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Truly Intensive Clinical Ethics Immersion at the Washington Hospital Center

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ABSTRACT

Opportunities for practical, hospital-based training in those skills demanded by clinical ethics consultation (CEC) have been limited. Given the number of individuals who provide part-time CEC, greater access to condensed, practical training such as the clinical ethics immersion course offered by the Washington Hospital Center, is necessary.

Two participants in the initial cohort evaluate their CE training at a busy, urban referral center, exploring prior expectations, perceptions of its utility and suggestions for improvement. Such training will prove valuable not only for bioethicists who lack practical CEC experience "at the bedside" but also for ethics consultants whose ethics services have a low consult volume who wish to sharpen their skills.

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INTRODUCTION

Those engaged in clinical ethics practice increasingly recognize that course work in academic bioethics alone provides inadequate preparation for consultants' responsibilities. Opportunities for practical, hospital-based training have been limited, and those programs with a more significant clinical focus may require relocation for a semester, an academic year, or more. Given the number who provide part-time clinical ethics service, either as a fraction of dedicated time or as other duties as assigned, greater access to condensed, practical training is necessary.

Mokwunye, DeRenzo, Brown, and Lynch at the Center for Ethics at the Washington Hospital Center (WHC) in Washington, D.C., sought to address this void, announcing a pilot Clinical Ethics Intensive course early in 2011.[1] The 40-hour, three and one-half day program would

not focus on philosophical bioethics *per se,* or its theoretical underpinnings, or on a single skill set such as conflict management, but on a spectrum of basic skills and attributes demanded by the practice of clinical ethics consultation (CEC). Within 24 hours of its posting, the first six-student cohort was filled and a waiting list was begun, demonstrating a collective, if unspoken, hunger for learning (and honing) the basic skills of clinical ethics practice.

Six pioneering trainees participated in the inaugural clinical ethics immersion experience from 20 to 24 May. The label "intensive" has been used to describe other programs that present information in a compressed time frame. The WHC program did this, but also immersed trainees in a busy, urban, acute-care center with one of the nation's highest volumes of CEC. This immersion mirrored the life of a clinical ethicist practicing in that world: emotionally charged, intellectually rigorous, inter-relationally difficult, endurance challenging, time sensitive, involving high-stakes decisions.

Both authors were among that first cohort. Both are academic bioethicists; one has taught bioethics to medical students and the other to baccalaureate nursing and allied health students. Both have long maintained part-time CEC practices in private, nonprofit institutions, one a 78-bed pediatric research center specializing in the treatment of children with life-threatening disorders, primarily malignancies, and the other a 350-bed, university medical center providing medical, surgical, pediatrics, obstetrics/gynecological, and psychiatric services.

THE FIRST COHORT

The pooled reservoir of experiences of the course participants, WHC Ethics Center staff, and an expert, outside observer made the discussions deeper, more practical, and challenged all to consider how paradigmatic cases and familiar issues might be viewed through different perceptual lenses. Participants reflected different professional and disciplinary backgrounds, nationalities, ethnicities, cultures, and levels of experience with CEC: a physician specializing in internal medicine and critical care, pursuing a master's degree in bioethics; an attorney specializing in healthcare law; two philosophers on medical school faculties; a theologian from a baccalaureate college of health sciences; a risk manager with a nursing background.

Four had prior experience on ethics consult services, either as individual consultants or as team members; one had more than 10 years' experience consulting in a specialized pediatric hospital; another had two years' full-time responsibility for an ethics service at a large academic medical center. These four also had hospital ethics committee experience, three in leadership roles (founding chair, co-coordinator, vice-chair). One had founded the first bioethics and professionalism program in a medical school in an Arabic-speaking context. That so many in the first cohort had so much experience with ethics consultation, yet still desired further practical training, evidences the felt need.

PARTICIPANTS' EXPECTATIONS

Participants from other backgrounds and with different levels of experience with CEC may have brought other expectations to the WHC training. These authors first anticipated an opportunity to shadow a clinical ethics service at a high-volume acute care and referral center as they practiced their craft, and gauge themselves against what the WHC ethicists judged to be best practices. Thus, the experiential training would provide an opportunity for self-reflection and consideration of areas for quality improvement in the authors' own practices. Second, the authors sought validation of their efforts in establishing clinical ethics services in their hospitals. Since few institutions employ more than one full-time (or even part-time) clinical ethicist, many ethics consultants practice solo and could benefit from outside peer review. Third, the authors expected to experience how some practical skills essential to clinical ethics practice could be taught, and thus how members of their hospital ethics committees who assist with case consultation might be better trained. Finally, the authors hoped to ex-

perience camaraderie with others, expanding opportunities for practical clinical ethics training, and exploring how they might adapt such to their own very different practice contexts.

PERCEPTIONS OF THE PROGRAM EXPERIENCE

The authors valued participation in this training and would recommend it to others. The weekend format was convenient, yet demanding. Eager learners continued discussion into scheduled breaks or volunteered for tag-along consults in lieu of breaks or after hours. Those experiential learning activities that were most helpful to trainees with some prior ethics consultation experience included tag-along consults with staff ethicists, observation of morning rounds in trauma/surgery and in the intensive care unit (ICU), a videotaped simulated CEC with an actor portraying a standardized patient, and a group process reflection session with a chaplain.

