the range of ethically acceptable alternatives (such an explanation may be done orally in a direct communication with the decision-maker/stakeholder(s) and / or documented in the consultation note in the medical record.

Concluding Remarks

Effective teachers help learners to gain knowledge or skill, but a coach – generally speaking – is one who empowers individuals to improve performance. Coaching is an interpersonal enterprise that emphasizes relationships and not merely tasks. Good coaches seize rich opportunities or 'teachable moments' for knowledge application, musing, and practice toward gaining expertise. Richard Byyny writes, "coaching holds that no matter how well prepared people are after their education and training, few can achieve and maintain their best performance on their own. Most people continue to practice what they are already good at, but need an outside perspective to learn how to continue to improve."[23]

Clinical ethics consultation as coaching involves a natural blend of educational and consultative activities. It complements proactive and interactive engagement of ethicists in addressing ethical issues in care delivery. Our understanding of coaching is rooted in integrity, such that it helps health professionals achieve excellence in their practices. This is possible in part because coaching organically connects the cognitive and emotional dimensions of the therapeutic relationships. This organic connection is compatible with both juridical and feminist approaches to normative thinking. We anchor our implementation of coaching in a concept of integrity[24] as the formational focus of health professions and thus the correlative ethical components to each profession's competencies or competency domains. That is, ethics coaching helps health professionals achieve excellence in their practices relative to their discipline or role in care delivery. Lastly, in our experience, coaching organically connects the cognitive and emotional dimensions of therapeutic relationships, and as such it is compatible with both juridical and feminist paradigms in normative thinking.[25]

Our effort to describe ethics consultation as coaching leaves many questions. Although we have articulated competencies for coaching that refine the ASBH core competencies, we leave open the question of whether there is overall synergy between ASBH's core competencies and our own. How compatible are the two? Also, this leaves the question of whether this fits with the quality attestation and other frameworks under development for the purpose of demonstrating the quality of consultation services? Does ethics consultation as coaching require a more skilled ethics consultant – even a professionally-trained ethicist? Finally, as in our framing of coaching and the connection between an ethics consult and care delivery, is there appropriate linkage and integration to quality improvement initiatives in care delivery systems? To answer these, and more questions, we welcome the dialogue of our colleagues.

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practicing ethics consultation at our shared practice setting.

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[1] John Tuohey and Nicholas Kockler, "Aconselhamento ou "coaching"? A consultoria ética no contexto da pós-graduação em educação médica [Counseling or "coaching"? The advice ethics in the context of graduate medical education]", in *Ética e Bioética Clínica no Pluralismo e Diversidade: teorias, experiências e perspectivas*, Proceedings from the 8th International Conference on Clinical Ethics Consultation (São Paulo, Brasil), May 2012. See also, American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd edition (Glenview, IL: ASBH, 2011).

[2] In our setting, three full-time ethicists provide ethics consultation; this is in contrast to a committee- or team-based provision of that service.

[3] We intentionally use the term *mode* to acknowledge that ethicists may use some terms interchangeably like "approach" or "model" or "method." We take an *approach* to ethics consultation as that which describes the role of the ethicist vis-à-vis competing metaethical commitments and so-called moral authority (note: ASBH identifies three principal approaches: consensus, ethics facilitation, and authoritarian, see 6-8). We take *model* to mean what James Walter describes as a disclosure model of ethical or theological inquiry (see James J. Walter, "Horizon Analysis and Moral Stance: An Interpretation of Cardinal Bernardin's 'Consistent Ethic of Life'," in *Contemporary Issues in Bioethics: A Catholic Perspective*, eds. James J. Walter and Thomas A. Shannon (Lanham, MD: Rowman & Littlefield, 2005), 33-48). By *method* we have in mind a particular *normative methodology* that may be evoked in any given model. According to Henry Sidgwick, a moral method is a rational procedure used to arrive at, or discover, a moral position. See James F. Childress, "Methods in Bioethics" in *The Oxford Handbook of Bioethics*, ed. Bonnie Steinbock (New York, NY: Oxford University Press, 2009), 15-45, especially p. 15-16.

[4] ASBH 2011, 2. The ASBH definition of health care ethics consultation reflects these dual goals when it refers to uncertainty or conflict about value laden issues.

[5] ASBH 2011, 19-33.

[6] J.P. Orlowski, et al., "Why Doctors Use or Do Not Use Ethics Consultation," *Journal of Medical Ethics*, 2006, 32:499-502.

[7] Susan E. Kelly, et al., "Understanding the Practice of Ethics Consultation: Results of an Ethnographic Multi-Site Study," *Journal of Clinical Ethics*, Summer 1997, 8 (2): 136-149.

[8] ASBH 2011, 3.

[9] Mark E. Thibodeaux, *God's Voice Within: The Ignatian Way to Discover God's Will* (Chicago, IL: Loyola Press, 2010).

[10] Richard M. Gula, *Reason Informed by Faith: Foundations of Catholic Morality* (Mahwah, NJ: Paulist Press, 1989), 315.

[11] Richard A. McCormick, *The Critical Calling: Moral Reflections on Moral Dilemmas Since Vatican II* (Washington, DC: Georgetown University Press, 2006), 353-367, especially 355-359.

[12] By moral distress we mean an emotionally distressing phenomenon or set of circumstances that puts one's integrity at risk. See Elizabeth Gingell Epstein and Ann Baile Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *Journal of Clinical Ethics*, Winter 2009, 20 (4): 330-341.

[13] Any threat, barrier, or temptation that hinders one's ability to fulfill her moral obligations.

[14] Kelly et al., 1997.

[15] ASBH, 22-33.

[16] In many ways, this is a type of uncertainty. The particular character of ambiguity or uncertainty here may be reflected in the stage of moral development or how adequately a stakeholder's conscience is formed. This is potentially an interesting area for further exploration.

[17] ASBH, 25.

[18] Nicholas Kockler, John Tuohey, and Marian Hodges, "Ethical Decision-Making for Patients

with Diminished Capacity," Paper Presentation, American Society for Bioethics and Humanities Annual Conference, San Diego, CA, October 2014.

[19] Patricia A. Marshall and Barbara A. Koenig, "Ethnographic Methods" in *Methods in Medical Ethics*, 2nd edition, eds. Jeremy Sugarman and Daniel P. Sulmasy (Washington, DC: Georgetown University Press, 2010), 215-231.

[20] See Jodi Halpern, "Empathy and Patient–Physician Conflicts," *Journal of General Internal Medicine*, May 2007, 22(5):696-700; and ibid., "What is Clinical Empathy?" *Journal of General Internal Medicine*, August 2003, 18(8);670-674.

[21] Bert Molewijk, et al., "The Role of Emotions in Moral Case Deliberation: Theory, Practice, and Methodology," *Bioethics*, September 2011, 25(7):383-393.

[22] Richard L. Byyny, "Mentoring and coaching in medicine," *Pharos*, Winter 2012, 1-3.

[23] Laura L. Nash, Good Intentions Aside: A Manager's Guide to Resolving Ethical Problems (Boston, MA: Harvard Business School Press, 1993).

[24] Joan Tronto, "Responsibility and Authority: Multiple Perspectives on Clinical Ethics," Public Lecture, 7th International Conference on Clinical Ethics Consultation, Amsterdam, Netherlands, May 18, 2011. Professor Tronto provided an insightful exploration of traditional "juridical" paradigms in ethics and contrasted them to feminist and relational paradigms.