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RESEARCH ARTICLE

An Educational Framework for Healthcare Ethics Consultation to Approach Structural Stigma in Mental Health and Substance Use Health

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Abstract

This paper addresses the need for, and ultimately proposes, an educational framework to develop competencies in attending to ethical issues in mental health and substance use health (MHSUH) in healthcare ethics consultation (HCEC). Given the prevalence and stigma associated with MHSUH, it is crucial for healthcare ethicists to approach such matters skillfully. A literature review was conducted in the areas of bioethics, health professions education, and stigma studies, followed by quality improvement interviews with content experts to gather feedback on the framework's strengths, limitations, and anticipated utility. The proposed framework describes three key concepts: first, integrating self-reflexive practices into formal, informal, and hidden curricula; second, embedding structural humility into teaching methods and contexts of learning; and third, striking a balance between critical consciousness and compassion in dialogue. The proposed educational framework has the potential to help HCEC learners enhance their understanding and awareness of ethical issues related to structural stigma and MHSUH. Moreover, context-specific learning, particularly in MHSUH, can play a significant role in promoting competency-building among healthcare ethicists, allowing them to address issues of social justice effectively in their practice. Further dialogue is encouraged within the healthcare ethics community to further develop the concepts described in this framework.

Keywords: education; healthcare ethics consultation; mental health; structural stigma; substance use

Background

Stigma related to mental health and substance use health (MHSUH) manifest in diverse ways across clinical practice, organizational policy, and public health. Stigma is a marker of difference and deviance; it tracks social disadvantage and intersects with other structural forms of oppression such as racism and poverty, which have an adverse impact on health.[1] Considering stigma as a fundamental cause of population health inequities demands that health professions' education (HPE) support learners in developing competencies to address structural stigma in MHSUH care.[2,3] For instance, MHSUH stigma can contribute to biased decision-making and intensify health inequities.[4] By learning how to acknowledge, act, and respond to scenarios of MHSUH stigma-related injustices, healthcare professionals (HCPs) can support ethical decision-making while promoting values of inclusive, compassionate, patient-centred care.

Stigma can be categorized into typologies of self-stigma, social stigma, and structural stigma, all of which impact populations experiencing MHSUH challenges.[5,6] Self-stigma (*intra*personal) is based on one's own internalization of negative attitudes toward their condition, whereas social stigma is concerned with the *inter*personal understanding of how we externalize these attitudes in relation to one another.[7]

Structural stigma refers to the "societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatized populations".[8] Anti-stigma interventions exist at micro-levels (e.g., individual education, professional development), meso-levels (e.g., educational programs, healthcare institutions), and macro-levels (e.g., public health education to advance policies, laws, and practice guidelines) with varying degrees of evidence of effectiveness.[9,10,11,12] Structural stigma is best described through a lens of structural competency, which "[recognizes] how "culture" and "structure" are mutually co-implicated in producing stigma and inequality".[13] Over the past several years, HPE has begun to integrate structural competencies into curricula beyond the social determinants of health to encompass the broader structures in which they exist.[14]

Bioethics, and healthcare ethics consultation (HCEC) in particular, supports the navigation of ethical issues in clinical contexts, including MHSUH. Healthcare ethicists offer HCEC services to a diverse range of stakeholders such as patients, caregivers, HCPs, and policymakers. The *American Society for Bioethics and Humanities* (ASBH) outlines core competencies to support healthcare ethicists in establishing rapport and integrity based on a pre-determined set of skills, knowledge, and attributes.[15] Examples of attributes, or values-laden competencies, include humility, courage, compassion, and the ability to effectively identify and address power imbalances.[16]

