ROUNDING AS AN ETHICIST: Challenges & Recommendations

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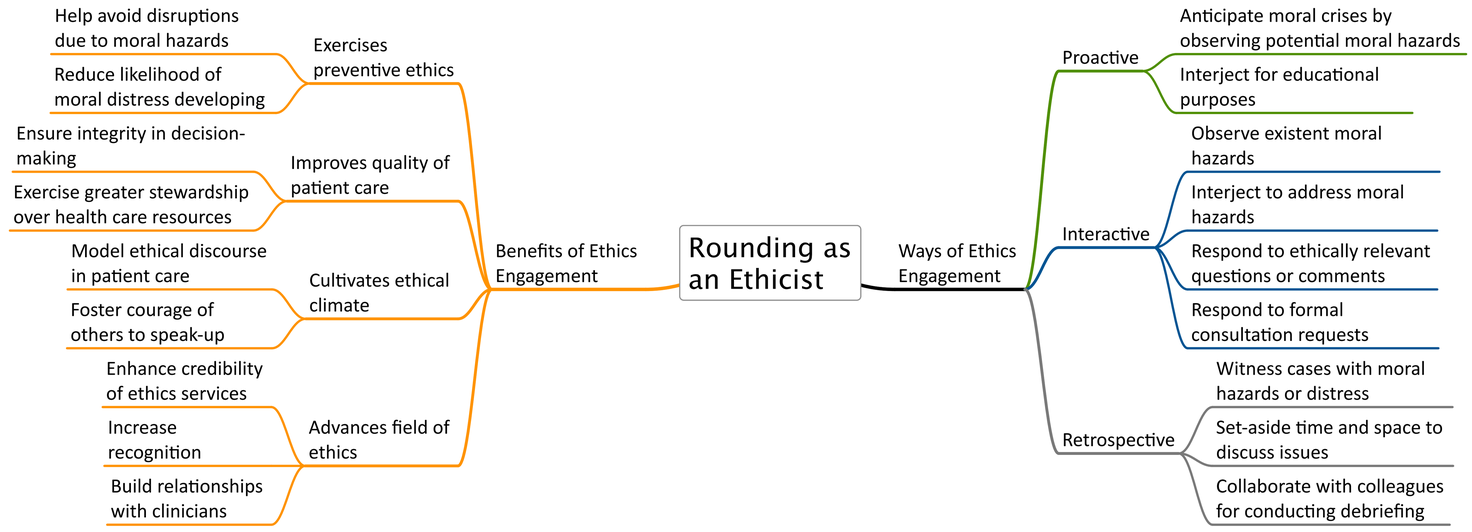
OVERVIEW

In contrast to formal ethics consultation, we define **rounding** as ***the literal or figurative, regular, and care-integrated tour of patients or cases to discuss, anticipate, attend to, and learn from issues or needs related to the provision of health care***. Examples of rounding with an ethicist include (a) participating with residents and faculty bed to bed during teaching (or "work") rounds in the ICU, (b) dialoguing with nursing staff or house staff in a unit or ward's conference room during an hour dedicated to addressing ethical issues (or "ethics rounds"), and (c) participating with members of the multidisciplinary team room to room or in a conference room in the ICU or other nursing unit (see photographs to the right). Other rounding examples exist, but these reflect the kind of rounds we focus on here.

There are many challenges observed by others who engage in teaching in clinical settings [1]. As ethicists possess the dual roles of teacher and consultant while rounding [2], there are challenges to rounding *as an ethicist*. Here, we focus on the challenges that distinctively affect the ability of ethicists to engage in clinical rounding effectively. The annotated images below illustrate distinct challenges and promising practices.

Although there are challenges to rounding as an ethicist, there are also many benefits (see right). Nevertheless, **if rounding as an ethicist is beneficial, how can an ethicist do it well in light of the challenges?**



BENEFITS

Others' arguments for making rounding a regular component of the work of an ethicist or ethics consultant include:

