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Ethics Consultation Practice

The Work of ASBH's Clinical Ethics Consultation Affairs Committee: Development Processes Behind Our Educational Materials

Courtenay R. Bruce, Jane Jankowski, Barbara L. Chanko, Anne Cordes, Barrie J. Huberman, Liza-Marie Johnson, Deborah L. Kasman, Aviva Katz, Ellen M. Robinson, Katherine Wasson, and George E. Hardart

ABSTRACT

The authors of this article are previous or current members of the Clinical Ethics Consultation Affairs (CECA) Committee, a standing committee of the American Society for Bioethics and Humanities (ASBH). The committee is composed of seasoned healthcare ethics consultants (HCECs), and it is charged with developing and disseminating education materials for HCECs and ethics committees. The purpose of this article is to describe the educational research and development processes behind our teaching materials, which culminated in a case studies book called *A Case-Based Study Guide for Addressing Patient-Centered Ethical Issues in Health Care* (hereafter, the *Study Guide*).[1] In this article, we also enumerate how the *Study Guide* could be used in teaching and learning, and we identify areas that are ripe for future work.

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INTRODUCTION

Conducting healthcare ethics consultations can be intellectually and emotionally challenging. Frequently, ethics consultations involve seemingly intractable conflicts between stakeholders on personal, value-laden ethical issues, such as end-of-life decision making, confidentiality and privacy concerns, informed consent, surrogate decision making, and professional or institutional responsibilities. Healthcare ethics consultants (HCECs) must possess knowledge about core bioethics topics to be able to provide recommendations that are in keeping with ethical consensus (when it exists), but core knowledge alone is insufficient to master ethics consultation.

To do ethics consultation well, HCECs should possess and exhibit a range of advanced skills that extend beyond familiarity with ethical issues.[2] For instance, HCECs should be familiar with national standards in clinical ethics, including consensus and policy statements promulgated by major healthcare professional organizations. Additionally, HCECs must be approachable and interpersonally comfortable working with patients, families, and healthcare professionals. They must be empathetic and able to interpret and respond to others' verbal and nonverbal cues, yet remain objective enough to avoid partiality. HCECs must be able to communicate with people who are not familiar with contemporary healthcare systems and use language that is accessible to people from many different backgrounds, which may require at least moderate degrees of interpersonal versatility and self-awareness. Additionally, HCECs must possess strong analytical and critical-thinking skills, and be able to think and respond promptly to situations that change incrementally over time. In crises, stakeholders' emotions can change quickly, clinical status can change abruptly, and courses of action must shift—all of which require agility of mind, or discursive agility.

Given the range of skills required to conduct ethics consultations, there has been some debate and uncertainty about the ideal method of teaching and learning ethics consultation.[3] An internet search suggests there is a wide variety of teaching modalities available, such as online videos on ethics consultation, modules, webinars, and intensive courses. The range of topics is diverse as well, often including some teaching on mediation and conflict resolution skills, underscoring the importance of cultivating strong interpersonal skills and discursive agility.

The available instructional materials on ethics consultation undoubtedly assist individuals in learning core bioethics topics and may help cultivate critical-thinking skills. However, most materials on ethics consultation can only go so far in demonstrating the integration of knowledge and practice. That is, available materials are limited in that they usually cannot provide the experiential learning that comes through in-person practice. A 2007 survey suggested that many HCECs learn ethics consultation through on-the-job experience, which presumably means that HCECs find experiential knowledge essential to becoming clinical ethicists.[4] These HCECs may feel they become stronger over time after conducting several (if not numerous) ethics consultations.

If it is true that HCECs learn primarily through on-the-job training and experience, then conceivably there may be missteps or (potentially) errors in the beginning of consultants' learning. Although some learning through practice in a real environment is likely inevitable in ethics consultation, an "on-the-job-training model" may not be ideal for the initial application of knowledge to actual clinical encounters.