Stigma is a complex concept, and is woven deeply into the fabric of our social, institutional, and healthcare structures. Healthcare ethicists are often sought by members of interprofessional healthcare teams to provide an external ethics expertise; however, the role of healthcare ethicists occupies space, power, and privilege, with the potential to influence decision-making outcomes.[17,18] When a healthcare ethicist socially positions themselves in relation to the ethical issue in question, they are able to better understand how their prior experiences and subsequently formed values influence both ethical decision-making processes and outcomes.[19,20,21] Issues of social justice are garnering greater attention in HCEC education, including the need for trauma-informed approaches to HCEC and racial justice in bioethics.[22] There is also increasing discourse for context-specific training to highlight the nuances of a unique clinical care setting, such as oncology or obstetrics and gynecology.[23,24,25] Within these areas, there is a need to advance educational competencies for HCEC at the intersection of clinical ethics and social justice to avoid perpetuating structural stigma in highly stigmatized areas of care (e.g., MHSUH, intellectual and developmental disabilities).[26,27]

Health professions such as medicine, social work, and nursing, offer extensive literature at the intersections of structural stigma, MHSUH, and quality of care. As identified in the HPE literature, effective teaching formats for ethical issues in MHSUH include case-study vignettes, case simulations, narrative-based learning, and role play. In HCEC, frequently cited teaching formats include didactic lectures, discussion-based learning, and case vignettes, studies, and simulations, with emerging literature on the use of virtual reality in online learning formats. Healthcare ethicists are positioned uniquely to critically engage with both the acute and chronic contributors to injustice that give rise to structural stigma, allowing them to act as agents of change within the structures that they serve.

Rationale

While literature exists on structural stigma in HPE developed *by* healthcare ethicists, there is limited literature on structural stigma education *for* healthcare ethicists, specifically in MHSUH care. Considering the impact of structural stigma is especially pertinent in scenarios where a combination of social, clinical, organizational, and systemic contextual factors may intersect, adversely affecting patient quality of care and raising ethical issues for those involved. For example, a healthcare ethicist might be requested to provide consultation for a team who is deliberating whether to offer a second heart valve replacement to a person who uses drugs who has infective endocarditis. This situation raises questions of resource allocation and who 'deserves' a second chance at a potentially lifesaving intervention, and the expectations many HCPs have about personal responsibility for health[28]. Existing HCEC core skills and knowledge competencies recognize the need to address issues of social justice; however, they lack specific guidance on developing these competencies to address the cognitive dissonance that learners experience when

translating theory into practice.[29,30] The ability for healthcare ethicists to skillfully approach ethical issues in MHSUH is essential given their intrinsic link to other areas of clinical care, health policy, and the broader public health system.[31] With 1 in 5 people experiencing a mental health issue in their lifetime, and the common co-occurrence with substance use challenges, the likelihood that a healthcare ethicist will receive a consult request related to MHSUH is high.[32] To our knowledge, there is no educational framework in the published literature that explores competency-building of MHSUH structural stigma as it pertains to HCEC learning.

Objective

We sought to identify key concepts that ought to be included in HCEC curricula designed to address structural stigma in MHSUH care. This paper describes the development process of creating an educational framework in this domain.

Population

The intended application of this proposed educational framework are HCEC learners enrolled in professional bioethics/healthcare ethics graduate degree or post-graduate fellowship programs in Canada and the United States (U.S.). Given the interdisciplinary nature of HCEC, learners begin consultation-specific training from varied educational backgrounds and professional disciplines (e.g., HCP, spiritual care practitioner, prior undergraduate and graduate academic training in philosophy).[33] Learning about biases and values-laden competencies are essential to support effective HCEC; however, not all professional disciplines include training on navigating stigma in practice. We envision that the key concepts in this proposed framework can be applied to various contexts of learning representative of both training and professional practice, such as bedside consultations, team meetings, in-class discussions, and academic and community presentations. The learnings from this framework also has the potential to provide downstream future benefits to affected stakeholders (e.g., patients, caregivers, HCPs, policymakers) who engage with HCEC learners and educators in various health-systems settings.

