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Article abstract

As clinical ethics learners, we have observed ethics consultations and have experienced an array of emotional responses as a result of these consultations, particularly surrounding topics pertaining to end-of-life decision-making. While there is extensive literature on the role and nature of emotions for many frontline healthcare providers, such as nurses and physicians, limited research exists on the emotional experiences of clinical ethicists and clinical ethics learners. We maintain that understanding these emotional experiences can deepen our understanding of the role and practice of clinical ethicists, especially given the challenging and values-laden healthcare contexts in which ethics consultations often occur. This research can also inform current and future ethics education to aid in the development of quality-driven training programs for future ethicists, such as bioethical simulation labs. This paper sought the voluntary contributions of seven clinical ethics learners, who provided a narrative account of their experiences with clinical ethics consultations as a means to identify key themes related to emotional responses to ethics consultations.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Exploring Learners' Experiences with Clinical Ethics Consultations: A Narrative Reflection on the Impact and Role of Emotions

Téa Christopoulos[a,b], Oluwaseun Sobode[a], Megan Bailey[a,c], Dylan McKibbon[a,d], Thomas Milovac[a], Sam Moshiri[a,e], Jessie Van Leeve[a,f]

Résumé

En tant qu'étudiants en éthique clinique, nous avons observé des consultations d'éthique et éprouvé diverses réactions émotionnelles suite à ces consultations, notamment concernant les décisions de fin de vie. Bien qu'il existe une littérature abondante sur le rôle et la nature des émotions chez de nombreux professionnels de santé de première ligne, tels que les infirmiers et les médecins, les recherches sur les expériences émotionnelles des éthiciens cliniques et des étudiants en éthique clinique restent limitées. Nous sommes convaincus que la compréhension de ces expériences émotionnelles peut enrichir notre compréhension du rôle et de la pratique des éthiciens cliniques, en particulier compte tenu des contextes de soins complexes et fortement marqués par les valeurs dans lesquels les consultations d'éthique ont souvent lieu. Ces recherches peuvent également éclairer la formation en éthique actuelle et future, contribuant ainsi à l'élaboration de programmes de formation de qualité pour les futurs éthiciens, tels que des laboratoires de simulation bioéthique. Cet article a sollicité la contribution volontaire de sept étudiants en éthique clinique, qui ont fourni un récit de leurs expériences de consultations d'éthique clinique afin d'identifier les thèmes clés liés aux réactions émotionnelles lors de ces consultations.

Mots-clés

professionnels de la santé, éthiciens cliniques, apprenants, émotions, soins de santé, empathie

Abstract

As clinical ethics learners, we have observed ethics consultations and have experienced an array of emotional responses as a result of these consultations, particularly surrounding topics pertaining to end-of-life decision-making. While there is extensive literature on the role and nature of emotions for many frontline healthcare providers, such as nurses and physicians, limited research exists on the emotional experiences of clinical ethicists and clinical ethics learners. We maintain that understanding these emotional experiences can deepen our understanding of the role and practice of clinical ethicists, especially given the challenging and values-laden healthcare contexts in which ethics consultations often occur. This research can also inform current and future ethics education to aid in the development of quality-driven training programs for future ethicists, such as bioethical simulation labs. This paper sought the voluntary contributions of seven clinical ethics learners, who provided a narrative account of their experiences with clinical ethics consultations as a means to identify key themes related to emotional responses to ethics consultations.

Keywords

healthcare practitioners, clinical ethicists, learners, emotions, healthcare, empathy

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INTRODUCTION

We are clinical ethics learners (CELs) at a community hospital system located in the Greater Toronto Area in Ontario, Canada. The term "learner" is used throughout this paper to refer to a formally engaged clinical ethics intern, fellow or practicum student with limited prior clinical ethics consultation experience. As such, learners assume an observational and supporting role during ethics consultations for hospital staff, physicians, patients, and their families, with the aim of gaining practical exposure that can be leveraged for future career pursuits. For the purpose of this paper, we define consultations as an interaction between key partners involved in patient care, such as hospital staff, physicians, patients, families, or other members of the healthcare team surrounding an ethical dilemma or issue. We define healthcare practitioners (HCPs) as licensed health-related professionals that exclude the clinical ethicist (CE) and CELs. These ethics consultations involve questions and challenges related to healthcare decision-making about a range of topics such as treatment, end-of-life, medical assistance in dying (MAiD), and discharge from the hospital. Typically, CEs leading the consultation will meet with CELs beforehand to discuss what is known about the case and what specific things to pay attention to while observing. This is followed by the consultation itself as well as an opportunity to debrief and ask questions following these observations to reflect upon relevant circumstances and outcomes.