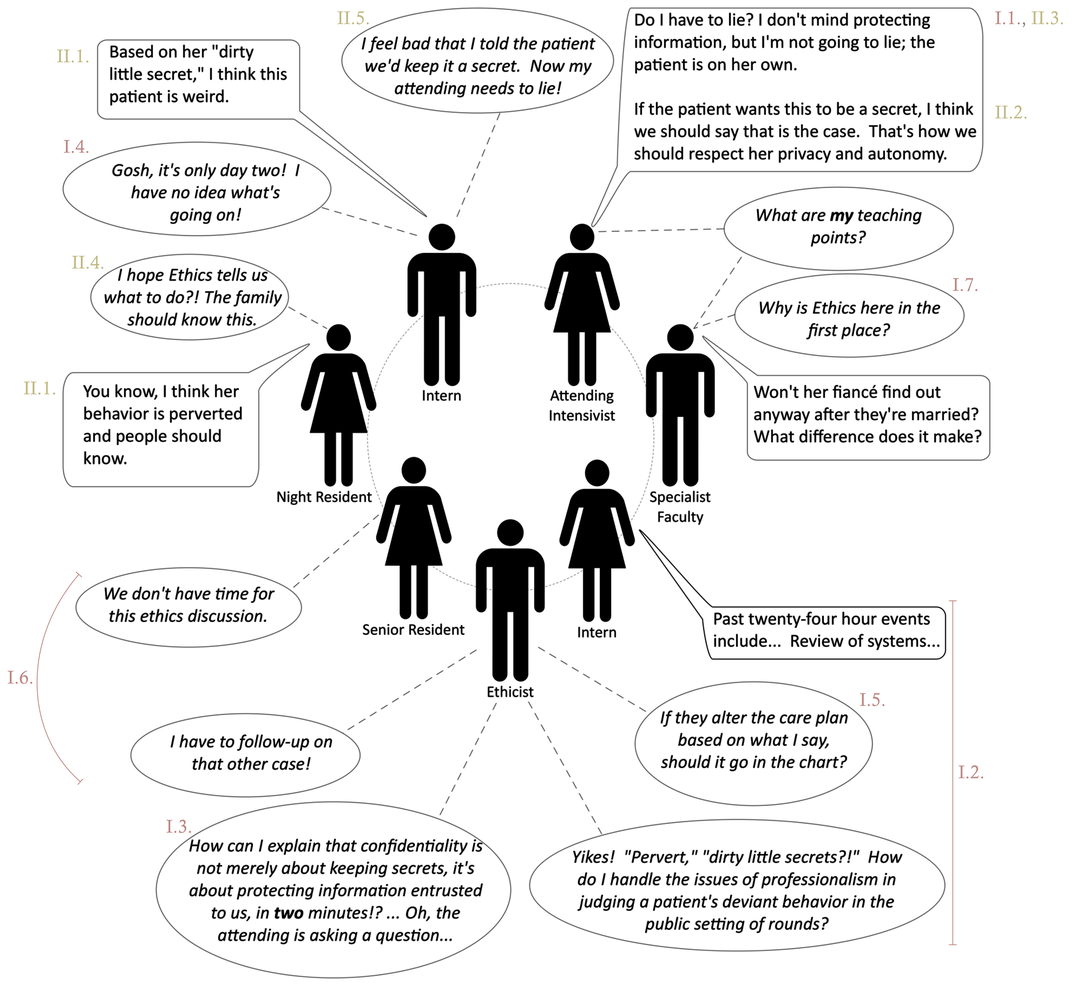
1. As an exercise in preventive ethics [3, 4, 5, 6, 7, 8], rounding with an ethicist reduces the frequency with which ethical issues cause disruptions in patient care (e.g., conflict and/or stalemate [9]). Similarly, rounding with an ethicist reduces the likelihood of moral distress developing in providers [1, 7].
2. As a proactive ethics activity [4, 5, 8], rounding with an ethicist improves the quality of patient care by ensuring the delivery of ethically appropriate care but also, though more controversial, improving health outcomes and lowering costs [10].
3. Rounding with an ethicist enhances the ethical climate because the ethicist models appropriate ethical discourse in patient care, which may translate into others having the courage to speak-up [3, 11]. Moreover, such rounding creates an environment wherein providers utilize formal ethics consultations more judiciously (e.g., for truly dilemmatic cases) [3].
4. Rounding with an ethicist enhances the credibility, recognition, and relationships an ethicist has within the institution [12, 13].