Theoretical approach

Transformative learning theory (TLT) and dialogic learning provide the theoretical foundation for our proposed framework. Bioethics education has a longstanding history of incorporating TLT, which posits that adult learners can reflect critically on new information to adapt their understanding of concepts formed by prior experiences.[34,35,36] Extending beyond knowledge acquisition, TLT describes how learners attribute meaning to experiences and how this subsequently shapes their worldview and influences learning.[37] The goals of HCEC merge concepts of instrumental and communicative learning, where healthcare ethicists are required to demonstrate excellent communication skills in problem-solving scenarios, not only of themselves, but to understand and effectively communicate the ideas of others. TLT also considers how beliefs, feelings, and judgements, inform how learners interpret information.[38] Two major elements of TLT include (i) critical reflection of one's own assumptions and an evaluation of its sources and (ii) full immersion in dialectical discourse to explore the epistemic nature of alternative solutions.[39] TLT outlines concepts that intersect with existing HCEC core competencies, for example, confronting a dilemma, critically assessing one's personal biases, exploring options for action by identifying and acquiring pertinent knowledge, and creating a plan of action.[40] Recent literature has highlighted the problematization of TLT with respect to issues of intuition and emotion, decontextualizing and rationalizing issues of power and privilege, and lacking discourse on social justice and morality.[41] While TLT supports the learner's ability to critically think about their preconceived ideas and critically reflect on their values and beliefs, it does not address *action* in scenarios of critical discourse.[42]

Dialogic learning promotes opportunities for knowledge exchange between learner-learner and educator-learner interactions.[43] Aligning with principles of health equity, dialogic learning seeks to

create space for emotion while engaging in dialogue.[44] By invoking dialogic learning models to address structural stigma in MHSUH, HCEC learners can minimize concerns of judgment from their peers as they process new information and consider factors that affect change at intrapersonal and structural levels. Dialogic learning is an effective teaching method to highlight the health inequities that structurally vulnerable and historically marginalized groups experience, such as racialized groups and people living with intellectual and developmental disabilities.[45,46] Dialogic learning also incorporates diverse teaching methods, ample opportunities for self-reflexivity in relation to structural forces of oppression, and emphasizes the collaborative, interprofessional role of the healthcare ethicist.

Methods

Framework design

We developed our framework by conducting a literature review and quality improvement interviews with content experts in bioethics, HPE, and stigma studies. To determine the relevant educational theories used to inform this framework, we reviewed literature in the education sciences. We adopted and adapted methods from scoping review frameworks, such as those of Hilary Arskey and Lisa O'Malley, to highlight meaningful engagement with relevant stakeholders.[47] We triangulated feedback from the interviews by conceptualizing the "Consultation" phase in the scoping review process as integral to developing a framework that seeks to benefit the target population directly.[48] This project received ethics review from the Centre for Addiction and Mental Health (CAMH) Quality Projects Ethics Review (QPER) service.

Literature review: data collection and analysis

We conducted a literature search using OvidMEDLINE and Google Scholar in the areas of (i) bioethics and the health professions, (ii) education sciences, (iii) stigma studies, and (iv) MHSUH. In consultation with an academic research librarian, we developed our search strategy based on a comparable framework for HPE in MHSUH.[49] Inclusion criteria for our literature review were academic and grey literature from Canadian and U.S. healthcare practice contexts. We excluded relevant literature where full-text access was irretrievable or unavailable in English. This yielded n = 439 eligible records for OvidMEDLINE, of which n= 81 were included in analysis. Thirty-eight articles were included from the Google Scholar search, as well as a conference presentation (n=1), and grey literature (n=3). We screened all search results and reference lists for relevance based on the populated titles and abstracts, when required. We generated a prioritized list of literature for full-text review based on relevance to our key areas of exploration. We recorded data using the charting technique, a commonly used method to sort data for literature review.[50] We categorized the data, where available, by database, title, DOI, authors, journal, date and location of publication, publication type, target demographic, practice context, and key findings.[51] We analyzed and summarized data inductively based on key ideas from the charted data.[52] These findings were consolidated to inform a preliminary draft framework for review by content experts.