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Some of the work of the CE can involve responding to the emotional experiences of the key partners named above, especially when it comes to complex healthcare decision-making. When ethical issues and questions arise in the healthcare setting, in addition to maintaining compliance with relevant laws and policies, CEs are frequently tasked with providing support to patients, families, and HCPs related to role clarity, values identification, and potential resolutions in alignment with ethical principles. This work can be laden with emotional dynamics, and our experience participating in rounds, debriefs as well as observing consultations as CELs, particularly those that involved difficult topics such as end-of-life decision-making, led us to wonder about the impact of emotions on CEs themselves. This prompted further reflection; how do CELs feel when engaging with and supporting these complex, emotionally charged dilemmas? How do we regulate our own emotional responses to consultations, both in the moment and over time? These questions percolated as we continued our learning and observing consultations, and it was in this context that we endeavoured to learn more about the emotions of CEs and CELs.

The purpose of this paper is twofold: we wish to further reflect on, highlight and analyze our own empirical experiences as CELs observing consultations as a unique contribution to the clinical ethics field. We also aim to demonstrate a gap in the literature with respect to both the presence and role of emotions experienced by CEs and CELs, to help advocate for empirical inquiry, theoretical reflection, and discourse to better understand the emotional aspects of clinical ethics work. To do this, we first offer our own personal narrative accounts of our experiences as CELs to thematically analyze them in meaningful ways to prompt further research in this area. Then, we turn to the literature to describe what is currently known about the field and practice of clinical ethics and emotions, as well as the role and impact of emotions for patients, families, and other HCPs. In doing so, we highlight the current gaps in the literature to motivate future empirical work in this area.

METHODS

The research questions that we sought to address were the following: What is currently known about the interplay between emotions and the roles of CEs and CELs in the practice of clinical ethics? What is known about the cumulative emotional burden of the clinical ethics profession?

A preliminary scan of the scholarly literature reflected little to no coverage of the role and impact of emotions, specifically in the context of clinical ethics practice. This motivated our own search for an accessible way to gain insight into the kinds of emotional dynamics experienced by junior and senior CELs working in our acute care system. As such, we elected to voluntarily contribute our own short narrative-style accounts, as CELs and co-authors of this work, in response to the following prompt: “Please write an excerpt about your own individual emotional experiences both during and after observing clinical ethics consultations.” In total, seven accounts were collected from all seven co-authors (consisting of two senior CELs and five junior CELs) from diverse backgrounds — graduate students, practicum students, and working professionals — belonging to the same 2023-2024 cohort of the intern program. The term ‘narrative account’ is used here to describe free-form, personal and descriptive reflections of lived experience that are written in each learner’s own voice, in the absence of a predetermined formal narrative framework to follow. This approach aimed to capture what felt most significant to each individual learner to reveal a range of insights into how emotions are encountered and navigated in typical clinical ethics consultations. Narratives reflected learners’ cumulative exposure to diverse cases over time rather than a single case or fixed time point.

To ensure the confidentiality of learners sharing their personal experiences, submissions were submitted anonymously via a Google document and then organized for analysis by a designated co-author. The direction provided by the lead authors (TC and OS) ensured that no specific case information was shared to protect the personal information of patients, as well as the CELs. Given the flexible duration of the internship program, the sharing of non-identifiable narrative accounts did not pose any financial or occupational risk to the CELs, and no author expressed concerns regarding safety or apprehension in sharing these accounts.

The collection of personal narrative accounts was treated as primary qualitative data. Once the narratives were collected, they were analyzed to elucidate what resonated with learners most. Using Braun and Clarke’s reflexive thematic analytic framework (1), we were able to identify patterns and themes across the data. This methodological approach allowed us to first code each learner reflection and then extract broader themes among learners’ experiences overall. We followed Braun and Clarke’s six phases of thematic analysis, by first familiarizing ourselves with the data and generating initial codes for each of the reflections. We collated the codes as we searched for themes, reviewed them, and defined each theme accordingly to generate our final product, which we then reviewed and scanned as a final opportunity for analysis.

