The Role of Communication and Interpersonal Skills in Clinical Ethics Consultation: The Need for a Competency in Advanced Ethics Facilitation

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ABSTRACT

Clinical ethics consultants (CECs) often face some of the most difficult communication and interpersonal challenges that occur in hospitals, involving stressed stakeholders who express, with strong emotions, their preferences and concerns in situations of personal crisis and loss. In this article we will give examples of how much of the important work that ethics consultants perform in addressing clinical ethics conflicts is incompletely conceived and explained in the American Society of Bioethics and Humanities *Core Competencies for Healthcare Ethics Consultation* and the clinical ethics literature.

The work to which we refer is best conceptualized as a specialized type of interviewing, in which the emotional barriers of patients and their families or surrogates can be identified and addressed in light of relevant ethical obligations and values within the context of ethics facilitation.

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INTRODUCTION

Clinical ethics consultants (CECs) often face some of the most difficult communication and interpersonal challenges that occur in hospitals, that involve stressed stakeholders who express, with strong emotions, their preferences and concerns in situations of personal crisis and loss. As Ford and Dudzinski write in their book, *Complex Ethics Consultations: Cases that Haunt Us,* "To be effective, consultants invest themselves in the devastating circumstances of others and attempt to assuage suffering by facilitating critical reflection. Emotions and facts are important to the dynamics of ethics consultation."[1] Much of the work done by clinical ethics consultants in performing a consultation requires becoming deeply involved in the cases as a facilitator and in helping the patient—and more often the patient's surrogate—come to terms with the grief and emotional barriers that impede them in making treatment decisions.[2]

There is plenty of evidence to indicate the frequency and relevance of such concerns. A number

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of authors have examined the emotional and moral distress that surrogates and family members experience when they face difficult end-of-life decisions, particularly in the intensive care unit (ICU), which may often result in mental health problems such as anxiety and depression. A survey of 920 family members of ICU patients found that more than two-thirds suffered from anxiety and depression significant enough to potentially affect their capacity to make decisions.[3] Recent research suggests that more than 80 percent of patients' family members who are involved in making decisions for a patient who eventually died in the ICU had a post-traumatic stress type of reaction.[4]

Other empirical studies have found that poor communication skills and a lack of empathy from physicians, particularly in family meetings, can amplify traumatic circumstances and intensify surrogates' psychological disturbance. Curtis and colleagues studied family conferences to identify missed communication and interpersonal opportunities to discuss critically ill intensive-care patients. These missed opportunities fell into three primary categories. The first deficit they identified was not listening and responding to family members. The second lapse was to not acknowledge and address emotions. The third was not pursuing chances to explain key principles of medical ethics and palliative care.[5] The most commonly missed opportunities involved the lack of empathic listening and responsiveness—the psychotherapeutic aspects of clinical ethics facilitation that are necessary to help resolve ethical issues and thereby prevent or lessen the psychosocial burdens that surrogates and family members bear.

These studies support our contention that, in many ethics consultations, strong emotional barriers are present that must often be overcome before value conflicts can be analyzed and resolved. We conjecture that what makes an ethics consultation occasionally "haunt us" is less that the consultant lacked the applicable ethics knowledge, or even adequate process skills to handle the ethical issues, but more that the consultant lacked the ability to deploy the advanced facilitation competencies needed to recognize and manage psychological reactions and coping patterns that interfere with the ability of surrogates to make reasoned choices.

It is concerning that among all of the health professions—nurses, chaplains, and physicians—involved in the care of patients with life-limiting illness and their distraught families and surrogates, ethics consultants alone are not required to receive any clinical training in basic counseling concepts and skills such as active listening, open-ended questioning, empathy, and reflection—among others. Increasingly, the accrediting organizations of the major care professions have established interpersonal and communication skills and professionalism as core competencies that every trainee must satisfactorily demonstrate to graduate from a training program.[6]

It seems self-evident that similar clinical education should not only be available, but be required in ethics consultation training. Curricula should be developed that utilize the evidence-based teaching methods that other healthcare training programs employ to develop these competencies, such as clinical supervision, videotaping and the use of simulated patients, and objective structured clinical examinations to evaluate consultants' ability to relate to patients.[7] While a few innovative clinical ethics programs employ these methods, they should become as foundational as courses in ethical theory and health law are in clinical ethics masters and especially fellowship training.