QI interviews: recruitment and sample

We recruited content experts in bioethics, HPE, and stigma studies who represent both learner and educator perspectives of potential users of this framework. We recruited educator-perspective participants from our professional networks in Canada and the U.S. along with key contributors to these domains of literature. To recruit learner-perspective participants, we contacted a Canadian healthcare ethics Fellowship program director. Participant inclusion criteria were healthcare or academic professionals in Canada or the U.S. with experience in:

(i) Creating or delivering university-level education in the following area(s): HPE, bioethics education, program evaluation; or
(ii) Providing HCEC as an actively practicing healthcare ethicist; or

(iii) Conducting research or scholarship on health-related stigma; or
(iv) Participating in a healthcare ethics Fellowship as a learner

We contacted 7 prospective educator-perspective participants and 2 prospective learner-perspective participants. Six educator-perspective and 1 learner-perspective participants agreed to be interviewed. Our educator-perspective participants included healthcare ethicists, stigma scholars, researchers, educators, and mental health clinicians, from both Canada and the U.S. Our learner-perspective participant was a healthcare ethics Fellow with no specialized training in MHSUH. We also contacted a recent healthcare ethics Fellow and a content expert in structural competency in HPE to review a preliminary draft of our manuscript and provide critical feedback.

QI interviews: data collection and analysis

The first author conducted 30-minute QI interviews on the secure, video conferencing platform, WebEx. Interviews were audio recorded but not transcribed. The first author took detailed notes of participant's responses, which were then analyzed to identify recurring themes or areas of interest worthy of further exploration in the literature. We provided participants with a draft framework prior to their scheduled interview for optional review and began all interviews by reviewing the framework. We followed a semi-structured interview guide that began with obtaining participant consent, describing the project's purpose, gathering a history of the participant's professional background, and asking specific questions about the strengths, limitations, and utility of the framework in their practice context(s).

We triangulated the feedback obtained from interviews with the findings from our literature review to support key concepts in our framework that are practical for implementation. To guide the format of our framework, we also reviewed key literature on how to design evidence-informed frameworks for HCPs, guides for structural competency building, and anti-stigma practice guidelines in MHSUH.[53,54,55]

Findings

Literature review

Based on our preliminary review of the literature, we identified the following key themes: compassion, critical reflection, humility, and interprofessional practice. Relative to other areas in HPE, such as nursing, medicine, and dentistry, we identified limited representation of HCEC learner perspectives compared to educator perspectives. Similarly, we observed limited empirical literature on HCEC education in independent and intersecting areas of structural competency, structural stigma, and MHSUH relative to other areas in HPE. We also noted less discourse on substance use disorders (SUDs) in the extant HCEC education literature relative to mental health disorders. As described in the literature, we identified a greater number of contributions to literature from the U.S. HCEC practice context relative to the Canadian context.[56] Themes that we identified in the literature review were used to inform the framework's key concepts.[57,58,59]

Draft framework

We formulated a draft framework based on the preliminary themes that were generated from our review of the literature. The draft framework described three key concepts, their significance, implications for HCEC education, and potential opportunities for implementation:

1. Embed structural humility into multiple teaching methods and contexts of learning
2. Balance critical consciousness and compassion in conversation
3. Integrate self-reflexive practice into aspects of formal, informal, and hidden curricula

QI interviews

Based on the feedback from content experts (Table 1), we revised the key concepts in our draft framework. Participants provided recommendations for further review of the literature, guiding education theories, and format of the framework. Participants also offered content-related examples based on their areas of expertise. Table 2 summarizes their recommendations for implementing the proposed framework.

To address feedback from context experts, we increased the number of case examples embedded throughout the framework, and further reviewed education science literature to integrate multiple theoretical lenses (e.g., the addition of dialogic learning).