The thematic analysis was conducted to support our broader aim of illuminating how emotions are experienced through clinical ethics learning opportunities among learners within the same training program. The choice to not distinguish learners in junior versus senior roles was intentional to avoid potential identification of the learners due to the small size of the cohort. Analyzing all reflections via coding and generating themes that were shared across the collective was intended to reduce potential bias due to seniority.

Our analysis led to a more focused exploratory narrative review of the literature to examine the emotional considerations and implications of clinical ethics experiences. Relevant literature was identified through PubMed/MEDLINE, Web of Science, and

Google Scholar in October 2023, and articles published in English were screened independently by two authors (TC and OS) based on titles and abstracts for relevance to the review focus. The full texts of relevant articles were reviewed, and seven relevant studies were included for analysis. Conflicts regarding independently selected literature were discussed between TC and OS to reach a mutual decision based on the research question.

LEARNERS' NARRATIVE REFLECTIONS ON ETHICS CONSULTATIONS

Each narrative account below has been written by one of the co-authors of this article. The term "Clinical Ethics Learner" encompasses both junior and senior learners, with diverse academic and occupational backgrounds. Experience within the clinical ethics program was also varied as the program does not have a specific duration of training. Two senior CELs had been in their role for over two years, whereas the five other junior CELs had been part of the program for less than six months. A description on the exact background of each learner is not provided to ensure the anonymity of all narrative accounts. These varied experiences and levels of seniority will be acknowledged in the analysis.

Clinical Ethics Learner 1

The experience of shadowing the CE during consultations and Medical Assistance in Dying (MAiD), coupled with their thoughtful check-ins to gauge our emotional well-being following each consultation, ignited a personal curiosity within me. It prompted me to reflect deeply on the profound implications of these consultations and whether they exert a cumulative emotional toll.

Clinical Ethics Learner 2

After observing an ethics consultation with a patient via phone, I would be remiss if I did not acknowledge the despair and sheer sadness I felt for the patient's predicament, and confusion about how I would personally remediate my own emotions post-consultation. Bearing witness to the fragility of end-of-life care and existential questioning made me confront my own positionality and reflexivity as a learner, exhausting the empathy for which I could exercise both for the patient and CE.

Clinical Ethics Learner 3

Post-consult would sometimes leave me feeling anxious. The ethical quandaries I learned about in my coursework, felt easy to discuss and deliberate. However, in these consults, I was now encountering real-world ethical issues with actual staff and patient(s). I felt a strong sense of empathy for the staff and patients and the difficult situations they were facing. Even though the CEs would provide support to the best of their ability, sometimes patients and staff were still in the same situation, without a clear path to resolve it. I realized that these issues do not just get left with the staff and patients, but also the CEs. I think as a future CE that it is important to acknowledge my emotions and learn how to debrief them constructively.

Clinical Ethics Learner 4

The question regarding the role of emotional experience in ethical consultation compels me to reflect upon the likely integration of Artificial Intelligence (AI) into the relationships that exist between patients, physicians, and CEs. How might this change one's emotional experience in the delivery of care? What will be gained and what will be lost? Will AI be deployed as "empathy machines", allowing clinicians and CEs to enhance their ability to communicate compassionately, or provide respite by allowing them to temporarily step out from under the weight of their consultations? Can the use of unfeeling machines help to fight burnout in a health system that is increasingly stretched thin? What happens when CEs become disconnected from the emotional gravity of their consultation? Does this enhance their ability to reason, or cripple it? Though the answers to these questions are presently unclear, what I am certain of is that more research is required to better understand the important and thought-provoking question of the role of emotional experience in ethical consultations.

Clinical Ethics Learner 5

Working in healthcare is undoubtedly an emotional experience and this fact is certainly not lost on CEs or learners who observe consultations. As a learner, my experience of a ChELO (Checklist to meeting Ethical and Legal Obligations), wherein the CE ascertains information about a patient's correct substitute decision maker, along with information about the patient's wishes, values, and beliefs, was invaluable in illustrating the CE-patient dynamic and the potential for shouldering an emotional burden given the medical and ethical context. This experience has made me pause and think about the emotional aspect of clinical ethics work and how that might reasonably impact CEs after particularly burdensome consultations or the cumulative effect of numerous consultations.

