

The Making of a Clinical Ethicist: Reviewing the Big Questions

In Era of Lay Leadership, Catholic Moral Tradition Must Be Protected



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With the declining presence of members of sponsoring religious orders, providing ethics resources to clinicians has become one of the many challenges facing Catholic health care. Sponsors were generally charged with all issues related to mission, including questions of medical ethics. Now, Catholic health care faces the same need as secular institutions: to provide ethics expertise in a competent and professional manner. Catholic facilities must further ensure that their designated resource persons appreciate the richness of the Catholic moral tradition and provide consultation consistent with these norms.

There is good news.

The professionalization of the discipline of clinical ethics has been evolving in an orderly manner in the United States, informed most notably by the expertise of members of the American Society for Bioethics and Humanities. Catholic academic health science centers have done their part by taking up the challenge of providing high-quality graduate training in clinical bioethics informed and enriched by the Catholic tradition. These programs are striving to meet the needs of Catholic health care by providing content in user-friendly formats tailored to the health care professionals whom they serve.

Below are our reflections on six major questions related to training, education and certification of ethicists:

1 HOW SHOULD ETHICISTS BE TRAINED?

Perhaps the first thing that strikes those of us

who have been around for a while is the deliberateness of the question. For many years, people who became clinical ethicists received various kinds of training, most often in graduate theology programs, before they ever thought about working as hospital ethicists. Thus, what was standard training may have been a *de facto* standard rather than a standard by design.

A variety of factors in the 1980s and 1990s led to increased demand by health care facilities for on-site and system-wide experts in ethics. High-profile cases involving the role of technology in health care challenged many clinicians and led to demands that hospitals demonstrate an ability to respond by meeting accreditation and regulatory requirements. Catholic health care facilities were further challenged to respond to such issues in light of Catholic social teaching, an area that called for still more subtle understandings.

Hospitals tried to fill these needs for expertise in a variety of ways, either by creating full-time positions devoted to ethics, or by asking employees to assume responsibility for making sure appropriate resources, such as ethics committees, were available. It is clear that Catholic hospitals and health systems generally led the way in the creation of full-time positions and have come to view availability of ethics resources as a major factor in their identity.

What is probably most important to note in this folk history is the contrasting skill sets brought to the ethics enterprise by full-time and part-time ethicists. Those hired as full-time clinical ethicists brought a good deal of theoretical knowledge, but were unlikely to be immersed in the culture and norms of clinical medicine. Their part-time counterparts were usually clinical professionals who needed to procure expertise in academic aspects of the developing field of bioethics, such as ethical theory. Each type of person need-

ed to find appropriate resources, though initially each found few places to turn.

2 WHAT EDUCATIONAL OPPORTUNITIES HAVE EVOLVED?

In many ways, a field of endeavor is invented by its first practitioners, who must begin without direct training, because none exists. In the case of bioethics, not only was the field invented by its early practitioners, the training programs have also been developed largely in response to their needs. For example, the master's degree in bioethics (a.k.a. health care ethics) was developed and has become the gold standard for training hospital ethicists, though programs offering the degree have undergone much evolution during the past 20 years.

The first generation of graduate degrees in bioethics began in such traditional humanities departments as philosophy or theology. These programs typically involved two or three newly created courses in bioethics, with the remainder drawn from standard department offerings. The model had several strengths and weaknesses. Clinicians in need of a theoretical background in ethics received copious amounts of theoretical, historical and analytical content. Readings would often focus on the writings of notable philosophers, such as Aristotle, Kant and Mill. The problem was that the programs stressed theory at the expense of application, and often lacked direct relevance to the work of ethicists in clinical settings.

The rapidly evolving landscape of bioethics during the past two decades has seen a proliferation of academic bioethics centers, many of them on the campuses of academic health science centers. Increasingly, these centers became the academic homes of bioethics degree programs. Many were able to create their own courses *de novo*, with the result that their degree programs offered courses of particular relevance to the work of ethicists. They were able to consider the full array of educational needs of ethicists and potential ethicists with a variety of backgrounds and training.

Many programs have continued to evolve to meet the needs of mid-career clinicians who are assuming more responsibility for serving their hospitals' ethics needs. The limitations of time and distance that constrict busy professionals have led to several online programs culminating in a master of arts. The Medical College of Wisconsin rolled out a primarily online master's degree in 1998 that provides bioethics training

from a secular perspective. At Loyola University Chicago Stritch School of Medicine, we developed an online master's program that can be taken entirely online, but allows the option of several intensive on-campus courses during summer sessions. Our program offers significant training in the Roman Catholic moral tradition.

