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Training in Clinical Ethics Consultation: The Washington Hospital Center Course

Jeffrey P. Spike

ABSTRACT

How can one be trained to enter the evolving field of clinical ethics consultation? The classroom is not the proper place to teach clinical ethics consultation; it is best done in a clinical setting. The author maps the elements that might be included in an apprenticeship, and sets out propositions for debate regarding the training needed for clinical ethics consultants and directors of clinical ethics consultation services.

I was invited to be an observer of the first Intensive Course in Clinical Ethics at the Washington Hospital Center (WHC).[1] I had no input into the planning. Having been present at a meeting of the Clinical Ethics Consultation Affinity Group of the American Society of Bioethics and Humanities (ASBH) when the issue of a lack of training programs was discussed, I was acutely aware of the need. Knowing how popular the various four-day intensive courses in bioethics have been, held at Georgetown University first, and then in Seattle and locations in the Midwest, it seemed time to have a four-day intensive course that was devoted to clinical ethics. The differences between bioethics and clinical ethics is substantial and largely unappreciated by those in bioethics. So when the WHC team agreed to take on the task of offering an intensive in clinical ethics, it was an important step for the field.

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Clinical ethics consultation (CEC) is a new field, not yet 40 years old. Until now there have been no standards set on how to perform a consult or on how to be trained to be a clinical ethics consultant. In part that is from lack of any organization empowered to make such decisions, and in part from a lack of consensus in a field that is extraordinarily diverse, with substantial numbers of people with medical degrees, and almost as many with nursing degrees, law degrees, and philosophy degrees.

But the past few years have seen some important steps taken in making ethics consultation in healthcare settings a true profession. First, an ASBH education task force helped de-

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fine some of the core issues that should fall under the expertise of ethics consultants, and gave some guidance on readings to help develop one's knowledge base on those subjects.[2] Then a national group of leaders in the field was assembled to construct a consensus statement on some basics of methodology, the proper role of ethics consultation.[3] Most recently, another ASBH task force has proposed the outlines of a "code of ethics" for the field. It is hoped that a draft will be completed by the end of 2012.[4]

These three steps, added to the recent update of the *Core Competencies for Clinical Ethics Consultation*,[5] signal that clinical ethics is coming of age.

At this point, the most important missing element of the evolving field is how one can be trained to enter it. There are few programs that are dedicated to training future clinical ethics consultants.[6] This is especially important because, during the same period that clinical ethics has evolved, bioethics has evolved, and it is easy (and common) to confuse the two.

Bioethics, as more of an academic field, has had an easier time developing educational programs. It has used an academic model, appropriate to its field, and a large number of masters and a few doctoral programs in bioethics now exist. As is to be expected, scholarship, publication, and, to some degree, grant-writing are the quality indicators for success in bioethics, as with other academic subjects.

However the classroom is not the proper place to teach clinical ethics consultation. It would be as if a medical school (using the traditional Flexner model[7]) was to end after the first two years, asserting that students have learned all they need to know. Training a clinical ethicist requires teaching skills and attitudes as well as knowledge, and is best done in a clinical setting.

In conversation with experienced clinical ethicists, I have observed strong agreement that experience is vitally important, and that classroom experience alone can never suffice to train someone to do hospital consultation. That is an important part of what is meant by calling the field *clinical ethics,* and distinguishing it from bioethics. One needs clinical education. That does not mean one must be a clinician prior to entering a training program, but one must be competent with clinical skills and professional attitudes before completing training.

Persons interested in clinical ethics consultation have been taking various online courses and attending four-day intensive courses in *bioethics* that, frankly, have very little value for preparing to do clinical ethics consultation. Some students, no doubt, think it is better than nothing, but probably most people simply do not attend to the differences between bioethics and clinical ethics consultation. Adding some cases for discussion is window dressing, especially when the cases are written by bioethicists to illustrate a point, rather than coming from real hospital experiences where cases are all complex, and never mere illustrations of a single "point."

Recently, it must be admitted, some bioethics programs have been adding valuable elements for clinical ethics training. In particular, a few programs now offer a few standardized patients to use in a role-play, and even giving feedback using an OSCE (objective, standardized clinical exam). These are hard to construct and run, and are worthwhile. But they are still best as preparation for the real thing, seeing a patient and talking to the patient, the patient's family, and the doctors and nurses, and helping to clarify complex choices and resolve differences of opinion.