Proposed educational framework

Our framework is illustrated by a gear mechanism to represent a collaborative learning environment where both learners and educators are responsible for addressing structural stigma in MHSUH (Figure 1). Each key concept (i.e., gear) acts as an interconnected component of a larger functioning system.

Summary of proposed key concepts

- Integrate **self-reflexive practices** into formal, informal, and hidden curricula
- Embed **structural humility** into multiple teaching methods and contexts of learning
- Balance **critical consciousness and compassion** in dialogue

Key concept 1: integrate self-reflexive practices into formal, informal, and hidden curricula

Self-reflexivity describes a learner's introspection to further their understanding of self in relation to their professional practice. In HCEC practice, this includes intentional reflection of the healthcare ethicist's position towards an ethical issue and how this may influence their interpretation of relevant contextual factors to the decision-making process.[60] There is increasing recognition of the need to expand MHSUH anti-stigma education across the health professions, however, there is uncertainty in how to effectively integrate self-reflexive practices into aspects of the formal (i.e., explicitly stated), informal (i.e., implicitly stated), and hidden (i.e., interpreted based on relational practices of the learning environment) curricula. A 2021 study found that mental health professionals' who experienced higher rates of compassion fatigue, burnout, and depersonalization, were more likely to display stigmatizing attitudes towards

Table 1. Summary of QI Interview Participant Feedback on Draft Framework

Category	Feedback
Strengths	• Key concepts and areas of emphasis (e.g., structural humility, interprofessional practice) based on experiences leading education initiatives in various practice contexts (e.g., psychiatry, public health research, HPE)
Limitations	• Lack of empirical evidence, explicit examples, and recommendations • Limited assessment and evaluation of competencies related to structural stigma • Capacity for academic institutions to invest resources to design dedicated MHSUH ethics curricula
Framework Utility	• Effective teaching formats include case study vignettes and video simulations • The opportunity to collaborate with people with lived and living experience (PWLLE) benefits both learner and patient populations • Proposed key concepts may be beneficial to other patient populations who historically experience structural stigma (e.g., people living with intellectual and developmental disabilities) • Education for specific clinical contexts (e.g., MHSUH) may mitigate some of the challenges in relating lived and learned experiences to inform decision-making • Potential next steps include creating versions for use in applied and theoretical contexts of learning

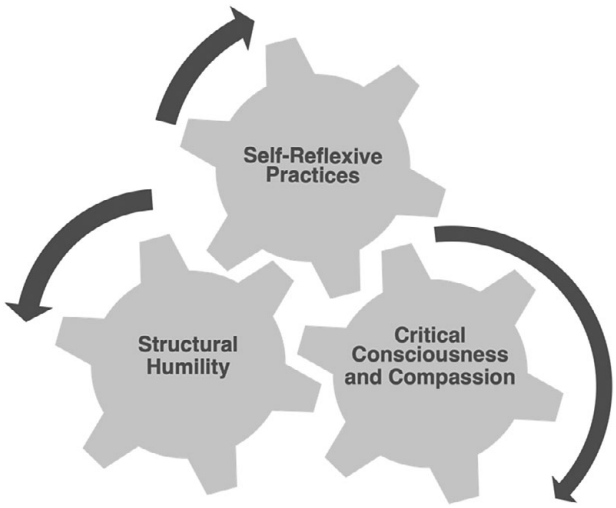

Figure 1. Visual representation of educational framework.

people with severe and persistent mental illness.[61] As recommended in the literature, institutions should incorporate assessments for these phenomena to address structural stigma experienced by MHSUH service users while simultaneously supporting HCPs' wellness.[62] To achieve this, curricula should prioritize fostering a positive relationship with self-reflexive practices, where HCEC learners advance their relational understanding of their surroundings by challenging their own values and assumptions. Once learners transition to professional practice, they will constantly engage in interpersonal interactions that require critical reflective and reflexive practices in hidden curricula.[63] Developing and strengthening this skill while in the theoretical safety of a learning environment allows for continuous and progressive growth. A significant challenge when incorporating MHSUH anti-stigma education into HCEC curricula is determining the degree and nature to which self-reflexive practices should be formalized. Providing learners with dedicated space and time integrated into formal curricula indicates importance and provides tangible opportunities to further develop their reflexive skills. Challenges of implementing self-reflexive practices into formal and informal curricula include determining what constitutes meaningful "reflection" for the purposes of assessment and evaluation.