3 WHAT IS THE CURRENT CONTENT OF GRADUATE ETHICAL TRAINING?

Graduate bioethics programs have increasingly designed their offerings based on the needs of their students and informed by recommendations from professional organizations, such as the American Society for Bioethics and Humanities. The society noted in its 1998 report, *Core Competencies for Health Care Ethics Consultation*, that ethicists need a good deal of cognitive knowledge in addition to process skills.

The knowledge content includes familiarity with ethical concepts, moral theories and moral reasoning, as well as relevant knowledge of health law and professional codes. In addition, knowledge should include familiarity with health systems, professional codes and an understanding of particular factors, such as the institutional policies, and the perspectives and beliefs of the local patient population and institutional staff.

Presumably, knowledge important to a Catholic institution such as the United States Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* is included in this category. Process skills typically include the ability to oversee and perform clinical consultations, from gathering information through running a family-staff meeting to charting recommendations. Masters degree programs have tended to place greater emphasis on knowledge elements than on process skills. This may be for the obvious reason that people running these programs are often academics who may prefer teaching bioethics content to teaching process skills.

Recognizing that knowledge and enculturation in the clinical setting is an important aspect of an ethicist's training, some master's programs, such as that of the University of Pittsburgh, have created clinical practice courses that provide a mentored immersion experience in the clinical setting. This kind of experience is particularly useful to students who come from traditional humanities backgrounds. In general, though, the teaching of process skills related to ethics consultation, like the pedagogy related to teaching those skills, has

OF NOTE

Included with this article are reflections by two medical students at the Loyola Stritch School of Medicine who are concurrently pursuing degrees in bioethics and medical policy at the Neiswanger Institute for Bioethics and Health Policy. See following pages.

The Making of a Clinical Ethicist: Reviewing the Big Questions

remained somewhat haphazard.

At Loyola University Chicago Stritch School of Medicine, we have pioneered a course that teaches process skills by simulating ethics case consultations. We use actors to play family members and physicians while students adopt the role of the ethics consultant conducting the case conference. Students are videotaped and given feedback by colleagues and faculty. This enables the students to gain hands-on experience in facilitating and mediating the kinds of interpersonal conflicts that occur. Because there are few other good options to teaching these skills, we believe such simulation courses to be the wave of the future.

Another highly desirable method is to have an ethicist in training shadow an experienced ethics consultant, but most hospital ethics consultation services have too low a volume of consultations for this to serve more than a handful of students each year.

4 WHAT TRAINING FOR CATHOLIC ETHICISTS IS REQUIRED?

Ethicists at Catholic institutions in the United States clearly should be familiar with the *Ethical and Religious Directives for Catholic Health Care Services*. Men and women educated at secular institutions will need to acquire this familiari-

ty. The directives are clearly written and easy to understand, especially for people with graduate training in bioethics. Additional training to assist with application and interpretation can be gained in a number of ways, including attendance at annual conferences designed for this purpose. Such conferences are offered by the Gateway Catholic Ethics Network, the Catholic Health Association, and the Loyola Stritch School of Medicine. Typically, these conferences include sessions that help participants understand the basic concepts in the directives and apply them to current challenges.

Perhaps as important as the conceptual training at these events is the networking that takes place. Application of Catholic teaching to clinical situations cannot be done effectively in isolation. It requires dialoguing with others so as to discern developing standards of interpretation. This discernment is a community activity, making it important that ethicists become a part of the national network of those engaged in this task. (The work of the Catholic Health Association in fostering this kind of dialogue has been invaluable.)

Skill in interpretation of Roman Catholic social and moral teaching can be enhanced through additional formal training. Graduate programs in

ETHICS: COMMITTING TO PATIENT CARE AND SOCIAL JUSTICE



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As a student trying to navigate the all-too-often daunting waters of medical education and patient care in our society, medical ethics has been something of a steady hand at the wheel. With the increasing complexity of human disease and medical technology, and the ever-broadening options for treatment, ethics can play an integral role in reorienting ourselves and our decision-making.

During the past two years that I have been a part of the master's program at the Neiswanger Institute for Bioethics and Health Policy, I have been able to find an intellectual grounding for the amorphous intimations I have long had about what it means to live and act morally, not only in the medical profession, but also in my personal life.