We sought to create teaching materials that could augment experiential learning through a distinctive, case-based methodology in a protected, artificial teaching environment.[5] We call our case-based methodology an "unfolding approach," which is described more fully below. The purpose of this article is to describe the educational research and development processes behind our teaching materials, which culminated in a case studies book called *A Case-Based Study Guide for Addressing Patient-Centered Ethical Issues in Health Care,* hereinafter, the *Study Guide*. In this article, we also enumerate how the *Study Guide* could be used in teaching and learning.

The authors of the *Study Guide* and of this article are previous or current members of the Clinical Ethics Consultation Affairs (CECA) Committee, a standing committee of the American Society for Bioethics and Humanities (ASBH). The committee is composed of seasoned HCECs, and it is charged with developing and disseminating education materials for HCECs and ethics committees. The CECA Committee members are appointed for one-year committee appointments, renewable annually up to a maximum of three years by the president of the ASBH. Candidates for CECA Committee appointments are typically evaluated according to the following criteria: substantive involvement conducting ethics consultations on a range of ethical issues in a variety of healthcare contexts, demonstrable leadership and professional development in clinical ethics consultation, experience writing and publishing clinical ethics scholarship or other academic

contributions to the field, and active engagement in quality enhancement initiatives within clinical ethics consultation. CECA Committee members come from a wide variety of disciplines and geographic areas. A majority of the members direct or previously directed high-volume ethics consultation services in tertiary academic or community settings or work as full-time HCECs. Many committee members conduct research on ethics consultation and frequently publish on best practices for HCECs and ethics consultation services.

BRIEF HISTORY

In 2000, ASBH established a Clinical Ethics Task Force (now the CECA Committee) to build on the *Core Competencies for Healthcare Ethics Consultation* report.[6] Through research, the group members found that some ethics consultations were being carried out by people who did not have formal education or training in ethics consultation. To fill in this gap in ethics education, the CECA Committee designed a self-education program guide in 2009, *Improving Competencies in Clinical Ethics Consultation: An Education Guide*.[7] The second edition of the *Improving Competencies* was published in 2015.

In 2014, the CECA Committee surveyed the purchasers of *Improving Competencies* to identify what those users would find helpful in a follow-up educational report. Survey respondents indicated that it would be helpful for the CECA Committee to create a supplement to *Improving Competencies* that featured case studies, but respondents did not provide any details beyond stating that case studies would be helpful.

Based on these survey data, the CECA Committee members set out to write case studies, but we were not sure of the appropriate format. We learned through conducting education psychology research that most learners think inductively rather than deductively, which makes examples an effective teaching methodology for developing critical-thinking skills. However, the same studies that touted the benefits of case studies also suggested that case-based teaching is often done poorly.

AVOIDING THE PITFALLS ASSOCIATED WITH CASE STUDIES

A case study is a descriptive document based on a real-life situation, problem, or incident, and case studies are frequently used to enhance lectures and group teaching.[8] There are at least five distinct reasons why case-based teaching has been criticized in the higher education literature. One common critique is that most case presentations are too lengthy and often laden with medical intricacies, redundancies, and unnecessary details that are not critical for medical (much less ethical) analysis. Conversely, other cases have been criticized for being so short and open ended that readers cannot conduct adequate analyses.[9] When there are too many unanswered questions at the outset of a case presentation, it is argued, learners become "stuck" in conditional framings of the case and circuitous logic, creating elaborate "what if" or "if then" statements that prevent them from moving forward beyond "issue identification." When this happens, learners cannot adequately conduct a thorough analysis in order to achieve a case resolution.[10]

A second common critique of case-based teaching is that the cases fail to actively involve learners during case presentations. It is only at the end of a case presentation that learners are asked to "conduct an ethical analysis," which essentially allows readers to disengage throughout the case presentation. When this occurs, readers may miss critical information or may perseverate on ethically irrelevant facts. A third critique of case-based teaching is that cases do not give adequate detail about psychosocial considerations or other dynamics that make a case truly "rich" with description. Rich description is often necessary for complete analysis.[11]

A fourth critique, particularly applicable to clinical ethics consultation, is that cases rarely contain "pivots," that is, facts that are introduced midway through a case that should shift learners' analyses in substantive ways. Pivots are essential to learning ethics consultation, because pivoting facts help cultivate discursive agility and creativity.[12] Only through pivots do learners enhance their ability to move in nonlinear ways to manage cases.