Participants accompanied WHC staff ethicists Mokwunye, Brown, and DeRenzo, as each responded to consult requests, and participants were able to witness each staff member's individual approach. During the program, the WHC Ethics Center responded to 14 consult requests, so that each trainee had multiple opportunities to see didactic content applied on the units by master consultants. (The high volume perhaps reflected clinicians' willingness to provide training opportunities for visitors and also reflected the strong partnership the WHC Ethics Center has forged with the staff of its nine ICUs and its trauma unit.)

Observing how the WHC ethics service normalized their presence at daily rounds was a valuable experience that encouraged one author to explore replicating this service. Evidently, reflection on ethical aspects of cases has become part of the WHC culture. Program participants received immediate and constructive feedback from the actor playing a simulated patient.

As might be expected in any group, some interpersonal conflict surfaced and, as often happens in ethics consults, was addressed late. This provided a opportunity to reflect on parallel processes and role expectations with Chaplain Robert Renix. The WHC team was open to challenge and made adjustments, modeling effective address of tensions and fractured relationships.

Experiential learning activities that were especially helpful to trainees with limited clinical experience included: a hospital tour, observation of an abdominal surgery, a Joint Commission "scavenger hunt,"[2] and a tour of the morgue. Trainees also experienced a late-night simulated ethicist on-call request. All of these highlighted the reality that clinical ethicists inhabit a world unlike that of armchair philosophers. Ethics was put in practice and observed to play a major role in the lives of physicians and patients. Most importantly, immersion into the world of WHC allowed greater appreciation of clinicians' distinctive roles, reflection on mortality and discomfort in facing the human condition, and, ultimately, more focus on patient-centered care.

Participants considered topics that bear on an effective CEC service, including moral courage, the way in which house staff physicians involve clinical ethicists in the care of patients, conflict management, and ethics and the law. The group also reflected on palliative care and the ethics consultant, chaplaincy models to improve self-reflection on interpersonal relations, and psychiatry and clinical ethics. Trainees also contributed cases to a session on best practices in clinical ethics. Their diverse backgrounds enriched the discussions and the learning experience.

SUGGESTIONS FOR IMPROVEMENT

The convenient weekend format with its demanding pace and 12-hour-plus days could be an issue for trainees coming off and heading into another full work week. (Planning for the late night/early morning simulated ethicist-on-call experience might consider this.) Students' eagerness for learning opportunities contributed to increasing fatigue. Setting boundaries and taking respite are also necessary skills for those hoping to avoid professional burnout.

Participants received more print resources than could be read and digested during the training. Including only those most critical to CEC and most aligned with experiential learning activities could enhance training. An online learning platform might also provide trainees with advance electronic access to readings and further discussions and applications even after the immersion is over. Augmenting the face-to-face clinical ethics immersion with such an online community (virtual clinical ethics mentors or an ethics cohort chat room) might further reinforce learning.

The program could allow more time for the various modes engaged in learning clinical skills (observation, practice, reflection, and verbalization). These modes need not occur in a set order; for example, trainees may first be briefed on what they may encounter on a burn unit and reflect on their apprehensions before observing rounds and later practicing skills in simulation. Allowing adequate time for each learning mode respects the diversity of learners (observers, doers, thinkers, talkers) and reinforces learning.

Participants would have benefited from reviewing their tapes from the simulated patient encounter alone and/or with the faculty of the course. The participants who are less experienced with CEC might benefit from a "dry run" before engaging in the simulation exercise. Even experienced practitioners might benefit from some role play before taping. Beginners might best focus on limited aspects of their interaction with the simulated patient.

Before engaging in the chart review activity, some trainees could benefit from advance instruction or a work sheet on how to glean information from a paper chart or electronic medical record. Nonclinicians will likely be unfamiliar with chart organization, common abbreviations, and expectations for chart notations.

Some discussion/practice topics could be added or expanded, for example, how to:

1. Encourage physicians or others to request ethics consultation,
2. Manage conflict,
3. Determine decisional capacity, and
4. Manage patients with questionable capacity.

Others might be condensed or eliminated. Clinical ethics practice doubtless requires moral courage; however, can such be taught, or even modeled, within a three and one-half day program? Given the variability of local law, the complex relationship of law and ethics might best be explored within the trainees' own contexts.

VALUE OF THE EXPERIENCE

The WHC clinical ethics immersion experience should prove to be most valuable for those interested in the practice of CEC who have little or no experience in the clinical world (including some academic bioethicists). Practicing clinical ethics consultants interested in honing their skills, including those whose own facilities have a low ethics consult volume, and/or those in specialized practice settings wishing to enhance their general ethics consultation skills, would also benefit from such training. The authors anticipate that the WHC experience will inform their teaching of clinical ethics and better equip them to serve as an ethics consultation resource for their respective healthcare systems.

NOTES

1. For a description of the immersion course, see 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. Trainees reviewed two patient charts for evidence related to Joint-Commission-required documentation of advance directives and of patient/family participation in care decisions. The former was sought first under the advance directives tab, then elsewhere in the chart; the latter was sought in the progress notes and consent sections of the chart.