My first course in the program focused on the basic principles that guide bioethics: beneficence, non-maleficence, justice and respect for autonomy. With these principles kept close at hand, I have been able to approach the clinical responsibilities of my third-year rotations well-equipped for the challenge. Thus, a patient on a particular medical service becomes more than a puzzle to be solved and a disease to be treated.

These principles echoing in my mind, I am constantly compelled to delve deeper, to ask myself the following:

- Is our treatment goal in line with the personal goals of this patient?
- Do our plans live up to the standards set by medical ethics?
- At the end of the day, can I go home and feel as if I have done justice to, and truly respected, this patient's personhood?

Although the task is often quite demanding, and the more logistical-clerical business of the day may win out, I am called back to these questions. They never lose their weight.

At Loyola, I have been lucky to be surrounded by many like-minded individuals.

bioethics or health care ethics sponsored by Catholic universities such as Loyola Marymount University, Saint Louis University and Duquesne University all offer substantive course work in Catholic social teaching as it relates to health care. Similarly, our Master of Arts program at Loyola Stritch School of Medicine offers a concentration in Catholic health care ethics that involves completion of three graduate courses devoted specifically to Roman Catholic thought. These programs are based on the idea that a deeper and broader understanding of the foundations and context of Catholic thought enrich an ethicist's ability to analyze ethical issues.

Because leaders of Catholic health care facilities have a rich understanding of the relation of clinical ethics to institutional mission, ethicists at these institutions need both depth of knowledge and commitment. Clinical dilemmas can sometimes evidence ethical conflicts related to "margin versus mission," cultural sensitivities, health care disparities, and other issues that point to larger social obligations of Catholic health care. As a result, it can be useful to develop facility in understanding and interpreting the relationship of institutional charity care policies to the "preferential option for the poor" called for in Catholic teaching. Also needed is an ability to use

tools to analyze problems afflicting particular populations, along with a variety of other business and public health skills. To meet the broadening demands, graduate programs in bioethics are increasingly attending to the evolving training that Catholic health care leaders need, such as organizational ethics, health policy and public health.

5 IS CERTIFICATION AT HAND?

Because the work of an ethicist fits so comfortably with the mission of Catholic health care, it is easy to forget that ethicists hold relatively new positions. Most have been created within the past 25 years. Bioethics has been similar to many professions in that the process of creating standards for education, practice and, certification has been a contentious one. While this period is not yet over, we can outline a likely direction for the future.

It is clear that some kind of certification standards are in the offing. One reason is that academics in health care ethics have a strong desire to help groups that review the performance of health care institutions, such as the Joint Commission on the Accreditation of Healthcare Organizations, to determine when hospitals are providing competent ethics resources. The ques-

Actually, what drew me to Loyola's Stritch School of Medicine was the resounding emphasis on caring for the whole patient, physically, emotionally and spiritually. I can still vividly remember the night before my interview when I was reading anything and everything I could find on the school's website. I seemed to keep coming back to this same motto "we also treat the human spirit."

From the curriculum to the student groups, the prevailing idea was that a career in medicine was a commitment to a life of service. It was a moment of clarity. I saw that my own goals were closely aligned with those of Loyola. I chose Loyola because I knew that I would be able to learn what it truly means to be a good physician, not just a good clinician.

From my past experience in Catholic education (and yes, I am the product of Catholic grade school, high school *and* college) I knew that the strong Jesuit tradition at Stritch would ensure that I continued to develop as an individual, and that my end-goal of working with underserved patients would be fostered and encouraged. The training that I have received has been exceptional, and all the more so because of the constant undercurrent of respect for human dignity that pervades our lessons.

In the future, when I finish my residency, the choice of where to practice will be guided by the same desires that guided my choice of medical school. Aside from a commitment to providing quality medical care, I need to know that the hospital/clinic is also committed to meeting

the more esoteric needs of our patients, and meets these needs in a way that is respectful of their humanity. It will be a comfort to know that the question will not be whether or not to treat the uninsured patients, but how to best treat them and how to ensure their health in the future.

The commitment to social justice and respect for human dignity that comes with practicing medicine in a Catholic institution has unrivaled appeal, and it is this commitment that has made me who I am today and has kept me coming back to Catholic education for more than 18 years. ■

The Making of a Clinical Ethicist: Reviewing the Big Questions

tion experts in the field must answer concerns whether certification will be primarily based on testing what an individual ethicist knows and is able to do, or about certifying graduate programs that provide the appropriate kinds of training, or both.