Consider an example where HCEC learners submit a course assignment where they reflect on their experience in MHSUH ethics training by either writing an essay or delivering a presentation. Both are examples of formal curricula assessments that promote the advancement of competencies surrounding self-reflexivity and structural stigma in MHSUH. The challenge, however, lies in finding the balance of integrating reflexive practices between formal, informal, and hidden curricula to meet the unique learner's needs.[64] The standards, validity, and moral authority by which values-laden competencies are assessed and evaluated remain controversial in HPE, including bioethics. Without clear guidance on how to navigate this ambiguity, learners may experience conflict when navigating between formal and informal curricula, which may be in tension with their own approaches to addressing MHSUH stigma. Policy-related interventions to address structural stigma can also advance self-reflexive practices at the formal curricula-level. For example, academic institutions may choose to prioritize inclusive hiring and recruitment practices of HCEC learners who also identify as PWLLE with MHSUH challenges. This requires greater acknowledgment of the awareness and aptitude that lived experience offers as a form of expertise in relation to conventional metrics in academia (e.g., publication record, grade point average).[65]

Key concept 2: embed structural humility into multiple teaching methods and contexts of learning

Structural humility is described as a learner's ability to recognize, acknowledge, and act upon the *limitations* of structural competency, requiring critical reflection of the self.[66,67] In healthcare ethics practice, greater awareness of the social and structural determinants of health can promote a more robust analysis of ethical tensions that include confounders of structural stigma. In the presence of enablers of structural stigma in MHSUH care, or in the absence of explicit policy to address it, structural humility promotes critical reflection for healthcare ethicists to understand how their socially-situated perspectives influence ethical decision-making processes and outcomes. Learning applied skills (e.g., HCEC competencies) in applied methods (e.g., case simulations) and contexts (e.g., bedside consultations) can increase difficulty in discerning implicit and explicit sources of bias. By incorporating versatility in teaching methods *and* contexts of learning, HCEC learners can better understand the causal implications of theory when applied in practice. The initial frame of reference for understanding structural stigma in MHSUH will vary based on a learner's prior experiences practicing reflection. While models for HCEC facilitation do not endorse positions of moral superiority, the healthcare ethicist still holds authority in the form of ethics content expertise, and subsequent privilege to engage in the ethical decision-making process. While identifying an ethical issue is a core skills competency in HCEC, learners also require an in-depth understanding of the structural forces that influence the process of identifying these issues to inform outcomes that minimize systemic harms.[68]

To address the limitations of one's content knowledge and expertise, a potential opportunity to incorporate structural humility into HCEC education is by co-creating the curricula and its delivery with PWLLE with MHSUH. Patient engagement can support HCEC learners to advance their understanding of MHSUH and structural stigma with authenticity and compassion, as there is some evidence that increased contact with PWLLE with MHSUH can help reduce stigma. Paula Chidwick et al. discuss the self-identified importance of humility and self-awareness in clinical ethics Fellowship training from the learner perspective.[69] By diversifying teaching methods and contexts of learning when approaching MHSUH education with HCEC learners, greater capacity for awareness can be achieved through the adoption of narrative inquiry – a teaching method in collaboration with PWLLE that has become increasingly popular in HPE. In HCEC, narrative inquiry presents unique challenges to implementation, namely in privacy and confidentiality; however, its proven efficacy in comparable health professions for addressing structural stigma in MHSUH warrants further exploration for HCEC.