In this article we will give examples of how much of the important work that ethics consultants perform in addressing clinical ethics conflict is incompletely conceived and explained in the second edition of the American Society for Bioethics and Humanities Task Force's *Core Competencies for Healthcare Ethics Consultation* (hereafter, the ASBH *Core Competencies*)[8] and the clinical ethics literature. The work to which we refer is best conceptualized as a specialized type of interviewing, in which the emotional barriers of patients and families—or surrogates—can be identified and addressed in light of relevant ethical obligations and values within the context of ethics facilitation. Although the ethics consultant need not delve deeply into the precise nature or origin of these psychological barriers, having the advanced skills that are needed to recognize and appreciate the general features of the psychosocial dynamics and coping patterns in particular cases enhances a consultant's ability to manage discussions with greater compassion and insight.

As a way to describe the general outlines of these emotional barriers, we will develop and analyze three model case scenarios. One case involves interactions with patients who have decision-making capacity; two cases involve interactions with surrogates who are acting for patients who lack decision-making capacity. In these cases, we will summarize how specific, advanced ethics facilitation skills and strategies that are based in behavioral health approaches can be employed to help CECs interact helpfully with individuals who are expressing strong

emotions in these situations. Finally, we will describe how our analyses of these cases clarify our conception of advance facilitation in clinical ethics consultation. As a first step, it is necessary to describe more clearly how intertwined values and emotions are in expressing a clinical ethics dilemma.

CLINICAL ETHICAL DILEMMAS AS EXPRESSIONS OF VALUES AND EMOTIONS

A pluralistic setting, of diverse values and moral conflict that are expressed through strong emotional reactions, is a basic feature of contemporary healthcare in the United States. As John Lantos observes, in relation to a difficult ethics case from the neonatal intensive care unit (NICU), "everyone started with a moral intuition, a gut feeling, a sense of what was right and wrong."[9] Although Lantos was referring to the divergence of moral views of healthcare workers, the same is true of all of the participants in a clinical ethics case. Rarely do disputants in a moral conflict have a change of heart or mind by hearing opposing moral positions and arguments.[10]

With no universal basis of moral authority to which to appeal for substantive moral answers,[11] caregivers and patients and their surrogates are left with the tools of communication and negotiation to find common ground in defining treatment goals and making appropriate decisions in individual cases, in light of well-established ethical and legal principles. Such tools reflect both the rise of democratic pluralism and the need for ethics facilitation as the most appropriate approach to ethics consultation,[12] which has been defined as the process skill that helps to resolve "value uncertainty and conflict."[13]

Yet we believe the description of ethics facilitation, as presented in the current professional literature and the ASBH *Core Competencies,* fails to fully capture much of the nature of the interpersonal competencies that are required to deal with the emotional responses at the level of "advanced ethics facilitation."[14] It is not enough to simply understand the process of facilitation; an ethics consultant at the advanced level must possess advanced interpersonal skills in order to engage participants and perform the work of facilitation. Clinical ethics must be seen as an active engagement in patient care by the CEC who performs the work of facilitation in "an interpretive interaction with others in the case."[15]

The specific skills that are most relevant to the focus of this article—that is, addressing the emotional reaction related to a value position in an ethical conflict—are listed under "Interpersonal Skills" in the ASBH *Core Competencies,* and include "listening," "clarifying values," "facilitating understanding of factual information," "identifying and supporting the decision maker," and/or "applying mediation or conflict resolution techniques."[16] Missing from this list is any mention of the core consultation skills that are used to discern and understand, in any depth, the basic psychosocial processes and coping patterns involved in the "doing" of clinical ethics consultations, namely, providing support for and constructively interacting with stressed and distressed participants in the common types of clinical ethics conflicts that involve patients, and more often their families and surrogates, who struggle to make an emotionally difficult, value-laden decision on behalf of the patient.

