Clinical Ethics Consultation

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Training in Clinical Ethics: Launching the Clinical Ethics Immersion Course at the Center for Ethics at the Washington Hospital Center

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ABSTRACT

In May 2011, the clinical ethics group of the Center for Ethics at Washington Hospital Center launched a 40-hour, three and one-half day Clinical Ethics Immersion Course. Created to address gaps in training in the practice of clinical ethics, the course is for those who now practice clinical ethics and for those who teach bioethics but who do not, or who rarely, have the opportunity to be in a clinical setting.

"Immersion" refers to a high-intensity clinical ethics experience in a busy, urban, acute care hospital. During the Immersion Course, participants join clinical ethicists on working rounds in intensive care units and trauma service. Participants engage in a videotaped role-play conversation with an actor. Each simulated session reflects a practical, realistic clinical ethics case consultation scenario. Participants also review patients' charts, and have small group discussions on selected clinical ethics topics. As ethics consultation requests come into the center, Immersion Course participants accompany clinical ethicists on consultations.

Specific to this pilot, because participants' evaluations and course faculty impressions were positive, the Center for Ethics will conduct the course twice each year. We look forward to improving the pilot and establishing the Immersion Course as one step towards addressing the gap in training opportunities in clinical ethics.

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INTRODUCTION

The need for clinical ethics training opportunities has become increasingly obvious, thus, we in the Center for Ethics at Washington Hospital Center, in Washington, D.C., have talked about how we might contribute to closing this

training gap. The conversations took on greater urgency when discussion of the need for such training opportunities entered open, general conversation at the professional association level at the annual conference of the American Society for Bioethics and Humanities (ASBH), which was last held in Washington, D.C., in 2009. Most notably, during the final plenary session of the 2009 annual ASBH conference, panelists noted the lack of opportunities for clinical ethics training, with the challenge to high-volume consultation service hospitals such as ours to provide such opportunities. After that, we started shaping the form that such training might take, given the availability of our faculty, leadership support, the kinds of experiential opportunities our particular hospital setting could best provide, and the ability of the hospital to absorb a training event without disruption of patient care responsibilities.

Because Washington Hospital Center (WHC) is a teaching hospital, there was a reasonable level of confidence that we would be able to launch the course without being disruptive to patient care. It is worth noting that we could never have conducted, or could plan to conduct in future, this kind of educational effort without the full and open support of the leadership of the hospital and the clinicians with whom we regularly work—which we had from the outset of the planning process, and to whom we are most grateful. But even with strong support from the hospital's leadership, it was critical to the success of the pilot, and the ability to run the course regularly, that there be broad-based and deep support throughout the hospital. Towards that end, e-mails and phone calls went out broadly across all clinical sectors of the hospital; that is, in addition to seeking physicians' support in each section where we explicitly planned to take our participants, we met with nurses in the units, explaining what the Immersion Course was for, how many students were coming, and providing other details useful to nurses. We made calls and sent e-mails to physician and nursing leadership, as well as to line nurses throughout the hospital. We had personal conversations with many of the physicians and nurses, particularly our clinical care facilitators, a special category of hospital nurse whose job it is to provide systems consistency to patient care. We spoke with social workers, chaplains, and many others, and coordinated closely with our Patient Advocate Department director, who assisted with logistical details throughout the hospital in preparation for the students' arrival. There was consistent support throughout the rest of the hospital. The result of that several-year planning process was our inaugural course, held 20 through 24 May 2011.

BACKGROUND

WHC is the largest private hospital in the nation's capital. A member of not-for-profit MedStar Health, which includes nine hospitals in the Washington, D.C./Baltimore, Maryland metro areas, the hospital center is a 926-bed, Level 1 Tertiary Care Center that provides care for adult and neonatal patients, and shares a 47-acre campus that includes the National Rehabilitation Hospital (which is also a member of MedStar Health).

During fiscal year 2009 (the most recent records available), 412,315 outpatient and 42,725 inpatient visits occurred at WHC, including 4,529 births. Regional medical facilities referred more than 7,000 of their most complicated cases to the hospital center. WHC has granted privileges to approximately 1,600 physicians, many of whom are involved in 400 clinical research trials. There are 26 clinical residency and fellowship programs, with more than 300 medical students annually.