Clinical Ethics Learner 6

> *Throughout my years as a clinical ethics intern, I have been afforded the privilege to enter spaces and places where individuals interact with the healthcare system in various forms. As an intern, I have grown a particular appreciation for the opportunity to engage with patients and families as they navigate through the healthcare system to offer support when invited. The situations I have been exposed to as a clinical ethics intern, whether discussing MAiD or patients sharing their wishes, values, and beliefs with the healthcare team, can be challenging for both the CE and patient/family. Consultations can take an emotional toll on both CEs and patients, as difficult conversations often occur. Over the years, I have recognized how vital open communication is in healthcare and how small gestures, such as listening to a patient's concerns, feelings, and goals, can impact their experience within the healthcare system. Initially, when leaving consultations that involved difficult conversations, I would harp on every word and small aspect of the conversation, feeling overwhelmed and concerned about what I said or didn't say. Over time, I have learned to separate my own expectations of consultations and discussions and focus on patient-centered care as an overall objective – this helps to ensure that the patient's wants, needs, and feelings are adequately addressed.*

Clinical Ethics Learner 7

> *While observing a physician-led family meeting regarding end-of-life options for a terminally ill patient, in the weight of the circumstances I found myself feeling admiration for the compassion with which the meeting was conducted. Here was the kind of deep and meaningful human-to-human connection I was learning to support in patient-provider relations. I watched and felt as the physician created space for understanding, preserving regard for the patient's values as well as the heavy emotions in the room, all the while demonstrating exemplary kindness and patience as everyone digested the devastating news being delivered.*
>
> *As the CE offered comfort, I experienced firsthand the ways in which learners take on the emotional residue of our encounters. While we help others process the weight of impossible scenarios and the moral and ethical questions that accompany them, some of that weight inevitably gets transferred onto us.*
>
> *That day, I felt it as I left the hospital. I felt heavy and disconnected, deeply struck by the pain that the poor prognosis of this patient unleashed on the family, the care team, and on me. I wondered what will I feel when I'm a CE? Who can I turn to when I need support as a CEL? What happens when emotions from the professional bleed into the personal?*
>
> *It is perhaps a cruel irony that our vocation calls us to support others with varied and complex human responses to ethical dilemmas in healthcare contexts, yet our training doesn't necessarily prepare us to process our own responses. For now, I'm hopeful that by leaning into these emotions, by experiencing them not in isolation but in community with patients, their families, providers, and other CEs, I will come to embrace the profound privilege we share of being so close to the fullness of our humanity in these moments.*

Analysis of learners' narrative accounts

To analyze the narrative accounts effectively, a thematic analysis was conducted by two of our co-authors (MB and JVL). Coding the narrative accounts with an inductive approach allowed us to develop four different themes. Themes across all reflections included the impact of varied experiences and seniority, the cumulative emotional burden of ethics consultations, post-consultation emotional regulation and processing, and prioritizing emotion management in clinical ethics training.

Both the varied experiences and level of seniority had an impact on each CEL's response and emotional experience after a consultation, as well as the ownership they felt over addressing the ethical quandary at hand. Some CELs had been part of consultations for more emotionally charged situations such as those involving MAiD, whereas other learners may have been part of consultations that although challenging, may not have been as burdensome on their own emotions, such an ethical issue arising in long-term care. Additionally, the length of training within the program has an impact on these responses and emotional experiences. A longer duration of training typically means increased exposure to a variety of cases, some more emotionally and ethically charged than others. This exposure may allow a more senior CEL to be able to better process and understand the outcomes of a consultation and how they may affect patients positively or negatively.

Despite these distinctions between learners, we elected not to indicate which learner authored which account. Furthermore, due to the small size of the cohort and because of the risk that participants could easily be identified depending on the context, themes were developed by identifying patterns that emerged across the full set of data, rather than drawing out themes from single accounts. Not all learners are reflected in every theme. Rather, each theme reflects multiple learners. Below, each theme is illustrated with excerpts.

Theme 1: Cumulative emotional burden of ethics consultations

Learners who reflected on the sensitive nature of ethics consultations and their own responses to them identified a need to create more support for CEs and CELs. Even though one may be able to regulate their emotional state following an ethics consultation, CELs expressed a belief that this ability would dwindle with more consultations over time, especially given the varying degrees of stress associated with different cases.