Thus the WHC immersion course was the first opportunity for many aspiring ethicists to be on the front lines, to smell the smells, carry a gun into the theater of war, and see the wages of war (or, in this case, smell the smells of the morgue, visit the operating theater, and see the human costs of the intensive care unit). And so, as Henry V said, "into the breach" went a half-dozen brave souls, with newly assigned pagers in their holsters.

In the three and one-half days of the WHC immersion course, 14 consults were requested—very few ethics consultations services can offer that. By restricting enrollment in the immersion course to six people, WHC was able to guarantee that every participant would be involved in at least one new consult, along with the follow

up of a few consults as well. I was embedded as an invited observer, not unlike a war reporter.

The immersion experience in a consult service that has 300 consults a year was as educational for consultants who may have been previously involved in only a handful of consults in their entire career as it was for someone new to the field. In other words, attending this course was an eye-opening experience, making participants see the horizon of a potentially larger (and busier) consult world than many of them had realized existed.

This is not to say that a four-day intensive course, even with 12-hour-a-day immersion, suffices to be a training program. But for those who think that one consult per month is acceptable for a 500-bed teaching hospital, this experience should help reset their expectations.

HOW LONG WOULD IT TAKE TO BE FULLY PREPARED TO BE A CLINICAL ETHICS CONSULTANT?

Most of the full-time clinical ethicists I have spoken to have suggested that, after completing a terminal professional degree, there should be an apprenticeship. For example, the apprenticeship might include the following elements:

- Participation as an observer in CEC performed by experienced consultants (for example, actively observe at least 10 case consultations, although viable standards will need to await empirical data);
- Attendance at a monthly multidisciplinary chart review, ethics committee meeting, or quality improvement meeting to debrief past and ongoing cases that raise ethical issues;
- Successful completion and documentation of at least three consultations as lead consultant, under the supervision of experienced mentors.[8]

While these might sound like a lofty goal, some in the field reprimand suggestions like that for being too permissive, making it too easy, and possibly allowing undertrained people to enter the field. These critics would rather we start with higher standards, such as a full year as a member of an active consult service (in case the above three elements could be done in only a month or six months).

There may be a way to come to some resolution. As a study by Fox, Myers, and Pearlman reports,[9] many current consults are done by consultants with little or no training at all, and setting a minimum training standard would therefore lead to progress, even if it is far less than ideal.

It is also important to factor in that the most common model for consultation involves teams, not individual consultants. It might be defensible to hold that an individual consultant needs to be very well prepared to face *any* common issue, while a team might be able to perform well so long as one member of the team is comfortable with whatever issues a case raises. Thus, so to speak, each member of a team of three might get by with less than a full year apprenticeship, even if a consultant would require (at least) a year to be prepared to go it alone.

So there might be two standards needed, a higher one for individual consultants (and people who would be directors or chiefs of ethics services), and a lesser standard for team members. What would the minimum be, and what would be the ideal—and how does the immersion course at WHC compare?

To be an effective member of an ethics team, perhaps it would suffice to have some clinical experience with supervision such as offered in the WHC immersion course, assuming one had a terminal degree in a relevant profession beforehand (such as a masters degree in nursing or in social work, or a PhD in religion or philosophy). Observing consults being done by an experienced consultant, interviewing a standardized patient, and discussing the first draft of a few consult notes are important additions to any skill set that does not involve actual clinical ethics consultation—even that of the most experienced clinician.

But if this is to be sufficient, it would only be as a member of a team; and it will be important for different members of the team to have strengths in areas that other team members lack. There would need to be readily available expertise of a person with clinical experience, a person with legal knowledge of health law (not

risk management), and a person with knowledge of clinical ethics (not ethical theory). While those are the three core knowledge areas, others might want to add other skills, such as mediation, or spiritual/pastoral counseling.

It would also help if one can choose the clinical members from a pool of people from different professions, like a dozen members of an ethics committee that includes nurses and social workers as well as doctors, and members from surgery and anesthesia, and pediatrics and obstetrics, and psychiatry and neurology as well as general internal medicine.