The hospital center has nine intensive care units (ICUs), including surgical, cardiac, medical, and neonatal intensive care. The Center for Ethics at WHC is a department-level organizational group within the hospital. Before the Center for Ethics was established, the clinical ethics consultation service at WHC was created in 1982, out of the hospital's newly established ethics committee, by the center's present medical director, John J. Lynch, MD, Associate Medical Director, the Washington Cancer Institute at WHC, Emeritus.

Today, the Center for Ethics at WHC runs a high-volume clinical ethics consultation ser-

vice. Annually, there are approximately 300 clinical ethics consultations, roughly divided equally between formal consultations (which we define as clinical ethics consultations that result in a consultation note being entered into the patient's medical chart) and what we have termed "coaching" consultations:[1] a consultation in which we are asked a straightforward question about a patient's ethical considerations or about a policy matter relevant to a patient's care, that does not require a full ethics consultation to be adequately assistive.

During this first class of Immersion Course students, there were 14 formal clinical ethics consultations, for which a clinical ethicist detached one, two, or three students from the class to have the students join the clinical ethicist on the consultation. Determination of how many students would accompany the clinical ethicist depended on the sensitivity of the consultation; fewer students were taken on an ethics consultation for which a high level of emotion from a patient or from family members was expected.

The clinical ethicists who staff the Center for Ethics at WHC run the clinical ethics consultation service at WHC (which is closely coordinated with the WHC hospital ethics committee), the WHC ethics committee, and the ethics committee of Union Memorial Hospital in Baltimore (a MedStar Health hospital). These clinical ethicists attend working rounds in the medical and surgical ICUs at Union Memorial Hospital and at another Med Star Health hospital in the Baltimore metropolitan region, Franklin Square Hospital Center. The center staff also attend multiple sets of sitting rounds weekly at WHC, such as intermediate medical care and neonatal ICU interdisciplinary rounds and social work discharge rounds.

Clinical ethicists are responsible for ethics education throughout WHC and in other MedStar Health institutions on the standard range of clinical ethics topics. Additionally, the center's director and staff are well integrated throughout the hospital center. Members of the center's group serve on or chair multiple committees. For example, the center director chairs the Patients' Rights and Responsibilities Committee; various members of the center conduct (as principle investigator) or collaborate on (as associate investigator) investor-initiated research, on topics such as using risk-management database files to inform strategic implementation of ethics interventions, and improving support for families of long-stay ICU patients. Members of the Center for Ethics devote additional time and resources to professional and lay community service. Professional association examples include ASBH and the American College of Chest Physicians (ACCP), as well as committees of the U.S. Department of Health and Human Services. Lay community service activities include talks about the importance of advance directives at churches and senior centers within the catchment area range of WHC.

BEGINNINGS

In May 2011 the clinical ethics group launched a 40-hour, three and one-half day Clinical Ethics Immersion Course, developed to address the gap in training opportunities in the practice of clinical ethics. "Immersion" refers to a high-intensity clinical ethics experience in a busy, urban, acute care hospital.

While the field of clinical ethics has been slowly progressing toward certifying individual clinical ethicists,[2] credentialing training sites,[3] and formalizing a code of ethics, clinical ethics consultation has become commonplace in healthcare facilities.[4] Since the advent of ethics committees and ethics consultation services over 30 years ago, ethics committees with ethics consultations services can be found in the majority of hospitals across the U.S. Given the possibility for clinical ethics consultants to influence patients' outcomes in unhelpful ways, the lack of opportunities for clinical ethics training is cause for concern.[5] What is lacking for persons involved in or teaching about clinical ethics are short, practical, clinical ethics training opportunities. The Immersion Course is designed to begin to meet this need.

The course is intended to meet the needs of several populations, most notably those who now perform clinical ethics consultations in healthcare facilities as either members or chairpersons of ethics committees or ethics centers,

and faculty who teach bioethics and want to enrich their instruction through participation in an intense, short course in clinical hospital ethics. The timing of the course, 40 hours over three and one-half days, has been explicitly designed with these professionals in mind.

Development of curriculum materials, practice experiences, and discussants' sessions rely heavily on the theoretical foundations found in Finder and Bliton,[6] and the new edition of the ASBH *Core Competencies*.[7] This effort is also undergirded by the ASBH *Improving Competencies in Clinical Ethics Consultation: An Education Guide*,[8] which provides additional foundational theoretical guidance for the Immersion Course's curricular design.