The emotional difficulty these individuals experience may relate to their perceived personal shortcomings, failed family expectations, troubled relationships, and a myriad of family-system dysfunctions and other emotional influences. In these situations, a CEC must facilitate a decision-making process in which the values and emotions that are expressed are intertwined such that an ethical decision cannot be made apart from, and often not until, the participants' emotional responses to the situation have been given an opportunity to be expressed in active interpersonal interaction. This basic feature of clinical ethics consultation receives no focused attention in the ASBH *Core Competencies,* and, at best, remains implicit and undeveloped in the clinical ethics literature.

For example, Tarzian and colleagues, in an important update on the *Core Competencies,* cite three articles to demonstrate how a distinction between basic and advanced skills means that some ethics consultations "require more expertise in one domain or another."[17] The first article cited by Tarzian and colleagues, written by Autumn Feister, describes the use of an overly simplified approach to ethical problem solving that Feister calls the "principlist paradigm." This paradigm provides only a partial grasp of the ethical issues before a normative assessment is made and a recommendation is presumptively formulated, based on a "set of reductive ethical concerns."[18]

In the case provided by Feister, a young patient who has strong feelings of powerlessness and a sense of being wronged refuses to consent to a have a central venous catheter. The catheter is necessary to provide a lifesaving blood transfusion, that follows several botched attempts to place an intravenous angiocath peripherally. The reductionistic, simplistic ethical answer the ethics consultant gives is that

this patient's autonomy cannot be violated, and he has a right to refuse treatment. Of course that is true. But a CEC who has advanced ethics facilitation skills would attempt to get to the core of the conflict. Instead of simply trying to cajole and convince this patient to consent, the CEC would execute something like what Feister recommends, which includes apologizing for the failed attempts, acknowledging the patient's pain, and trying make amends.

But Feister's thoughtful recommendations are stated in terms of knowledge and process skills only. It is not enough to know what to *do.* The clinical caregiver, whether a CEC or a physician, must be able to know why these recommendations make sense as ways to address a strong emotional reaction and facilitate a beneficial outcome in an interpersonal interaction with the patient. This interaction would be necessary to bring to light the patient's strong emotional reaction, which is a barrier to his accepting lifesaving treatment. If done successfully, advanced ethics facilitation may allow the patient to pursue what seems to be his genuine goal, which is to get better and live. In contrast, when approached from the vantage point of the principlist paradigm, without adequate advanced ethics facilitation, the patient will likely die because of a superficial application of respect for his autonomy. This whole level of skill analysis in discussing advanced ethics facilitation is at best implicit, even in this sophisticated article.

The second example cited by Tarzian and colleagues is from a article by David Adams, which involves a 70-year-old patient who suffered a brain stem infarct following a coronary bypass graft (CABGx6). The thrust of the article is to show how ethics facilitation failed to adequately resolve the conflict between the physician and the medical team, who want to continue treatment, and the patient's family members, who are convinced the patient would not want to be on life supports and endure a diminished quality of life. The author, who was the ethics consultant called to consult on the case, focuses on the lack of defined constraints that would clarify how to balance the competing claims. Yet it is on this basis that Adams claims that the ethics facilitation process failed, and he resorted to encouraging the family to agree to a court-appointed conservator.

But, at the same time, astonishingly, Adams states, "No real effort was made to conduct a meaningful dialogue among the involved parties."[19] Clearly, Adams does not view ethics facilitation as involving a CEC who directly engages the participants in discussion in order to clarify more fully the medical facts of the case, particularly the patient's prognosis, and how they fit with the known wishes of the patient. This is a competency that we would consider basic for a CEC.

Tellingly, the case ended when a wiser physician, who was covering for the physician in charge while he was on holiday, held several family meetings and finally respected the request of the family to extubate the patient, allowing the patient to die. In this article there is no mention of the fact that a CEC with advanced ethics facilitation skills—most crucially the developed interpersonal skills of listening to and acknowledging a family's strong emotional concerns and considering them in relation to the patient's medical condition and prognosis—is what is missing in this case. There is no mention of the fact that when these skills were brought to bear by the second physician, a negotiated resolution to the conflict was reached.