> "*It prompted me to reflect deeply on the profound implications of these consultations and whether they exert a cumulative emotional toll.*"

> "*This experience has made me pause and think about the emotional aspect of clinical ethics work and how that might reasonably impact CEs after particularly burdensome consultations or the cumulative effect of numerous consultations.*"

Theme 2: Post-consultation emotional regulation and processing

Other CELs spoke more specifically to what post-consultation emotional regulation and processing might entail. Since CEs engage in emotionally laden work, it is reasonable to consider the potential positive effects of talking about the emotions experienced and perhaps learning methods to aid in decompressing after consultations. Intuitively, it may be difficult to deal with strong emotions, especially when one does not have the space to talk about their emotions. In the context of clinical ethics, this truism should be dealt with effectively and CEs and learners could benefit from engaging with one another and debriefing. Collaborating and debriefing with HCPs who specialize in mental and emotional well-being, such as registered social workers and psychotherapists, could be particularly promising.

> "*I think as a future CE that it is important to acknowledge my emotions and learn how to debrief them constructively.*"

> "*[...] our vocation calls us to support others with varied and complex human responses to ethical dilemmas in healthcare contexts, yet our training doesn't necessarily prepare us to process our own responses.*"

Theme 3: The impact of emotion on the ethicist's ability to reason

One concern that was identified in the narrative accounts related to the acknowledgement of the emotional aspects of clinical ethics consultation — that is, the impact of emotion on the CE's ability to reason through ethical dilemmas. Emotions are often thought of as loud, dramatic, observable, and obvious; while this can be true, they are often more complex and not always outwardly visible. We can never fully comprehend the internal emotional experience, and are often not fully aware of our own, as it tends to quietly unfold in our inner worlds, under the surface, unseen, and unheard. Although we formulate explanations for what and why we feel, the limitations of our awareness allow us only to capture pieces of it; our ability to articulate these experiences is therefore reduced to what we can identify. Yet emotion is not merely a passive experience. Rather, it is a dynamic and essential tool that shapes and guides our reason, offering valuable information beyond what logic alone can render intelligible. Whether salient or obscure, enduring or ephemeral, our emotions and that of others are deserving of recognition. We would all do well to acknowledge our emotional experience for what it is; a valuable source of information, and warranting serious consideration in the activities of ethical consultation and discernment.

> "*What happens when CEs become disconnected from the emotional gravity of their consultation? Does this enhance their ability to reason, or cripple it?*"

> "*[...] I would harp on every word and small aspect of the conversation, feeling overwhelmed and concerned about what I said or didn't say.*"

Theme 4: Emotion management in clinical ethics training

Regarding emotion management in clinical ethics training, the need for robust coaching in navigating consults as well as the acknowledgment of the inherent privilege of the profession were sub-themes identified in learners' narrative accounts. Investing time and energy in coaching that is individually tailored can provide learners with essential tools to ensure they are equipped to deliver quality-driven ethics support to patients, families, and healthcare providers. Effective coaching for consultations might include making time for emotional debriefs, honing and recognizing the importance of communication skills, centering patients' values, wishes and beliefs, and creating a space for empathy.

When it comes to navigating clinical ethics consultations, learners also reflected on the importance of recognizing the emotional gravity of these consultations. They acknowledged that these consultations take an emotional toll on all parties involved, highlighting the importance of open communication in their reflections. Since listening to patient concerns, feelings, and goals significantly impacts their healthcare experience, learning how to create spaces for understanding and preserving patients' values amidst these conversations was identified as a vital skill. Recognizing consultations as a vulnerable experience allows

for a deep appreciation for this work and acknowledging the privilege of entering these vulnerable spaces can be a way to balance the gravity of the experience with its profound impact and potential to improve health outcomes for so many.

> "*[…] I experienced firsthand the ways in which learners take on the emotional residue of our encounters.*"

> "*Over time, I have learned to separate my own expectations of consultations and discussions and focus on patient-centered care as an overall objective – this helps to ensure that the patient's wants, needs, and feelings are adequately addressed.*"

The above analysis highlights key themes that are central to the experiences of CELs, and both underscores the need and provides a foundation for exploring, in the following section, what is known about emotions in clinical and ethics practice.

BACKGROUND

The complex and emotionally charged environment of a clinical setting experienced by patients, their families, and HCPs makes the consideration of emotions particularly salient for healthcare decision-making. Emotions affect the process of making effective decisions, alongside other influencing factors such as knowledge, perceptions, and instincts (2). In clinical settings, the provision of care can evoke different emotional responses on either side of the hospital bed for both patients and HCPs (3). As CELs, we recognize that there are clear distinctions between the role of an HCP and CE. The differences between these roles in a clinical setting stem from their involvement in the clinical processes, treatment, and overall role in care. Surveying what is known about the nature and impact of emotions for patients and HCPs can thus provide the contextual background necessary to pose a parallel inquiry for CEs.