A final critique (not found in the literature, to our knowledge, but rather our own thinking) is that cases rarely present procedural elements, that is, the consultative activities that HCECs use to manage cases. As the *Core Competencies* enumerate, as part of ethics consultation, HCECs engage in a number of activities for fact gathering or facilitation purposes.[13] Specifically, HCECs meet one-on-one with patients and families to elicit morally relevant perspectives on a case. Ethicists may mediate or facilitate staff-only meetings involving only the care team, or HCECs may facilitate family meetings involving patients' families and the care team to, for instance, discuss prognostic information or treatment options. HCECs document cases, and they talk with a number of stakeholders at various points in time.[14] For

each consultative activity, new facts and information emerge that have the potential to impact ethical analyses and the appropriateness of some courses of action. The consultative process, and the underlying reasons for the consultant's activities, should be described in cases so that learners may rehearse how cases unfold from beginning to end. By operationalizing the procedural elements of ethics consultation, learners may gain a better sense of how consultative activities play an integral role in fact gathering and analyses.

Thus, as the CECA Committee, we knew we needed to develop case studies to meet HCECs' needs, but we wanted to avoid the common critiques and pitfalls associated with case presentations. In practice, that meant the length of each case had to be just right—not too long and not too short. The cases presentations needed to actively engage the reader, and the case descriptions needed to introduce elements that make ethics consultation complex: dynamics, pivots, and conversations with multiple stakeholders.

DEVELOPMENT PROCESS FOR THE *STUDY GUIDE* AND ITS CONTENT

Drafting and Piloting Processes

The drafting processes consisted of having one member of the CECA Committee write a case, with a few members writing more than one case. Then, the principal author of each case shared it with a randomly assigned reviewer who was also part of the CECA Committee. These two individuals (principal author and reviewer) then submitted their case to the chair of the CECA Committee (CRB) who further revised the case in two rounds of edits.

At this stage of development, we were ready to pilot the cases. Through the efforts of using a principal author, a second reviewer, and the committee chair, the authors were able to create 14 full "draft" cases to pilot. To ensure that the cases were medically accurate and representative of actual clinical-ethical dilemmas, we then piloted each draft case with at least one physician-reviewer and one trainee (medical student, nursing student, or clinical ethics fellow), all of whom had an interest and at least minimal expertise in ethics consultation. Typically, these "outside" reviewers were members of ethics committees, ethics course students, or secondary faculty members affiliated with ethics departments or centers within the Texas Medical Center. The cases were assigned to outside reviewers based on specialty interests, to the greatest extent possible. Thus, for example, a case involving neonatal ethics was sent to a neonatologist for review, and a case involving heart failure treatment options was sent to a cardiologist.

After outside reviewers edited and commented on each case, the CECA Committee dropped two drafted cases because of negative feedback from reviewers. Then, the principal authors of the 12 remaining cases conducted additional edits to fully respond to the outside reviewers' comments. Next, the principal authors returned their cases to the committee chair, who further refined each case. Finally, we sent the full manuscript to 11 additional outside reviewers. This second-round of outside reviewers were selected using a combination of two methods: purposive sampling of clinical ethicists who were willing and able to review the manuscript within a short time frame, as well as drawing on the newly appointed 2016-2017 CECA Committee. As newly appointed committee members, these reviewers were not involved in the writing of the *Study Guide.*

After the committee chair made additional edits to respond to the second set of outside reviewers' comments, the manuscript was then reviewed by the ASBH Board of Directors. The CECA Committee chair made final edits in response to the board's comments and suggestions.

In all, the cases were refined through at least six rounds of revision using multiple reviewers, at least two rounds of which involved outside reviewers. The end result is a 121-page book consisting of 12 cases—nine involving adult patients and three involving minors—on various topics in clinical ethics, including decision-making capacity, informed consent, advance care planning, end of life, and privacy and confidentiality, among many other topics. The cases are actual cases (the patients' names have been removed and some facts were changed to preserve anonymity) and represent the authors' collective experience in performing ethics consultations. The 12 cases we ultimately chose include complex patient and family narratives that are interwoven with ethically relevant medical, surgical, and psychosocial-spiritual features.