The final case that Tarzian and colleagues reference is presented in an article written by Joseph Kaufert and Thomas Koch.[20] These authors discuss a case that is presented by "two clinicians" to an audience that includes disability advocates. The intent of the article was to show how the case of a patient with ALS (amyotrophic lateral sclerosis), who wanted to be withdrawn from mechanical ventilation and die, was successfully handled. After discussions between the two clinicians (presumably at least one of whom was a physician) and the patient, an agreement was reached to respect the patient's wishes.

The disability advocates attending the conference reacted quite negatively, much to the presenters' surprise. The single case narrative failed to convince the audience that the patient's decision to forgo continued life support and die stemmed from a rich and informed dialogue that was "thick" in terms of demonstrating the patient's authentic goals and wishes. Of course, to accomplish this level of narrative, it was necessary for the clinicians to share the particularities, not just of the clinical reality, but also of the nature of their interpersonal encounter with the patient—which they did not do. For that encounter to truly be successfully completed, the skills of advanced ethics facilitation would be essential. The article instead focused on the conceptual aspects of the case narrative, leaving to one side any discussion of the actual interpersonal interaction that would have been necessary to adequately resolve the case.

In all three articles, there were patients and families who required a CEC (or clinician) with advanced communication and interpersonal skills to interact

with the patient or surrogate about their strong emotional state or reaction, in order to process the pertinent ethical issues—getting valid consent to receive lifesaving treatment in the first case, and finding an ethical basis to withdraw lifesaving treatment in the next two cases. In none of these three examples do we see the importance of advance facilitation skills and competencies adequately defined and demonstrated. Rather, these skills and competencies are the subtext of the articles, and what is discussed are the more abstract, intellectual topics related to facilitation, such as the narrow interpretation of principles, moral constraints, and "thick" versus "thin" patient narratives.

Never do the discussions get to what happened—or what should happen—at the "ground zero" clinical level of direct, interpersonal interaction between a CEC or clinician and patient. Thus, the skills necessary to do advanced ethics facilitation do not receive the attention they deserve. A fundamental characteristic of advanced ethics facilitation, which we develop in this article, is that before a CEC or clinician engages a patient or surrogate in a discussion about value-laden conflict related to medical goals and treatment decisions, it is first necessary to interact at a meaningful level with a patient or surrogate about emotional reactions and concerns.

EXPANDING OUR UNDERSTANDING OF WHAT WE DO IN CLINICAL ETHICS CONSULTATION

Although most experienced ethics consultants would readily acknowledge that such fully integrated core skills pertaining to ethics facilitation are essential to perform consultations, we reiterate that, in our judgment, these skills have not been adequately discussed and developed as advanced ethics facilitation skills within the field of clinical ethics education and practice. One possible exception is the work of George Agich on the role of defense mechanisms in ethics consultation, from which we draw in our own formulation.[21] Agich recognized that a hallmark of challenging cases is not infrequently a characteristic psychological dynamic of the individual patient or surrogate, often embedded in a family dysfunction. This dynamic, which Agich refers to as a defense mechanism, may be an emotional barrier that is limiting the individual's ability to see the ethical issues at stake in the present situation.[22]

Part of the barrier to adequately addressing this area of clinical ethics consultation relates to our tradition of modern dualism, which divides the intellectual activity of ethical analysis from the emotional realities to which those analyses relate.[23] The result has been a division between the theoretical and abstract ways of thinking in relation to the core elements of interpersonal and communication skills.[24] In the field of clinical ethics consultation, skills involving knowledge, analytic reasoning, and process are tacitly prioritized over skills relating to interpersonal communication and interaction with human beings who are expressing strong emotions. While the emerging field of clinical ethics consultation debates the need for cognitive certification examinations,[25] there appears to be less concern that the CECs who are currently performing consultations have skills in what we refer to as advanced facilitation. We contend that deficits in these crucial areas of human interaction are much more likely to negatively affect the outcome of an ethics consultation—and even potentially harm the participants—than gaps in knowledge areas that are often emphasized in the education of CECs, such as ethical theory and philosophical argumentation.