Knowing is never the same as doing, and the doing in clinical ethics, especially the doing well, requires observing ethics consultations and then practicing leading consultations, which calls upon using the skills listed in the ASBH *Core Competencies*.[9] Additionally, for a clinical ethicist to be depended on to reliably assist clinicians in taking excellent care of their patients,[10] these skills must be built on a foundation of psychological strengths and virtuous personal qualities. These strengths and qualities, addressed in Section 2.4, "Attributes, Attitudes, and Behaviors of Ethics Consultants," in the new edition of the *Core Competencies*,[11] can only be refined through practice. Some of the most important strengths and qualities in this foundational set of attributes includes:

- Moral courage,
- Straightforwardness,
- Awareness of personal biases and prejudices
- The ability to tolerate, manage, and reduce conflict,
- Self-reflectiveness,
- An ability to take criticism without defensiveness.

Because of their importance, we included an adaptation of a well-known and widely used interpersonal relations (IPR) small group experience adapted from chaplaincy training to help address this difficult area of clinical training.[12]

The mastery of such skills and accompanying psychological self-awareness begins with opportunities to observe others performing clinical ethics functions, leading to personally performing these functions, and then reflecting on the experience by affirming strengths and identifying potential barriers in the performance of ethics consultations. This process represents the core of learning and nourishing good practice. The Immersion Course provides participants with these experiences.

SHAPING THE COURSE: CURRICULUM, TIMING, FACULTY, LOGISTICS

Curriculum

As we began planning for the Clinical Ethics Immersion Course pilot, the essential work focused on refining goals and objectives, shaping activities that would meet the goals and objectives, identifying faculty, identifying possible pilot course participants, and assuring we could conduct a course without disrupting patient care. To figure this out, we began by developing an overarching mission for the course: the mission of the Immersion Course is to provide opportunities to observe, participate in, and discuss real cases in real time to refine the practical clinical skills involved in the daily work of a clinical ethicist.

To actualize this mission we created the following objectives:

1. Participants will observe rounds, clinical ethics consultations as these may (or may not) be called into the hospital's ethics consultation service, and a surgery case.
2. Participants will discuss ethics issues that arise in the course of caring for patients in an acute-care hospital setting.
3. Participants will practice conflict management skills.
4. Participants will review patients' charts to identify documents relevant to patients' rights and to sharpen chart-writing skills.
5. Participants will simulate a conversation with a patient, played by an actor in the hospital's simulation laboratory.
6. Participants will reflect on their own strengths and limitations in order to improve their own practice in clinical ethics.

These objectives are met by having participants engage in the following activities.

- To meet Objective 1:
  - A. Join in working rounds in a medical ICU and with the hospital's trauma team.
  - B. Join the center ethicists, and other consultation team members as relevant, on actual clinical ethics consultations as they randomly occur during the Immersion Course.
  - C. "Scrub in" and observe a surgical case being performed.
- To meet Objective 2:
  - A. Participate in luncheon and dinner discussions, facilitated by invited speakers.
  - B. Participate in activity "debriefs" and discussions in small group and individualized conversations.
- To meet Objective 3:
  - A. Participate in a conflict management skills training session.
  - B. Discuss how and where conflict arises in the clinical care of patients and during clinical ethics consultations and how it might be reduced.
- To meet Objective 4:
  - A. Review patients' charts to learn how they are arranged, what is typically contained in a chart, and where to look for specific documents of interest.
  - B. Discuss differences between writing a note in the progress section of a patient's chart versus filing a full consultation report in a chart.
- To meet Objective 5:
  - A. Participate in a videotaped clinical ethics case consultation simulation, in which students role play with a trained actor who was given a scenario common to ethics consultation, but in which the scenario was not given to the student ahead of time.
  - B. Have group and individual conversations about the experience of the simulation and individuals' performance.
- To meet Objective 6:
  - A. Tour the hospital, including the burn unit and the hospital morgue.
  - B. Participate in an interpersonal relations (IPR) small group self-reflective experience.

With the curriculum set, the next matter was to figure out course timing, logistics, and faculty.

Timing

The Immersion Course is a 40-hour training course compressed into three and one-half days. Participants arrive on Thursday or Friday, and the course begins officially at dinner time Friday. Participants need to arrive early enough on Friday to allow for administrative activities, including obtaining temporary hospital badges. The first evening's activities, including signing hospital confidentiality statements, receiving the course reading binder with reprints, and taking an initial hospital tour, end around 9 p.m.