The Unfolding Approach

To actively engage readers, as well as to introduce dynamics, pivots, and procedural elements, we present the cases in what we refer to as "the unfolding approach": a process in which we "interrupt" each case at several junctures to ask questions of the reader. Then, the case continues until the next break, when we ask more questions. We chose the term "unfolding" (a term that, to our knowledge, has not been used elsewhere) to describe what we hope

will become a new pedagogical advancement in how case studies are written.

In designing the unfolding approach, we drew on the work of Daniel Kahneman's cognitive science work described in his *Thinking, Fast and Slow,* that posits that our brains are comprised of two systems.[15] "System 1" operates reflexively, intuitively, often automatically—like when we drive or make facial expressions. On the other hand, "System 2" requires deliberating, reasoning, computing, and analyzing data. Examples of System 2 thinking might include recalling memories of childhood, formulating a presentation, or analyzing a math problem. The two systems often conflict with each other, and each of them have limitations. System 1 relies on heuristics and may be susceptible to factual inaccuracy. System 2 can suffer from being overly analytical and slow. In reality, the ideal mode of thinking is likely a combination of both, recognizing situations in which mistakes are likely and avoiding serious mistakes in high-stakes situations.[16]

Recognizing that strong clinical ethicists can likely navigate System 1 and System 2 thinking with little trouble, we wanted to create a case studies environment that could foster the balancing of both systems. We believed that an unfolding approach could help cultivate critical thinking in a way that could balance both systems. Specifically, in most books and e-modules including case studies, the author presents the contours of a case, and then, at the end of the case presentation, encourages readers to "analyze the case," giving the false impression that cases proceed in a linear fashion and that the facts are as they are written at the outset of a case. In reality, cases rarely occur neatly, discretely, or linearly, and new facts are introduced as the cases evolve. Thus, to be clinically accurate and representative of actual clinical-ethical dilemmas, we used pivots in each case to introduce new facts, and we ask readers questions involving our new factual pivots.

In using pivots in this way—presenting new fact pivots throughout the case and asking readers questions involving the pivots—we hoped to encourage readers to abandon at least part or some of their current mode of analyses and approaches, in which they have to shift to an entirely new frame of thinking to conduct subsequent steps in an ethics consultation. The pedagogical benefit of our unfolding case presentation is that the pivots deliberately press readers to think quickly, yet thoroughly—engaging System 1 and System 2 thinking. Readers are pushed to re-evaluate their positions and options, sometimes ultimately taking on a new position that was not ethically feasible at the outset of a case. For example, in one case involving issues of confidentiality, the most ethically appropriate action for an HCEC would be to wait until an unconscious patient regains capacity and is able to communicate his preferences regarding disclosure of confidential information. However, this course of action becomes impractical because the patient's family arrives. Thus, the HCEC is confronted with the issue of whether and how much to inform the patient's family when the patient is unable to communicate his current wishes. The HCEC must think both quickly (engaging System 1) yet very deliberately (engaging System 2).

We also purposefully interrupt cases at high "points"—times in a case presentation when we anticipate that emotionality, greenness, or uncertainties may tempt HCECs or trainees to lose confidence or become hurried, emotionally vulnerable, or unsteady. In other words, we use the unfolding approach at times when we anticipate that an HCEC might be drawing too heavily on System 1 thinking to encourage HCEC readers to become more deliberative.

The pedagogical benefit of using interruptions at high points is to help elicit and foster HCECs' interpersonal skills, including their overall confidence in their ethical assessments and in their presentations of their assessments. Thus, in one case, a patient's family becomes very angry, if not hostile, towards the HCEC. A natural but inadvisable position would be for the HCEC to respond reflexively and defensively. In our questions, we ask how the HCEC should ideally respond and what strategies could be used to help de-escalate the situation. In our answers to these questions, we provide trade-offs (outlining challenges and benefits) of a variety of frequently employed mediation strategies.