EMOTIONS OF PATIENTS & FAMILIES

For patients, accessing health services can be an emotionally charged experience due to the often invasive, unfamiliar, and high-stakes procedures that carry with them various potential risks. These emotions may result in a sense of powerlessness over their bodies, often exacerbated by past interactions with the healthcare system (4). Families of patients can also experience a range of emotions such as fear, anger, and sadness alongside their loved ones who are facing serious illness (3).

EMOTIONS OF HEALTHCARE PRACTITIONERS

Given the proximity to patients, families, and other HCPs, HCPs undoubtedly also experience emotions throughout their practice, even while being expected to uphold a decorum that maintains professional distance (3). Studies that have focused on HCPs' emotions elucidate the impact emotions have in clinical practice. For example, HCPs have expressed feeling hurt or frustrated when delivering bad news to new parents (5), having feelings of powerlessness in managing difficult engagements between patients and next-of-kin, unease over inequality, and discouragement over non-compliant patients (6). Recently, Goldenson and Gutheil (7) described psychiatrists feeling traumatized and distressed during forensic mental evaluations. Notwithstanding one's own responses to these encounters, emotions may also arise when attempting to manage the emotions of patients throughout the course of their care, which not only requires continuous regulation and effort, but over time can pose an increased risk for suboptimal care (4).

Emotions are also known to come from organizational aspects of the HCP's work, such as system settings and the allocation of resources (8). The COVID-19 pandemic in particular highlighted how intense stress affected HCPs and led to burnout being overlooked in healthcare deliberation, resulting in suboptimal provision of care and decision-making (9-11). When emotions are left unchecked and unregulated, the increasing emotional load can influence the mental well-being of HCPs, which can compromise the quality of health outcomes for patients (12), and result in burnout, compassion fatigue, empathic fatigue, and physical and emotional burden (8,13). This may also lead to detachment from one's own emotions, and consequent empathy degradation, which has downstream effects on patients and their families (14).

The emotional toll on HCPs is particularly pronounced in contexts involving workplace violence and abuse, and the literature documenting this relationship is extensive: a recent meta-analysis of 75 studies involving 139,533 healthcare workers across 32 countries found that the median frequency of workplace violence was 51%, with violence associated with higher burnout rates, increased anxiety, and higher turnover intentions (15-20). Structural and organizational factors (such as social support, quality of the working environment, and workload) have been shown to moderate the relationship between workplace violence and burnout (15-20). Primary studies corroborate these patterns: among nurses and emergency medical service workers in Germany, frequent verbal abuse was reported by 44.7% and 59.9% respectively, with both physical violence and verbal abuse significantly associated with high burnout risk in the dimensions of emotional exhaustion and depersonalization (15-20). Similar correlations between workplace violence, bullying, burnout, and depression have been documented in other nursing populations (15-20). These findings underscore a well-established relationship between difficult clinical encounters and healthcare worker emotional well-being; a relationship that warrants examination in the context of clinical ethics practice.

EMOTIONS AND CLINICAL ETHICS?

A common theme explored is empathy, which is the ability to understand the patient's point of view, show understanding, and make suggestions that reflect shared understanding (21). Empathy, and its impact on therapeutic relationships and quality of care, has been widely discussed in medicine, nursing, and other professions (22). Yet there is sparse mention in this literature of CEs as specific HCPs who experience these emotions, and even less for CELs. Even though CEs have direct relations with patients and their families, little is known about how they deal with emotions associated with these interactions, and whether there are untoward effects of the accumulation of these emotions over time.

The role of emotion is particularly relevant for CEs, who face some of the most difficult and emotionally laden challenges in hospitals, replete with stressed stakeholders, conflicting preferences, strained communication, insurmountable loss, and grief (23,24). CEs differ from other HCPs in that they have a multifaceted and far-reaching scope of practice; not only do their roles encompass healthcare decision-making, clinical consultation, and direct patient care, but they also extend into policy development, education, research, and organizational ethics (25). CEs consistently find themselves treading water in situations loaded with theoretical, interpersonal, and interdisciplinary ambiguity, conflict, and uncertainty. As a result, there is a disparity between the reality of practice and the expectations that those without formal bioethical training have with respect to the role of CEs — an expectation that commonly involves a desire for direction and guidance regarding what the "right" answer is. Indeed, although there may often be no "right" answer, the CE is, at the very least, highly skilled in identifying the right question. CEs therefore play pivotal roles in conceptualizing and assisting with ethical dilemmas in clinical contexts, communities, professional organizations, political spheres, and industry (26).