Thus, we need an expanded vocabulary and new sensibilities in clinical ethics consultation that better capture all of what we do. It is crucial for CECs to have an appropriate conceptual understanding of how strong emotional responses function in patients, surrogates, families, and careproviders, and how they affect, and sometimes create, a barrier to decision making that can lead to ethical conflict. It is equally crucial for CECs to be competent in using those skills to actively engage participants in a beneficial dialogue in the clinical setting.

CONNECTING BEHAVIORAL HEALTH THEORY TO CLINICAL ETHICS CONSULTATION

For CECs to acquire these interpersonal skills and the required knowledge base, we propose that CECs must first be familiar with the basics of behavioral health theory and psychological constructs in order to enhance and complement the ASBH *Core Competencies*—specifically, to develop advanced-level ethics facilitation skills.

Although it is clear that CECs play a significant role in how participants in ethics consultation process, express, and act on their emotions in relation to ethical decision making, there is much we need to learn about how the core skills related to ethics facilitation are used to help participants deal with their strong emotions in reaching an acceptable ethical resolution. The skills listed in the ASBH *Core Competencies* notwithstanding, the field of clinical ethics consultation needs a robust explication of how these specialized, core communication and interpersonal skills might be attained at an advanced level,

with input from behavioral health approaches and psychological constructs to guide such preparation. Just as academic philosophy shared its tools with healthcare to help establish theoretical frameworks for approaching challenging healthcare dilemmas, we propose that the field of clinical ethics consultation should draw from behavioral health approaches and psychological concepts to develop a more complete theoretical understanding of interpersonal skills in clinical ethics consultation practice.

Common approaches that seem to be the most clearly related to the day-to-day work of clinical ethics consultation include a blend of (1) solution-focused strategies, (2) crisis intervention, and (3) family-systems theory.[26] Each of these selected approaches will now be briefly summarized. These three approaches have been chosen over more well-known types of formal counseling, such as cognitive-behavioral or psychodynamic, for several reasons. First, they do not require an CEC to subscribe to any particular theoretical understanding of human functioning or the origin of psychosocial dysfunction that could potentially distract or distort the fundamental orientation of a CEC as one of facilitation, not therapy.

Second, these approaches do not require the long periods of training and supervision required for the competent practice of cognitive or psychodynamic psychotherapy; as with the other helping professions discussed below, these three approaches could be taught and learned with a reasonable amount of effort and time.

Third, and most importantly, these three approaches include ideas and techniques that are foundational for all of the helping professions; practitioners in these professions are required to master them because they must deal with distressed human beings. The strategies utilized in these approaches are directed toward elucidating and shifting behaviors or dispositions in particular, short-term clinical situations, rather than altering personality structures or patterns of thought over time. The goal of these approaches is to train a CEC to sit compassionately with a distressed individual or family as a supportive presence for the venting of strong emotions, or the telling of past narratives to the extent that they are impeding the ethical decision-making process in the here and now. These are teachable techniques that are essentially mature relational responses, not complicated psychotherapeutic interventions.

Fourth, each of these approaches is patient-centered, as they foster empathic listening, respectful validation, and a generally hopeful orientation, overall. They help those involved to mobilize internal resources and external supports to resolve the dilemma.

We believe that the most successful CECs either have acquired these abilities through one of three ways: (1) other forms of training such as social work or chaplaincy, (2) informal trial and error, or (3) being simply temperamentally adept at interpersonal interaction. It will be instructive now to provide some initial evidence of how these three approaches might apply to typical clinical ethics cases.

TYPES OF CASES WITH STRONG EMOTIONS

Patients With Decision-Making Capacity

Patients who have decision-making capacity may become the center of an ethics case when they do not make decisions in a manner that is consistent with what appears to be their own prior known wishes or best interests. Once patients demonstrate that they have the capacity to make their own healthcare decisions, the principle of respect for patients' autonomy requires that their preferences be honored—in most cases. This is certainly true in the context of a capacitated patient's right to refuse any and all treatment: this negative right to be left alone is perhaps the closest thing there is to an absolute rule in clinical ethics.