General agreement among academics and ethics professionals on minimal standards for what ethicists should know and be able to do is the *sine qua non* of professionalization, i.e., articulating the body of knowledge and the skills that define the profession. As we noted, the American Society for Bioethics and Humanities took a large step forward with the publication of the *Core Competencies for Health Care Ethics Consultation*, soon to be released in a revised edition. In addition, the society is about to release an important publication called *Improving Competence in Clinical Ethics Consultation: A Learner's Guide*. This guide sets forth approaches to acquiring the core competencies and lists a

large number of resource materials to aid the effort, making it at least theoretically possible to create a written, oral and/or performance test.

The strength of such a guide lies in the recognition that people come to bioethics from a broad variety of backgrounds and supplement their training in various ways. This pluralism of training could be preserved if everyone were required to pass the same test. Nevertheless, creation of a valid and reliable testing instrument is a sophisticated exercise, one that is unlikely to be adequately developed in the near future.

Certifying the type of training aspiring ethicists should complete seems to be more promising in the near term. As we noted earlier, the *de facto* training standard seems to be a master's degree in health care ethics or bioethics. Relatedly, some ethicists who acquired doctorate in traditional philosophy or theology programs may have a concentration in bioethics. In addition, there are a few doctoral programs that provide degrees

ETHICS: A BRIDGE BETWEEN RELIGION AND MEDICINE

**BY MARK STOLTENBERG**

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I started college as both a pre-medical student and a religion major. It did not take me long to realize the differences in these worlds. In my religion classes, we were constantly asking "if" and "why." In my pre-med classes, it was "what" and "how." Eventually, though, I actually began to like bouncing back and forth between the two types of courses. Some days, it got really tiring to go round and round with amorphous thoughts about questions that we could probably never know the answers to. But, at the same time, after spending several hours weighing powders in

chemistry lab and learning yet another set of enzymes in biology, I would long for ideas and essay questions that actually had some bearing on how we live our lives.

However, while I was thoroughly enjoying both of these two disparate worlds, they were still mostly functioning, as separate, independent parts of my life. It was only after I took a course in general ethics that I could imagine the two coming together, and another year and a half after that before my career goals and personal interests truly began to hybridize. The course titled "Religion, Medicine and Suffering" was taught by a professor with an appointment in both the religion department and the medical school. I was sold immediately. Ever since taking that course I have never looked back, and each step of the way I have found more and more of my vocation resting within the space between religion and medicine.

I think what I like most about the exchange between religion and

medicine is the way they seem to correct each other. In my experience, religion sometimes has a tendency to float into the clouds, getting lost in surreal concepts and idealized constructs. As for medicine, I think it can have the opposite tendency. In the midst of staving off death and fighting suffering day after day, it can be easy to forget what we are doing and why we are doing it.

My most vivid witnessing of these differences occurred many years ago. I was 13 at the time and volunteering at a children's hospital. One evening, I spent most of my shift with a boy just six months younger than myself who had a severe mental disability. He would often struggle when trying to express himself, and after a few minutes of visible frustration, he would often stare out the window quietly, appearing lonely and defeated. As I got to know him during the course of a few weeks, I had a lot of trouble making sense of his situation and understanding why he had to suffer. I spoke with a priest, who calmly reminded me that we needed to trust in God's

based on work entirely in bioethics or health care ethics (Saint Louis University and Duquesne University are notable for such offerings.) If a panel of expert reviewers were easily able to ascertain that a particular master's or doctoral program offered appropriate training to produce competent ethicists, the standard for hospitals would then be to show it offered ethics consultation from an ethicist who graduated from a certified program.

6 WHICH DEGREE WILL BECOME THE STANDARD?

A master's program in bioethics usually offers a candidate at least 10 courses in the field. This is typically more than sufficient background to enable a person to function in a clinical setting as an ethicist. This is especially true of persons who hold additional graduate or professional degrees in health care related fields and if these persons have the ongoing support of networking with other ethicists and the resources available

through the Catholic Health Association. However, additional considerations make the doctoral degree desirable. In particular, additional training beyond the master's may enable ethicists to contribute to a national dialogue on important questions. Recall that we noted that even relatively clear ethical documents, such as the *Ethical and Religious Directives for Catholic Health Care Services*, require nuanced understanding and interpretation in light of the Catholic tradition and new and subtle developments in clinical medicine, medical technology, and systems of health care delivery.