Saturday, Sunday, and Monday each involve at least 12 hours of activities. For some participants and faculty, the day may be longer due to ongoing consultations. Because the course is over at approximately 9 p.m. Monday evening, participants leave on Tuesday.

Faculty

Core faculty is composed of the director and staff of the Center for Ethics. Luncheon and dinner speakers included the center's medical director and colleagues invited from outside the center. Topics were selected to facilitate discussion. Invited pilot speakers were:

- John J. Lynch, MD, on moral courage.
- Jack Schwartz, JD, University of Maryland School of Law, community member of the ethics committees of WHC and Johns Hopkins Hospital, on the intersection of law and ethics in clinical ethics consultation.
- Matt Schreiber, MD, Fellow, Critical Care, Department of Medicine, WHC, on how house staff physicians work with the Center for Ethics.
- Hunter Groninger, MD, Staff Clinician, Pain and Palliative Care Service, Clinical Research Center, National Institutes of Health, on how ethical issues, and clinical ethics consultants, are integrated into palliative care medicine.
- Steve Peterson, MD, Chair, Department of

Psychiatry, WHC, on how the Department of Psychiatry and the Center for Ethics work together.

Logistics: Ground Rules for the Management of Participants in Hospital Areas

For rounds and surgery observations, preferably two and no more than three participants accompany a course faculty member. When a clinical ethics consultation comes in, no more than two participants will accompany the course faculty member involved in the case. Although it was not made clear for the pilot, in the future it will be clarified that attendance is expected at all scheduled sessions.

Course participants are issued temporary hospital badges that allow them to move freely around the hospital. For the purposes of decorum and logistical convenience, however, for the most part, participants are escorted everywhere. For the pilot, escorts were either one of the center staff or volunteers who had been recruited from the hospital volunteer pool specifically to assist with the course, to whom we are most grateful. We expect that future courses will have similar logistical management.

Evaluating the Course

There are not yet any cumulative data to report. Our initial impressions are drawn from the participants' evaluations, the thoughts shared by a senior clinical ethicist who was invited to attend the pilot as an observer, and the faculty for the program.

The participants' evaluations were generally positive, although not all of the participants turned in an evaluation form; four of six participants submitted an evaluation form. Of the four, all indicated they would recommend the course to others, they found it useful, and they thought the course, along with similarly designed other courses, might be a useful approach to filling the clinical ethics training gap.

As we, the faculty from the center, evaluated ourselves, we saw much room for improvement. The most fundamental related to timing, density of planned experiences, and skills training. First of all, more time will be devoted in future sessions to processing the clinical ethics experiences, that is, rounding, role play, and observation of real-time cases. Secondly some activities will need to be shortened or run concurrently, with students self-selecting activities each finds most relevant to their specific needs. Finally, students' verbal feedback towards the end of the first Immersion Course, which were clear in their written evaluations, was that we need to increase the amount of time devoted to conflict management skills training.

We were pleased that the self-reflection IPR session lead by our hospital's clinical pastoral education (CPE) supervisor candidate, Chaplain Renix, was well received. This activity takes place weekly with WHC's clinical pastoral education students, but was new to the Immersion Course students and relatively new for those of us at WHC. In conducting this self-reflective process, there was some confusion about whether it was too much like group therapy, which it is not. It is a group dynamics process that is not about feelings, generally, but rather, a group process focused specifically on work performance. We have been eager to attempt this training because we think the practice of clinical ethics requires a deep level of self-reflectiveness and self-awareness. The students' willing participation and favorable evaluations confirmed our expectations that it can become an important clinical ethics training tool. It will be a regular feature of the Immersion Course.

Whether to include this session was uncertain at the planning stage. We (and others[13]) have for some time noted the impressive depth of the training model used widely in hospital chaplaincy training programs. We have given much thought to how this piece might be appropriately adapted to clinical ethics training and decided that, given that the whole pilot would serve as a test, this would be a perfect time to try out such an adaptation. The post-session course faculty discussions and participants' evaluations reflected a consensus that it was a highly useful session. One participant said, "the discussion about 'stuff' that gets in the way, made me think/realize why I have difficulties with certain types of ethical issues." That comment alone is enough to give us confidence that adapting this self-reflective process from hos-

pital chaplaincy training programs will add an intensity of self-reflection that will be useful for course participants. We have now made the IPR process part of the center's regularly scheduled performance improvement processes, and it will continue as a core activity in future courses.