But even in these instances, physicians and other caregivers, including CECs, may not disregard their beneficence-based obligations to interact with patients when a treatment is likely to produce what seems to be a beneficial effect. It is possible that, through sustained conversation, a CEC who utilizes the above approaches can move, or even remove, a powerful emotional obstacle that may be blocking a patient from coming to a new realization about the benefits of the proposed treatment.

Case Scenario 1: Asserting the Right to Make an Unsafe Choice

An 85-year-old patient at high risk for falling due to the progression of Parkinson's disease wants to return to her apartment against medical advice. Her strong preference to return home has created an impasse for her care team, who believe it is dangerous for her to continue to live alone. She has the option of going either to a long-term care facility or of moving in with her adult son, but she insists on returning to her apartment in order to maintain her independence.

Solution-Focused Intervention

The utility of a solution-focused intervention in this case is that the patient may be encouraged to

consider what is possible for her, in a future-oriented sense. Although the CEC should compassionately acknowledge the patient's grief about losing her independence due to disease, the CEC can use solution-focused techniques to help the patient realize that dwelling on what was once possible will not be the most productive response to the impending need to adapt to a new life situation. By redirecting the patient's energies toward the practical needs of the situation, the CEC may help resolve the ethical question. The CEC, by using a solution-focused intervention, can orient the patient toward the basic problems of living that she now faces, such as physical disability that requires additional assistance, and to think about what supports or adaptations can be offered to solve these problems in ways that permit her the most independence.

Crisis Theory

Understanding crisis theory may be helpful in this case because this patient is facing what she may perceive to be a very serious crisis. Losing her independence and moving her residence may represent critical changes that disrupt her emotional stasis in such a significant way that she may be unable to formulate plans or problem solve without assistance. The CEC can empathically engage the patient to move beyond the intense immediate feelings of sadness and anger to consider options that might preserve some of the autonomy and dignity the patient fears is being taken from her.

Family-Systems Theory

A family-systems perspective on the patient's situation may also be helpful. Such a perspective will consider how such changes in residence may especially affect the patient's son and the mother-son relationship, and also affect others who depend on, or are depended upon, by the patient. It is likely that the patient's dilemma is also concerning to her family and friends, for any number of reasons, and understanding how this crisis impacts others may help lead to a richer understanding of what an acceptable resolution should include for this patient. It may also uncover resources of which even the patient is not aware.

Surrogates: Individual Surrogates and Group/Family Surrogates

Many, perhaps most, difficult clinical ethics cases involve patients who lack the capacity to make their own decisions, and thus a CEC's primary interaction may be with surrogates and family members. The reactions of individual surrogates, especially when they are highly distressed over a difficult decision, often reflect dual and even conflicting role expectations. Surrogates are often grieving or in emotional pain because of the serious medical condition of a loved one, yet they are also expected to function as informed, rational decision makers. Thus, their emotional responses may be a function of the tension between their subjective reaction to—and a way to cope with—the patient's illness, versus their role responsibility to objectively act on behalf of the patient's wishes or best interests.

When a strongly felt, personal emotional response precludes a family member from acting appropriately in the role of surrogate, a barrier to decision making and a possibly value-laden conflict arises. When conflicts develop for family members or group surrogates, it is usually the result of differing opinions about the patient's wishes and values or the medical prognosis. Thus they are unable to reach consensus regarding the goals of care for the patient. These differences may pertain to many possible factors within the family-system framework and the individual psychological makeup of individual surrogates.

Case Scenario 2:
Surrogate with a Firm but Erroneous Understanding of the Medical Facts

The patient is a 16-year-old boy who was injured in an ATV (all terrain vehicle) accident and is currently on a ventilator in the ICU. His parents are told he has a very serious, irreversible brain injury and will never regain consciousness. Due to the injury, the patient is kept sedated to prevent a dangerous rise in blood pressure that could kill him. His mother insists that her son "is in there" and that he is trying to wake up. She pleads with the doctors to back off on the sedation to allow her son to show that he can respond to commands. The physicians say that if her request is followed, the patient will be at risk of suffering and even of dying.

Solution-Focused Intervention

In this case, it may be difficult even for a CEC to take a future-oriented stance until the clinical facts of the present situation are adequately understood. Once the patient's loved ones are able to accurately perceive the risks of honoring their request, small goals may be set to allow for some future-oriented thinking, when possible.