Now, what about the training needed for someone who would be doing most consults as an individual, or who would be the director of the clinical ethics consultation service or chief of clinical ethics? I will set out a few propositions, to use as starting points for the debate:

1. The skills needed are, like Aristotelian virtues, habits that can only be inculcated by repetition until they become internalized character traits.
2. One's skills can always be improved, so even one year of full-time experience is not as good as two years of full-time experience.
3. To develop the skills requires repeated, preferably daily experience with cases. Thus the training can only be done at a site that has an adequate number of consults.
4. It can be difficult to find out how many consults any particular service does. Many consult services are evasive about the number of consults they do, perhaps out of embarrassment. Some others react to the same data with something more like denial: asserting they have few consults because there aren't that many cases at their hospital that would benefit from consults. Furthermore, some of the most well-known bioethics programs have no affiliation with an active clinical ethics service. They cannot be home to a clinical ethics training program.
5. There are 13 core ethical issues outlined in *Improving Competencies in Clinical Ethics Consultation: An Education Guide*,[10] and it is not intended to be a complete list. But it would be reasonable to think that a good training program would expose a trainee to at least one case involving each of those 13 issues. Given a normal, uneven distribution, to get to see one case involving each issue, a trainee would likely end up involved in two or three cases involving some of the other issues.
6. Thus we might estimate that one would need to be involved in 25 to 30 cases before seeing at least one case involving each major issue. That is more cases than many consult services see in a year.

One may conclude that training programs should be set up only in hospitals with very active services, such as WHC, that get at least 100 consult requests a year. My best guess is there may be a dozen such hospitals in the U.S. A one-year fellowship in such a hospital would be the ideal training program for a future clinical ethicist who may be doing many consults as an individual rather than with a team.

I would suggest letting anyone doing any residency add a year of ethics fellowship, full time, rather like chief residents in some programs. Or, if a residency program would give an interested resident two months off to do ethics each year, perhaps it could be done concurrently with a three-year residency (and have them be a member of the hospital ethics committee the entire three years). Or, if they are already doing a fellowship, this might be combined with it. A two-year fellowship in ethics and palliative care would be one obvious possibility, but a three-year fellowship in cardiovascular surgery and ethics, or in critical care medicine and ethics, would be intriguing possibilities as well. Lastly, it would be important to allow PhDs from any field to participate, something they would most likely think of as a one-year full-time post-doc (except that it is still focused on clinical experience).

There are many options worth exploring, but what they share is that they involve aspects that are similar to the Washington Hospital Center clinical immersion experience, but must last far longer than four days, and enable the trainee to master knowledge content in diverse areas as well as the opportunity to practice many clinical skills.

Looking back, then, the most valuable achievement of the WHC program was simply to give us all a picture, a taste, of a real clinical ethics training program—a taste of the battle front where our job is to help people where they are, many of whom are—literally—facing death. Classrooms and simulations can help you prepare, but nothing can replace the experience of your pager beeping unexpectedly, and someone asks you for advice that will go into a chart, with 24 hours to collect information from both sides of a conflict, analyze the results, and reflect on the best strategy to achieve a just and peaceful resolution.

NOTES

1. N.O. Mokwunye, E.G. DeRenzo, V.A. Brown, and J.J. Lynch, "Training in Clinical Ethics: Launching the Clinical Ethics Immersion Course at the Center for Ethics at Washington Hospital Center," in this issue of *JCE.*

2. ASBH Clinical Ethics Task Force, *Improving Competencies in Clinical Ethics Consultation: An Education Guide* (Glenview, Ill.: ASBH, 2009).

3. N.N. Dubler et al., "Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation," *Hastings Center Report* 39, no. 6 (November-December, 2009): 23-33.

4. An outline of the professional responsibilities to be included has been proposed and posted on the ASBH website: *http://www.asbh.org/uploads/files/membership/pdfs/111013%20ceca%20mtg%20minutes.pdf,* accessed 23 April 2012.

5. *Core Competencies for Healthcare Ethics Consultation,* 2nd ed. (Glenview, Ill.: ASBH, 2011).

6. Dubler et al., see note 3 above.

7. A. Flexner, *Medical Education in the United States and Canada* (Boston: Merrymount, 1910).

8. Dubler et al., see note 3 above, p. 32.

9. E. Fox, S. Myers, and R.A. Pearlman, "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics* 7, no. 2 (February 2007): 13-25.

10. ASBH, *Improving Competencies in Clinical Ethics Consultation: An Education Guide,* see note 2 above.