WAYS OF ENGAGEMENT

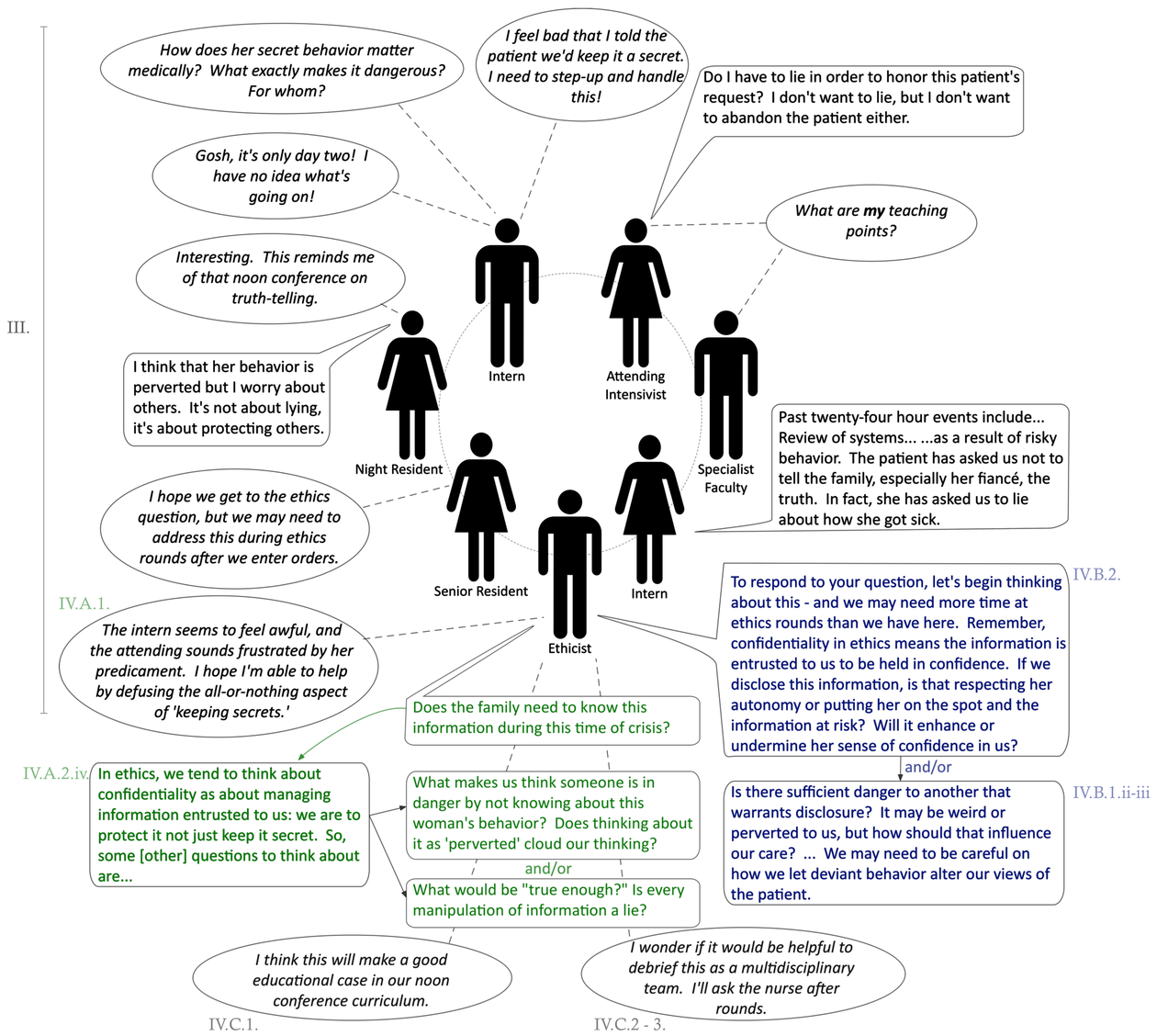
Engagement refers to ***ethical discourse over patient care issues with clinicians***. Two key actions lay the foundation for rounding as an ethicist: (1) outreach and (2) ethics coaching (see below). This foundation allows ethicists to round effectively through proactive, interactive, and retrospective engagement. Each way of engagement has correlative actions (see above).

While rounding, ethicists are alert to cues related to ethical issues. We use the term **moral hazards** to describe ***features of a case that puts one's ability to fulfill his or her ethical obligations at risk***. Moral hazards are present in clinical circumstances that are ethically not self-evident, controversial, or morally ambiguous. They may derive from disagreement, uncertainty, or other realities. Alertness to moral hazards is a precondition to an ethicist noticing and sharing ethically relevant clinical insights during rounds.

DISTINCT CHALLENGES faced by the ethicist as illustrated during ICU teaching rounds.