Questions Embedded Throughout the Text

As part of our unfolding approach, we present questions at the beginning of each case, throughout the case, and at the end of each case. The questions are a combination of knowledge questions, reflective questions, and procedural questions.

Knowledge questions are usually based on rote memorization. The knowledge questions are specifically designed for students and/or novice HCECs. For example, knowledge questions might be: "What are the elements of decision-making capacity? What is the difference between *capacity* and *competency*?" Reflective questions, on the other hand, go beyond knowledge questions by encouraging critical thinking, such as: "Why is guardianship not an option in this case?" or "Are there any circumstances in which

chemical or physical restraints might be warranted to provide treatment for an incapacitated patient who refuses treatment?"

The difference between knowledge questions and reflective questions is that, for the latter type of question, readers are primed to think about specific facts of cases and evaluate how those facts fit within larger ethical and legal frameworks. Knowledge alone is insufficient for navigating complex cases. Reflective questions challenge readers to integrate knowledge and apply this knowledge to the circumstances at hand. Our goal in asking reflective questions is to encourage HCECs to become intimately familiar with areas for which there is ethical consensus (or lack of consensus), and to encourage HCECs to become self-aware of areas in which they may lack expertise. We think the reflective questions will be most useful to novice HCECs or seasoned HCECs who would like to reflect on their practices.

The final type of question we ask in the *Study Guide* are procedural questions. These are questions that focus on ethics consultative activities, or processes—how HCECs should "move" cases, that is, the persons they should talk to, for what purpose, how they should frame the conversation, questions to ask other stakeholders, *et cetera.* For example, in one of the cases, we ask, "HCECs should value the importance of building rapport with patients. What are two concrete strategies, questions, or statements that might help the HCEC build rapport?" In another case, we ask: "Which treatments being provided to Mr. Garcia are life-sustaining treatments? What specific questions should the HCEC ask the clinicians to help them articulate the risks, benefits, and burdens of these interventions and the alternatives to them?"

Our reason for asking procedural questions is to encourage even the most seasoned HCECs to reflect on their approaches, including particular steps they should take in each case, for what purposes they should take those steps, and the justifications or motivations behind each step. We contend that HCECs should be systematic and deliberate in their approaches to ensure consistency, fairness, and thoroughness, as well as to minimize the possibility of short-circuiting ethical analyses. We aim to continuously nurture self-reflection regarding HCECs' consultative activities and the techniques they use during ethics consultations to advance their skills and expertise.

At the end of each case, we provide robust answers, including extensive explanations, for each question we ask. We arrived at the answers using a consensus approach among the writers and reviewers of the book. In our answers and explanations, we often provide a range of several different, ethically acceptable answers and provide justifications for ethically less supportable (and even unacceptable) courses of action. We very rarely identify only one course of action and state that it is the only ethically acceptable answer. However, we also acknowledge that our answers are not exhaustive, and it is also possible that reasonable minds may disagree on our evaluation of the ethical feasibility of various options. There may be well-justified answers and options beyond what we provide in the book.

THE INTENDED AUDIENCE

Our goal in developing the book was to encourage HCECs to build their competencies from basic skills used to address common ethical issues to advanced consultative skills that can be used to address complex ethical concerns. To that end, the primary audience for the *Study Guide* (and this article) is students, as well as new and seasoned HCECs.

Much of the *Study Guide,* however, is applicable to any healthcare professionals who emphasize interpersonal communication and ethical analyses skills in their profession, including most clinicians, chaplains, social workers, and others. For instance, we include tips related to communication and decision making in medicine, such as strategies for guiding fruitful patient interviews, elucidating patients' or surrogates' concerns or perspectives, and conducting family meetings. We provide guidelines and strategies for the "ideal" overall structure of a family meeting, including its content and flow, and we support these recommendations with empirical findings to anchor our suggestions. We offer model questions that clinicians could use to elicit patients' values, goals, and preferences, and we provide examples of questions we would suggest that clinicians should try to avoid using in such efforts. For every tip and practical suggestion we provide (as well as our tips on phrases or actions to avoid), we include justifications from the empirical literature to help ground our statements and contextualize our positions.