To fulfill their specialized role, CEs possess multidisciplinary and professional knowledge that is specific to hospital administration and policy, and skills for successful conflict resolution, such as mediation, communication, and recognition of moral problems from varying perspectives (25). CEs are often involved in multiple aspects of patient management, from informed consent to determining substitute decision-makers to supporting end-of-life decisions, such as Do-Not-Resuscitate Orders and MAiD. This requires full immersion in cases and consultations to assist both patients and their families in overcoming the emotions that accompany complex decisions; and it also requires providing support to manage emotional stress and burnout for the HCPs involved (23,24).

Despite being called upon to support emotional regulation for patients, families, and HCPs, an aspect of clinical ethics practice that remains neglected and under-examined in the academic literature is the degree of emotional expenditure required to provide quality-driven normative guidance on ethical issues (26). Though the role of emotions extends across a broad scope of practice and appears quite profound, there is little empirical evidence about how emotions are experienced and regulated for CEs, and what the impact of these emotions are as they accumulate over time. This lack of knowledge may stem from ignorance or suspicion toward both the practical and reflective role of emotion in a field that is predicated upon rational anthropology (27), or it may be a result of a lack of awareness of the cumulative and relational implications of emotions. Given the fact that many CEs often come from diverse academic and disciplinary backgrounds, they are also unlikely to have received the appropriate training specific to recognizing and dealing with their own emotions and those of others, which negatively affects their professional aptitude (24). The lack of data that explicitly focuses on the cumulative and relational management of emotional distress, compassion fatigue, and moral residue in the context of clinical ethics and clinical ethics training is of critical importance, not only given the increasing rates of clinician burnout among HCPs generally, but also because of the potential for emotions to significantly impair information processing, communication, and decision-making, skills which are essential for the work of CEs (24).

In the purview of practicing clinical ethics, ethics consultation, in the epistemological sense, is largely premised on emotion. Emotions are thought to constitute a "self-articulating hermeneutic competence" (28, p.303) in ethical deliberation, such that their articulation both dialogically and discursively reveals a person's moral experience as well as their situational perception of the particular ethical situation, supplying relevant parties with a practical orientation to understand oneself and others (28). Because emotions constitute such complex cognitive experiences, they may persist unbeknownst to us, and efforts to reduce this opacity have been given little attention, despite the role they play in effectively carrying out ethics consultations (28,29).

Some CEs claim that addressing emotions in the context of consultations displaces the application of ethical theories and concepts to cases, which are otherwise considered the "real" skills of the ethics consultant (30). These CEs tend to view ethical cases as idealized compilations of ethically complex facts that neglect to consider the dynamic circumstances, settings, and structures of meaning that presuppose the holistic interpretation of actual cases (30). In doing so, by positioning the acquisition and application of cognitive analytics skills and theory as the most championed capacities for performing ethics consultations, we risk relegating the communicative process and interpersonal emotional aspects associated with cases to the periphery (30).

Notwithstanding the view that cognitive analytic skills and theory be ranked higher than communication and emotions in the work of the ethicist, as part of an integrated role within a healthcare team, CEs inevitably take part in discussions and consultations which may offer opportunities to identify, address, and respond to different emotions. These emotions include the relational and existential suffering of patients, their families, and other HCPs, as well as addressing the moral distress of HCPs. Yet there remains a lack of both descriptive and empirical literature that identifies the cumulative emotional work that

is endured to provide this level of compassionate care (31). What has been noted, according to Redinger and Gibb (24), is the intense emotional burden implicit in the role of CEs; and by drawing from the psychotherapeutic clinical psychology literature, suggestions have been proposed for consultant training reform such as advocating for systematic reflection on the emotional aspects of challenging cases (24).