PROMISING PRACTICES that consistent rounding can promote as illustrated during ICU teaching rounds.



I. Distinct Challenges to effective rounding as an ethicist:

1. A specific question is asked in an abstract way (too theoretical).
2. Being too quiet or too loud: not knowing when to interject and risk inconvenience.
3. What is obvious to an ethicist may not be obvious to a clinician.
4. Lack of continuity of players.
5. Uncertainty of how to document an "intervention" if done.
6. Time constraints on the responsibilities of an ethicist and the team.
7. Others who round do not see the value of ethics.

II. Being Alert to Moral Hazards:

In this case, the moral hazards include:

1. Lack of professionalism in caring for a patient who engages in deviant behavior;
2. Misperception of duty to respect patient privacy by deflecting role of protecting information under guise of respecting patient autonomy;
3. Default legal position of patient privacy as all-or-nothing 'to breach or not to breach' question;
4. Presumption that surrogates need to know as much information as possible about a patient's condition to make informed decisions; and
5. Emotional cues may reflect deeper feelings of moral distress.

III. Promising Practices in laying the foundation for effective rounding:

***A. Outreach*:** Outreach to key clinicians to build trust and respect involves:
(1) Building relationships with physicians, faculty members, and others (e.g., residents and nurses) [3];
(2) Ensuring adequate time in the ethicist's schedule;
(3) Making rounding routine and regular while adjusting the routine periodically [3];
(4) Being present in real-time patient care [3];
(5) Possessing certain traits *qua* ethicist, teacher, and person [14];
(6) Demonstrating professionalism [14]; and
(7) Soliciting and providing feedback [1, 15].

***B. Ethics Coaching*:** Ethics coaching means adopting an approach to helping the patient by coaching clinicians to identify and address moral hazards [3, 16]. Ethics coaching involves:
(1) Modeling ethical discourse in patient care [3, 17];
(2) Drawing on other educational content;
(3) Listening to cases by using imaginative regard through an ethical model [18];
(4) Seizing teachable moments and taking initiative (see IV. right);
(5) Engaging empathic attention [19, 20];
(6) Being enthusiastic and personable [14];
(7) Being competent as an ethicist [14]; and
(8) Practicing mindfulness while rounding and budgeting time wisely.

IV. Promising Practices in how an ethicist engages rounding:

A. *Proactive engagement*: The ethicist should seize teachable moments by
(1) Anticipating moral crises by observing potential moral hazards; and
(2) Interjecting for educational purposes by
(i) Assuming nothing (i.e., do not assume clinicians are aware of the moral hazards),
(ii) Asking provocative, often open-ended questions [1],
(iii) Positing analogous examples and why the particular case makes you think of it, and
(iv) Making suggestions as appropriate.

B. *Interactive engagement*: The ethicist should take initiative when confident a moral hazards is present by
(1) Interjecting to address moral hazards through
(i) Assuming nothing (see IV.A.2.(i).),
(ii) Asking open-ended probing questions [1],
(iii) Positing observations or concerns based on what is known or heard,
(iv) Modeling "thinking aloud" about issues [1],
(v) Making suggestions, and
(vi) Offering explanations;
(2) Responding to ethically relevant questions or concerns (even if not addressed to the ethicist) by
(i) Answering as directly and succinctly as is possible [1, 3],
(ii) Identifying areas for potential elaboration [1], and
(iii) Recommending, if appropriate, deferring to a later setting or a formal ethics consultation; and / or
(3) Responding to formal ethics consultation requests.

C. *Retrospective engagement*: The ethicist may recognize that the best time to address ethical issues may be deferred to a later time. Retrospective engagement suggests that rounding may address past cases, recurrent themes, or revisiting questions on a routine basis. The ethicist should do this by
(1) Witnessing cases with moral hazards or moral distress, or an incidence of moral residue in a particular unit or team [19];
(2) Setting aside time and space to discuss the issues;
(3) Collaborating with select personnel to achieve pre-determined goals of
(i) Quality improvement,
(ii) Education, and/or
(iii) Emotional support and stress management; and
(4) Dialoguing about issues (not debating) [21] by
(i) Using plain language as much as possible [22],
(ii) Creating opportunity for others to participate, and
(iii) Encouraging insights while discouraging opinion.

REFERENCES: A bibliography is available upon request; please email nicholas.kockler@providence.org or john.tuohey@providence.org.