HOW TO USE THE *STUDY GUIDE*

The *Study Guide* can be used in myriad teaching settings. For instance, the *Study Guide* may be particularly useful for nascent ethics committees or ethics committees when there is a low volume of ethics consultations in order to provide its mem-

bers with experiential learning. We also contend that the *Study Guide* could be used in core clinical ethics curricula in order to provide an experiential, practical, clinically based approach that may be lacking in clinical ethics curricula.

The *Study Guide* could also be used in quality enhancement practices. For instance, we can envision using the *Study Guide* to see whether there is consistency or legitimate deviation in consultative practices between different consultants on one ethics service, or differences between consultants on various ethics consultation services. For example, an ethics consultation service could consider using one of the cases with all of the HCEC on the service, asking them some of the questions we provide in the book. If one HCEC consistently provides a response that is not covered in our responses (and yet continuously asserts that he or she is correct), we can say with some confidence that such an HCEC likely could benefit from additional training. Likewise, if all of the HCECs on the service select very different responses and rarely come out similarly in analyzing the cases, it can likely be argued that there might be too much inconsistency or variability between the HCECs in their approaches and procedural activities.

Several of us have found it helpful to use cases to evaluate prospective job candidates for HCEC positions in order to discern their critical-thinking skills and their approaches. For instance, one of us used part of a case with prospective job candidates, asking the candidates to listen to the case and then answer two questions we provided in the book. A couple of the candidates gave shortsighted answers, barely scratching the surface of the case and providing overly legalistic and dogmatic responses. One candidate who received very high marks on this portion of the interview provided a response that touched on several of the elements and options discussed in the "answers" section of the book, showing mental agility. Thus, by using cases with job candidates, we could learn more about their interpersonal skills and critical-thinking skills.

Finally, the *Study Guide* could play a role in the professionalization movement of clinical ethics. It is designed to evaluate a number of skills that are integral to conducting high-quality ethics consultation, including discursive agility and interpersonal skills. Therefore, the *Study Guide*, conceived as an accompaniment to the *Education Guide*, could serve as an essential resource for material that can be integrated as part of the HCEC certification written examination currently being developed by the ASBH HCEC Certification Commission.

LIMITATIONS AND FUTURE DIRECTIONS

We acknowledge that there are important topics and strategies unaddressed in our *Study Guide* that could be developed through future work. For instance, we focused on the inpatient consultations in the *Study Guide,* and we did not move beyond hospitals to include other healthcare settings. Future work could explore issues that are particularly salient in other contexts. Additionally, our primary focus on properly conducted ethics consultations and limited attention to common missteps that can occur during consultations may represent a missed opportunity. HCECs also learn from cases that do not go well, and future work could focus on developing case materials involving poorly conducted ethics consultations.

Future efforts could develop video simulations to accompany our *Study Guide.* For instance, we can envision a video simulation on any of our family meetings within the book, pausing and asking the reader to assess the family meeting thus far, or asking the reader how the HCEC should proceed. Another timely project might be the development of instruments or evaluation tools used to formally assess novice HCECs' skills in conducting certain procedural elements of ethics consultations. For example, in our book we list several important procedural elements of family meetings, such as introductions, elicitation of values, and closures. Novice HCECs can be assessed on whether they helped to ensure that these elements occurred and were satisfactorily met during family meetings. We can envision a tool consisting of definitions, Likert-item scales, and evaluative criteria to help novice HCECs differentiate their skills.

CONCLUSIONS

In this article, we describe our rationale and development process for the case studies book, *A Case-Based Study Guide for Addressing Patient-Centered Ethical Issues in Health Care.* We contend that this book addresses gaps, concepts, and strategies that have, thus far, been underdeveloped in clinical ethics.

As for future plans, the CECA Committee will continue to be flexible and responsive to the needs and preferences of HCECs. One way to provide support is to develop educational materials that HCECs or prospective HCECs could use to prepare for the ASBH HCEC certification written examination. However, our plans may evolve or shift, depending on learners' needs. This *Study Guide* represents only

one step (albeit a significant one) towards achieving ASBH's goal to develop and disseminate education materials for HCECs and ethics committees.

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