Furthermore, it has been argued that empathy and the provision of empathic care (32) play an indispensable role in ethics consultations and substitute decision-making (33). These might even constitute a primary competency and ethical command (32) for ethics consultants to facilitate communication, though also potentially negatively affecting moral reasoning by hindering neutral perspectives (3). Although the choice to not be empathetic is commonplace in healthcare, given the perceived costs of being so, empathetic care, as conceived by the field of healthcare bioethics, parallels the ethics of care in highlighting the importance of interdependent relations, needs, and emotions in offering moral insight and is constitutive of patient-centred care (32). What remains to be sufficiently outlined in the literature is the interpersonal and cumulative effects of CEs practicing empathic care over extended periods, which warrants further investigation.

That said, a recent qualitative study by Goff and colleagues (20), involving 34 semi-structured interviews with CEs across the United States, represents an important contribution to addressing this gap. Their findings reveal that particular features of clinical ethics work significantly affect the emotional state of CEs, that lack of role clarity exacerbates emotional burden, and that CEs employ a variety of professional and personal coping mechanisms when experiencing adverse emotions (15-20). This empirical work confirms what has long been theorized: that CEs are profoundly affected by their work at both individual and systemic levels. However, even with this recent contribution, empirical knowledge specifically regarding CELs remains virtually absent.

DISCUSSION

The work by Goff and colleagues (20), which documents empirically the emotional impact of clinical ethics work on practicing CEs, validates the concerns raised by the learners in our reflections and underscores the importance of this line of inquiry. Our paper contributes a complementary perspective by highlighting the experiences of learners; individuals who encounter these emotional dynamics while still developing the frameworks and support structures to process them. As previously mentioned, there is extensive literature on the role and nature of emotional responses for many frontline HCPs, such as nurses and physicians; relatively little exists on the emotional experiences of CEs and CELs. Our analysis of narrative accounts thus aims to draw attention to a critical knowledge gap by detailing the interplay between the practice of clinical ethics and emotions whilst advocating for empirical inquiry to better understand the cumulative emotional burden of this profession. As CELs, our reflections emphasized the emotional challenges inherent in ethics consultations. Learners in our paper cited emotional burden associated with clinical ethics consultations in practice that can affect CEs and learners alike. As a response, we outlined possible tools for emotion management such as debrief sessions to mitigate the impacts of consults, offering learners a space to decompress post-consult. Learners acknowledged in their accounts that emotions, whether subtle or apparent, are influenced by complex factors and can/do significantly affect parties involved in these consults. Education, training, and support surrounding the emotional burden associated with consultations, along with recognizing the privilege and emotional gravity of this work is vital.

LIMITATIONS

As early career CELs, we recognize that the opportunities we have been afforded may differ depending on the type of clinical ethics learning program in which one is engaged. All learners included in this paper are based in a community hospital system located in the Greater Toronto Area. Individuals are eligible for the program at any stage of their career. Learners thus come from various stages in their educational and professional careers, with varying degrees of experience with clinical ethics work, patient populations, and the health care system more broadly. We recognize that these differences likely shaped how each learner experienced and reflected on clinical ethics consultations. However, because the cohort size was small, a key priority for the collection of narrative accounts was to maintain anonymity. To maintain confidentiality, individual characteristics were not linked to specific accounts. Our interpretation instead focused on identifying patterns of emotional experiences that were shared across learners rather than attributing themes to particular individuals, and we explored emotional dimensions rather than providing an exhaustive synthesis of empirical evidence.

CONCLUSION

This paper raises the question of the cumulative impact of encountering emotionally charged clinical ethics cases over time, and how this could affect the overall well-being of CEs and CELs. As such, this work sheds a critical light on the need for more nuanced attention to the role that emotions play for CEs, learners, and clinical ethics practice. Although complex and subjective, and given our clinical experience, we argue that emotions should not be regarded as a less important aspect of the practice. As emotions can influence all parties involved in clinical ethics consultations and decision-making, it is not only imperative that further studies be done but that we raise the question of whether CEs and learners are sensitive to and aware of their emotions and clinical experiences. With this in mind, we advocate for researchers to conduct empirical studies focusing

on the presence, identification, and management of the emotions of both CEs and learners before, during, and after consultation. This may include longitudinal studies to better understand the cumulative effect of emotions. Additionally, the integration of simulation labs in bioethics curricula, perhaps modeled on real life case studies, could prove beneficial in equipping learners with the necessary tools to engage both meaningfully and constructively with the types of emotional experiences they are likely to encounter in practice, as well as furnish them with tools to internally manage the impact of those encounters. This is a fruitful area of future study with important practical and pedagogical implications for the clinical ethicist profession.

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