Crisis Intervention

The tragic events surrounding a serious and life-altering injury such as this certainly constitute a cri-

sis for the patient, and most urgently for his parents and other loved ones. Here, a crisis approach seems to require the CEC to express a compassionate appreciation of the emotional impact of this devastating situation for this particular family and to be willing to hear the story they tell about why they think their son is trying to wake up.

Family-Systems Theory

While most CECs readily appreciate the magnitude of such a traumatic event in any family, an understanding of family systems can prompt a more robust intervention to attend to the multiple persons affected. Does the patient have siblings? If yes, what is the nature of the relationships between the siblings, parents, and this child, respectively? Are their extended family members or close friends available and able to support the nuclear family? Sometimes during a consult we learn that families are already dealing with multiple crises that are compounded when a health event occurs, and they may require additional support. Such a realization can help a CEC to appreciate the intensity of the emotional reaction.

Even when there is a formally designated surrogate, the cultural pattern of many families is to include all of the key members of the family in making decisions about the patient's plan of care. This becomes problematic when family members see treatment options differently and are guided by strong feelings, usually grounded in their divergent relationships with the patient. These positions are often diametrically opposed, creating a dilemma when healthcare professionals expect that a single individual, for example the "surrogate decision maker," to speak for the patient. This situation is illustrated in the following case example.

Case Scenario 3:
Divisions Within a Family

The patient is Mr. C, a 70-year-old man with four children. His wife and the three children who live in the same city have provided daily care for Mr. C during a long chronic illness. The fourth son, who lives in a distant state and has not visited in years, wants to continue treatment for end-stage heart failure, while Mrs. C and the other siblings want to discontinue treatment according to the patient's wishes. The family is unable to agree on any course.

Unexpressed long-standing feelings of anger, guilt, and resentment among family members may be so powerful that a CEC cannot even have all parties in the same room, much less facilitate a consensus. CECs must be adept in conducting family meetings in such cases and allowing emotions to be vented and validated using the approaches outlined here, with the aim of reaching an ethically justifiable resolution within the consultation procedural process.

Solution-Focused Strategy

In this case, a solution-focused strategy might assist the family in clarifying their goals of care for Mr. C, as well as in clarifying individual goals with regard to the decision-making process. A CEC working from a solution-focused strategy would engage the family stakeholders to help them to see the importance of clarifying care goals and reaching a consensus that reflects the best interests of the patient. From the perspective of this approach, a CEC would engage the patient and family in the "now," rather than on what once was.

Crisis Theory

In this scenario, Mr. C's family experiences crisis on two levels: a medical crisis for the father, and an interpersonal crisis among the family members, because the current medical crisis is the occasion for an intense family disagreement. If the CEC using this approach can define the problem and provide support to the family while encouraging them to examine alternatives, some of the tension may be diffused, allowing the divided group to come together to make plans for the good of the patient.

Family-Systems Theory

It can be useful to have Mr. C's family members define Mr. C's role within the family as part of an ethics consultation, in order to understand the disequilibrium that has been created in the family structure with his present illness and threat of losing their father. By using this approach, the CEC can better understand how the patient fits into the fabric of his family's life, and can open a discussion of the changes that the loved ones are facing in this time of crisis.

It is crucial for a CEC to create a space in which family surrogates can speak and voice their deepest hopes and fears with someone who is able to listen empathically and nonjudgmentally and provide a supportive yet nondirective presence. Many cases can be resolved at this level of discussion once the emotional barriers have been identified and discussed. In all of the scenarios presented above, the CEC seeks resolution within the established ethics

consultation procedural process of finding a way for surrogates to reach agreement with physicians on establishing reasonable goals of care.

This is the initial and most fundamental competency of a CEC, but, in our framework, this is achieved through compassionate interaction and focused communication—what we call advanced facilitation—between the CEC and surrogates. In cases when agreement is not reached even through advanced facilitation, then the CEC must consider the facts of the case in light of well-established ethical principles. The CEC will then be able utilize more traditional ethics consultation competencies to determine how to frame a recommendation that is grounded in ethics knowledge to a physician regarding his or her obligations to the patient. And this may include supporting a physician in setting limits regarding which interventions will be provided.