Key concept 3: balance critical consciousness and compassion in dialogue

Critical consciousness describes a learner's ability to appreciate the diverse social and structural factors that inform the identification, analysis, and actionability of ethical issues different from their own experiences. Compassion, often described as the actionable response to empathy, has been highlighted in both literature and practice as a requirement for effective HCEC.[70] As described by ASBH, the acquisition of complex constructs such as compassion is challenging to implement in dynamic, professional healthcare settings.[71] While debate is a conventional teaching method in philosophy and bioethics education, there are multiple methods to engage in critical discourse that supports an ethics facilitation model in HCEC.[72] Recognizing the value of practicing compassion in collaborative learning, critical discourse and interprofessional communication can support key skill acquisition for healthcare ethicists. Examples include learning respectful and inclusive terminology and being able to integrate diverse perspectives into analysis thoughtfully.

Consider a scenario of HCEC learners participating in a class debate about policies on illicit substance use and access to healthcare services and resources. During this discussion, a learner expresses their beliefs about the voluntary "self-inflicted harm" that PWLLE of substance use engage in, claiming that because "addiction is a choice", people who use drugs "do not deserve" access to life-saving scarce resources, such as ventilators during a pandemic. The learner does not provide any reasoned empirical or ethical rationale

for their statement, and the instructor does not comment. After class, another learner who self-identifies as PWLLE of substance use expresses emotional distress to their instructor about the views shared by their peer. In this scenario, both the instructor and learners should practice compassion while actively address MHSUH stigma within the learning environment. Practicing compassion requires acknowledgment that an individual's prior experiences, social identity, and the relative power, privilege, and disadvantages, that these experiences have formed, will influence their initial understanding of ethical issues of all kinds, including cases in MHSUH. Collaborative learning spaces are most effective when they create a culture of safety to both teach and learn in without fear of judgment. One approach to navigating challenging discussions during critical discourse is to practice conflict resolution skills. These are theoretically outlined in existing HCEC skills and knowledge competencies; however, there is lesser guidance on how to actualize these concepts in an inclusive manner, specifically for HCEC learners.

The capacity to develop critical consciousness is known to be most effective when learners receive support in challenging social norms and inequities.[73] In the example above, the instructor may serve as a mediator between learners with conflicting values, while upholding values of safety and trust in the classroom. For HCEC learners to foster trust and demonstrate trustworthiness in professional practice, they must grow in their understanding of interprofessional collaboration and dialogue through mutual respect. This includes both learners and educators supporting a learning environment that underscores the challenging of assumptions as important learning opportunities.[74] In alignment with dialogic learning, HCEC learners can further advance their understanding of compassion by minimizing judgment towards opposing opinions and maximizing opportunities for collaboration.[75] Applying a transformative learning approach acknowledges prior lived experiences, and dialogic learning models help healthcare ethicists emulate practices of compassion and active listening in their own professional practice.

Limitations

Our inclusion criteria for the literature review and participant recruitment for QI interviews were limited, geographically, to Canada and the U.S. Although this supported a valid evidence base given the similarities in HCEC practice, this resulted in majority of the data being informed by Western approaches to bioethics that dominate HCEC literature. Additionally, we limited our search strategy to the academic, peer reviewed literature. As such, content found in the grey literature, including non-academic documents such as advocacy position papers that may reflect the perspectives of PWLLE, were not included. Any broader, cross-referenced, or recommended grey literature was included in the development of key concepts, where relevant. Future research should include a comprehensive scoping review which captures both the academic and grey literature, along with literature generated in jurisdictions beyond Canada and the U.S. Participants in interviews also expressed gaps in empirical evidence in areas of HPE and MHSUH scholarship external to education, such as health policy and guideline development, both of which strongly influence practice. Canada has at least 3-5 active healthcare ethics/clinical ethics Fellowship programs, each of which recruit approximately 1-2 Fellows per year.[76] While we were only able to interview one learner-perspective participant, they shared rich and important insights about the need for greater data to inform curricula for HCEC learners, as suggested in the literature.