A timing problem we anticipated, but for which we could not fully plan, was the *ad hoc* nature of how requests for consultations come into the center's consultation service. Because requests come in randomly, there is no way to anticipate the number that may emerge. Given that there were close to a dozen clinical ethics case consultations called during the course, and several of those came in late at night, it is possible that having clinicians know that center staff were in the hospital later than usual, and all day on Saturday and Sunday, may have encouraged slightly heavier than usual weekend use of the consultation service. Although the consultation service is widely advertised as being available on a 24/7, 365 days/year basis, ordinarily consultation requests usually peak late Friday afternoon and then sharply decline over the weekend, indicating a disinclination on the part of hospital clinicians to utilize the service during nonstandard business hours. Because there were so many consultations that interrupted the prescheduled course activities, key faculty were occasionally pulled away from the group, along with two participants.

Even though the *ad hoc* nature of the interruptions might have given the course a feeling of randomness, living with these interruptions is consistent with the ordinary day of a clinical ethicist, and so, we think, they are a useful feature of the course. In addition to adapting to the rhythm of a busy clinical ethics consultation service, the high number of consultations allowed for all of the participants to accompany clinical ethicists on several parts of various consultations, increasing the numbers of consultation observations and discussions about real patients and their care. Because we will alert others throughout the hospital, broadly, to the start of each course ahead of time, we expect that the high volume of weekend consultations may be comparable in future sessions.

Other areas for course improvement include the kind of adjustment any faculty member is used to making when introducing a new course at the graduate and professional level. Timing is never precise on the first effort, and our course was no different. As noted above, too many activities were planned, resulting in too little time for "debriefing" sessions. In the future, adjustments will be made, including the following:

- Fewer activities will be planned and/or times for activities will be adjusted to assure sufficient time for "debriefing."
- Schedules will be adhered to more rigorously.
- Time will be scheduled to allow for individual feedback for each participant on his or her videotaped role play.
- We will do more to accommodate participants' levels of experience: participants with greater experience will have conversations with faculty that will differ from the conversations that other faculty will have with less-experienced participants.

The numbers of readings will be reduced, and we will substitute some of that material with handouts, such as tips for refining one's consultation skill set. Course objectives will be more clearly articulated. Pre-arrival information, dealing with mundane but important information (such as how to find the right hospital entrance) will be more detailed. In short, the matters under our control will be more finely tuned in future courses. But, in having run the Immersion Course for the first time, we have demonstrated proof of concept sufficient to adjust our center's work load to include conducting the course on a regular basis, and believe that the experience, even with all of the bumps of a pilot, was useful for the participants.

CONCLUSION: MOVING FORWARD

We are now looking forward to future sessions of the Immersion Course. Given our present staffing, we will run it twice a year, the first weekends of November and June, annually. We continue to expect to have classes of no more than six until further notice.

The costs to participants for the initial

course offering reflected a discount based on the inherent uncertainty of the endeavor. Now that we have run the pilot, we can improve what needs improving and the course registration fee will increase to a level commensurate with the course's real costs.[14] Expenses for participants can be expected to stay relatively the same: lunch and dinner provided, discount meal tickets for breakfast, reduced hotel fees relative to standard hotel prices in Washington, D.C., and transportation to and from the group's hotel(s) provided at no cost.

Now that we know that this kind of course can be conducted, we encourage others to develop such courses. One can imagine courses springing up at other high-volume consultation service hospitals around the country, providing some sort of rough, regional coverage. In the meantime, we are relieved to have finally tackled—we believe successfully—a course offering to the field that will begin filling a gap in opportunities for clinical ethics training. We look forward to settling into the swing of a regularly set schedule for our Clinical Ethics Immersion Course and to having lively conversation about the course with our pilot and future participants specifically, and with our bioethics and clinical ethics colleagues more generally.

NOTE

The first course was titled the Clinical Ethics Intensive Course. Because of feedback from the participants, as part of the evaluation process, it was suggested that we change the title to the Clinical Ethics Immersion Course. We liked the suggestion and think it more fully describes the experience we anticipate the course will be for our participants, and so we have changed the title accordingly.

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NOTES

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