We should not be hasty in assuming that a person with a master's degree in bioethics is incapable of such contributions. After all, our graduates sometimes publish articles in the bioethics literature (See www.bioethics.lumc.edu/online_masters/student_publications.html). However, little doubt exists that additional academic training, especially training that provides

plan. I did not like this answer. As for the nurses and doctors, their primary (and sometimes only) concern seemed to be my friend's blood count results and the dosing rate of his IV.

Now, don't get me wrong. The concept of God's plan is an immensely important one, and surely it was a good thing that someone was monitoring my friend's infection. However, I couldn't help but feel that something was missing. We should be able to offer a better explanation. We should be capable of something more.

Though I am still young (and admittedly naive both theologically and medically) I think the answer I was seeking might lie in a bridge between religion and medicine. By bringing the two together, as ethics does, I believe those of us who work in medicine are better held in balance and forced to be more honest. We are better able to stay grounded in the realities of the present while still keeping our eyes focused on the way the world could one day be.

The motivation provided by a belief

that we are a part of God's plan can give us strength to face death and dying year after year, while a genuine engagement with the sick can remind us that at the bedside, what is often needed most is not answers and explanations, but presence and relationship.

This, of course, is not always easy. In most situations, it can actually be quite difficult to find the balance between naive idealism and cold cynicism. Though a Christian perspective and a standard medical perspective can often be congruent (when a patient comes in with a broken wrist, it's pretty clear both medically and theologically that a cast is the most appropriate course of action), at other times there can appear to be a genuine discrepancy between them. What makes it so hard to bring the two together at these times is that our differences are found not so much in *what* we value, but rather in *what order* we put those values.

The recognition that isolation can cause as much suffering as physical pain, and that we need always to remember to care through our curing, is

held in common by most in the medical field. But, it is with a Christian emphasis that these ideals are heightened, reminding us to offer presence and prayer in response to our patient's loneliness and to learn to care most when we are no longer able to cure.

It is because of all of this that I chose both to attend a Jesuit institution for medical school and to concurrently get my master's degree in bioethics. I had seen the incredible synergy that happens when religion and medicine are forced to answer each other through the language of ethics, and I wanted to continue to learn from this relationship. I had seen how challenging it could be to find the right path when the difference between being inexperienced and cold, or realistic, was often times so subtle, and I wanted to be with people who would help train me to see the difference.

Though they may seem small, it is within these subtleties that I have found not only a response to the suffering of my childhood friend, but also the seeds of my vocation. ■

The Making of a Clinical Ethicist: Reviewing the Big Questions

rigorous mentorship in research and publication skills, can increase the ability of persons to contribute at a national level.

We believe the future is likely to see the proliferation of professional doctorate programs that, similar to those in pharmacy and psychology, are geared specifically to bioethics. Although it is a somewhat artificial distinction, professional doctorates are sometimes described as degrees for clinical practitioners, in contrast to traditional Ph.D. programs, which are usually described as research degrees for academics. (Duquesne University, for instance, offers a Doctor of Health Care Ethics in addition to its Ph.D. program.) Programs offering professional doctorates usually require the same course work as a traditional program, but substitute a project, such as publishing an article in a peer-reviewed journal, for the dissertation.

If a dissertation prepares men and women in traditional doctoral programs for one standard of success; that is, book publication, a parallel path in medical ethics would be to direct students toward publication in the bioethics literature. In the academic world of health care, the peer-reviewed article has become the paradigm for reporting research and contributing to the dialogue in the U.S. Catholic community, and is thus the measure of success.

In response to a perceived need, the Loyola faculty is reviewing the possibility of creating an executive-style program, one that embraces significant online components and short on-campus

intensive courses. This would enable ethicists who are presently employed by health care facilities to continue their professional development in a convenient yet rigorous manner and to build relationships with other ethicists throughout the United States, and even abroad. Such an approach goes a long way in cultivating a robust, engaged and thoughtful community of ethicists.

CONCLUSION

Catholic health care continues to face myriad challenges as it transitions to a period dominated by lay leadership. But so much is positive about the way the laity has been stepping up to meet those challenges. We have recounted how this has been particularly trying in the area of clinical ethics. As health care professionals have sought to gain the expertise needed to provide clinical ethics consultation, bioethics centers at Catholic medical schools and universities have become innovators in offering the kinds of training needed. Challenges remain as we seek ways to foster an expanding array of on-the-ground leadership skills as well as the scholarly ability to contribute to the ongoing national dialogue on the application of Catholic teaching to new clinical quandaries. Judging from recent successes, the future is promising. ■



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