When implementing educational frameworks, a frequently noted barrier in both the literature and interviews include the potential challenges of evaluating and assessing values-laden competencies fairly between peers, namely for self-reflexive exercises that require vulnerability on behalf of the learner.[77] Research indicates that micro-level and meso-level interventions, *alone*, are not sufficient methods to address structural stigma in MHSUH.[78] While our proposed framework is designed as a micro- and/or meso-level intervention, it promotes competency-building and awareness of issues that exist at the macro-level. Acknowledging issue identification as intrinsic to problem-solving, this framework equips HCEC learners with the knowledge and awareness needed to become *part* of the solution to larger structural issues that exist within the systems that they serve. Our proposed framework also deepens

HCEC learners understanding of MHSUH stigma and structural stigma – an intersection that HCEC

Table 2. Recommendations for implementing proposed educational framework

Key Concept	Opportunities for Implementation
Integrate **self-reflexive practices** into formal, informal, and hidden curricula	• Provide clear expectations for formal reflective assessments, and rationale for methods of evaluation • Conduct formative assessments to achieve an optimal balance of integration into formal and informal curricula
Embed **structural humility** into multiple teaching methods and contexts of learning	• Support learners in identifying personal enablers and barriers to conducting HCEC • Extend beyond traditional teaching methods (e.g., case vignettes for clinical cases, didactic lectures for philosophical theory) to methods that incorporate multidisciplinary perspectives (e.g., narrative inquiry) • Collaborate with PWLLE to engage in narrative teaching methods to help amplify the experiences of affected populations
Balance **critical consciousness and compassion** in dialogue	• Provide learners with a dedicated opportunity for relational, critical reflection of their experiences to foster trust during critical discourse with colleagues and service users

requires further discourse in to promote potential for the "primary prevention of downstream health inequities".[79]

Recommendations

Future directions

Our findings suggest a need to increase engagement with learners, educators, and PWLLE, to explore further how HCEC competencies and curricula can address structural stigma in MHSUH care.

Examples include:

- Conducting empirical investigations on how learners and educators find current pedagogical approaches serve their learning goals
- Integrating continuous quality improvement measures into HCEC training by obtaining diverse forms of feedback from learners and educators to inform curricula and future practice
- Collaborating with PWLLE with MHSUH to co-create curricula that advances anti-stigma initiatives
- Developing applied tools for use in professional practice that are informed by conceptual frameworks

Our proposed framework provides concrete suggestions on how to support healthcare ethicists in building competencies and increasing awareness of structural stigma in MHSUH care. This work highlights the potential to advance the bioethics community's understanding of the role of the healthcare ethicist in context-specific training capacities (e.g., MHSUH) and in addressing issues of social justice. This conception of the role of healthcare ethicists involves navigating professional identity in relation to interprofessional collaboration when encountering different types and levels of stigma.[80] Our framework also has the potential to provide downstream benefits to stakeholders who interact with healthcare ethicists, including patients, caregivers, and HCPs. As identified by QI interview participants, key concepts from this framework may be translatable to other areas of care that serve structurally vulnerable and stigmatized groups, such as people living with intellectual and developmental disabilities. These other, potentially applicable clinical contexts are also often underrepresented in the bioethics literature and require greater attention in HCEC education – a gap that this framework may be able to support with further development.

Conclusion

In this paper, we propose a novel educational framework for HCEC learners that supports competency-building to address structural stigma in MHSUH. A fundamental aspect of HCEC described in both bioethics theory and existing core competencies is the ability to identify competing ethical tensions and balance the perceived and potential harms and benefits in a given scenario.[81] With the key concepts in this proposed framework, we highlight the importance of self-reflexivity, structural humility, compassion, and critical consciousness. Based on the interdisciplinary and collaborative nature of HCEC, it is critical that learners develop a strong understanding of how power, privilege, and structural stigma in MHSUH care interact within the larger healthcare system.[82]

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Competing interest. The authors do not have any financial conflicts of interest.

Notes

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