A truly comprehensive ethics consultation will integrate all of the ASBH *Core Competencies* at a high level of proficiency. As the above scenarios suggest, a CEC's ability to utilize several different behavioral and psychosocial approaches can create a place in which all stakeholders can safely voice painful emotions. We posit that a CEC who can empathically hear these strong emotions and employ approaches like those briefly described here is in the best position to discern and resolve hidden value conflicts.

A SHORT-TERM, TASK-ORIENTED CONCEPTION OF ADVANCED FACILITATION IN CLINICAL ETHICS CONSULTATION

All of the above scenarios reflect common types of communication and interpersonal conflicts that CECs encounter. In such situations, CECs can actively engage individuals in one-on-one dialogue. In groups, CECs can support, assist, and, if possible, make easier the process of making difficult decisions that reflect principled ethical resolutions. Because of the delicate, complex, and extensive psychological and family issues that are encountered in these scenarios, and the CECs' time-limited exposure to them, we should reject the temptation to see CECs as a type of professional therapist or counselor, which would be a clear violation of boundaries. Nonetheless, CECs who deal with these most intractable and difficult ethical issues in the clinical setting, particularly at the end of life, must have advanced facilitation knowledge and skills rooted in established, relevant behavioral health theory.

We propose that we enhance and expand the ASBH *Core Competencies* of clinical ethics consultation in the domains of communication and interpersonal skills that are necessary to perform advanced facilitation by emphasizing the following claim: CECs engage the patient, family surrogate, or family as a whole in a short-term, active dialogue that is a type of task-oriented supportive interaction, and may incorporate the common elements of counseling that are similar to those used in almost all other helping professions in the service of patient-centered care.

In this sense, the work of CECs is continuous with the mission of the entire care team, which is to provide excellent patient care by clarifying and pursuing ethical, patient-centered goals of care. CECs who can use these enhanced communication and expanded interpersonal skills to engage all of the stakeholders in a dialogue, to the degree that they are able to talk about their emotions, may guide the parties involved to an awareness of how their emotions may be related to, or even interfere with, the charge of ethical decision making.

The specific task of the advanced facilitation we propose in this article is for CECs to be competent to support and guide patients and surrogates in parsing out the most salient values that are intertwined with, and often hidden or confused in, the overwhelming emotions that surround serious or life-threatening illness or injury. Once the emotions and values involved have risen to a conscious level and have been clarified in words as much as possible, patients and surrogates—often with the support of CECs—may be able to arrive at a reasonable decision that honors and validates the personal authenticity of the stakeholders' emotions while it accommodates the ethical responsibilities and medical realities at hand. At this point, it is often possible to reach a new consensus or agreement about the goals of care and options for treatment. Regardless, because CECs are able to delve more deeply into the emotions that underlie ethical dilemmas, they are in a stronger position to write an ethics recommendation that affirms the interests of all involved.

CONCLUSION

Value-laden conflicts that are addressed in clinical ethics consultation require CECs to use advanced communication and interpersonal skills to engage in active dialogue with patients—and even more frequently, their surrogates—who are experiencing strong emotions about a difficult clinical ethics decision. Most often it is necessary for CECs to support patients or surrogates in expressing their strong emotions before an ethical decision can be made.

We propose that the support and help provided by CECs in these settings be construed as an advanced ethics facilitation, be taken seriously as an area of inquiry in clinical ethics consultation, and developed as a core skill.

It is troubling that these most basic human skills have not been more widely discussed and identified in the professional and educational literature of a profession that was forged in the integration of ethics and the humanities into biomedicine. Not only must the field of clinical ethics consultation remedy this deficiency, it must also find ways to ensure that trainees are fully competent in these core skills. The first step is to define the range of challenges encountered in ethics facilitation when dealing with strong emotions. Next, we need to show how behavioral approaches can help the field better understand and define the core skills used in active dialogue with participants, and translate them into educational initiatives. This article represents a beginning in this effort and will be developed by the authors in their future work.

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