Rounding: A Model for Consultation and Training Whose Time Has Come

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Ethics rounds in clinical ethics have already taken hold in multiple venues. There are "sit-down rounds," which usually consist of a bioethicist setting a specific, prescheduled time aside for residents and/or others to bring a case or two for discussion with the bioethicist. Another kind of rounds that occurs on an ad hoc or infrequent basis is to have either a staff or outside bioethicist give hospital-wide and/or departmental "grand rounds." Grand rounds is a traditional educational format in medicine and adding bioethics to the topics covered in grand rounds is an important means of elevating ethical awareness within a department or throughout a healthcare organization. Newer is the rounding practice of adding a bioethicist to other established rounding processes, such as case management and utilization review rounds. All of these kinds of ethics rounds are important opportunities to elevate the level of moral discourse within a healthcare setting and are becoming part and parcel of any full-service hospital bioethics program.

The kind of rounding that is the subject of this paper, however, is one in which a clinical bioethicist joins regular working, or "walking," rounds on a hospital unit. Hereafter, it is this kind of rounds on which we focus and the activity to which we refer when simply using the term "rounding" or "rounds." Our rounding experience of more than six years teaches us that this kind of rounding is a highly successful means of advancing the ethically appropriate care of patients and for teaching clinical staff the fundamentals, and ultimately the fine points, of clinical ethics.

Going Beyond Our Past

In looking back at the development of clinical ethics services, the standard function of ethics committees became teaching, policy development, and case consultation. Ethics committee case consultation was expected to produce an acceptable moral consensus,[1] assure ethically optimal patient care, and teach medical ethics to hospital staff. The initial thought was that, where there are conflicting moral judgments, conflicts result from legitimate values conflicts; where there are legitimate values conflicts, resolution is best sought through the pluralistic process of ethics committee consultation. We believe these assumptions have much

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merit. The diversity of perspectives represented on an ethics committee can provide insight and thoughtful deliberation where deciding what is ethically optimal is truly dilemmatic.

Mostly, however, ethical issues arise in a routine fashion in the everyday care of patients, and many of the cases that come to ethics committees arrive because routine ethics issues have gone unnoticed or unaddressed so long that having missed them produces conflict. Whether conflicts arise between patients and/or surrogates and clinicians or within the clinical team, these differences ordinarily will not rise to the level of a bona fide ethical dilemma. Rather, they are merely the ethical aspects of everyday clinical practice. They are the kinds of ethical issues that even if complex, even if emotionally wrenching, can be sorted out at the bedside with a minimum of conflict and moral distress if handled expeditiously. It is this kind of ethical case input that ethics committee case consultation is ill suited to provide.

The core limitations of ethics committee consultation for everyday utility are that it is retrospective and conflict centered. That is, by the time an ethics committee consult has been called, there is so much conflict that no matter how the case is resolved, there will be negative residue. These residual negative feelings and perceptions are damaging to the everyday functioning of the hospital and need to be prevented by avoiding or reducing the originating conflict.[2]

Conflict is at the heart of ethics committee consultation, and conflict resolution is the anticipated product of the consult. Sometimes, however, the consultation exacerbates the conflict through its values clarification process. Even when the consult does result in tempers being calmed and making recommendations that seem to all to be a fair and appropriate compromise, hard feelings can linger. If hospital staff and/or community clinicians have been embarrassed, intimidated, or felt "ratted on" in the consult process, these outcomes will further reduce the respect and prestige of the committee throughout the hospital. The consult may leave a bad taste in the mouth of patients and/or surrogates, as well, reducing their trust and respect for the hospital, its clinicians, and for the medical profession.

Attempting to address weaknesses in the ethics committee model, a variation on committee consultation called mediation has been gaining attention.[3] The notion here is that formalized due process is lacking in the ethics consultation model and that this is a serious missing piece that mediation adds back into the equation on behalf of the patient. Nonetheless, mediation suffers from the same central weakness as a standard ethics committee consultation. Mediation is a retrospective, conflict-centered process. In fact, it is just mediation's focus on due process that may make it an even less useful conflict resolution method in everyday practice than is standard ethics committee or subcommittee consultation. Mediation distances the process even further from the bedside and adds more layers of review and greater delays to case resolution.

The weaknesses in ethics committee consultation and mediation of their retrospective nature and their resulting inability to prevent serious conflict from arising in the first place, however, do not undermine the importance of either service. Rather, they underscore that clinical ethics has matured to a point at which it should be refining its own methodologies and applying the full panoply of bioethics services in more targeted ways.[4] That is why we recommend using ethics committee consultation in only the truly dilemmatic case. Mediation, too, can

be expected to have high utility in certain kinds of situations. One can imagine instituting a process at a hospital where any time a case moves toward litigation, the parties are encouraged to try mediation first. Such a process could save untold distress and dollars. Neither committee consultation nor mediation, however, are practices well suited to advancing goals of ethics training and consultation in the everyday activities of a hospital. On a routine, day-to-day basis, rounding is a better fit.

"Walking" Rounds as the Preferred Model for Routine Ethics Case Consultation and Professional Training

Going from bed to bed, presenting each patient's case, seeing each patient, and setting the care plan is how hospital clinical medical care is routinely coordinated and delivered. The addition of an ethicist to this process of rounds is a natural enhancement to this normal daily activity.

The purpose of rounding is to enhance the quality of clinical care. That is, like everyone else employed by a hospital, the bioethicist is there to serve the good of the patient. Our experience has taught us that the most effective way for the rounding bioethicist to serve the patient is by serving the team, most notably the attending physician, in thinking through the various ethical issues relevant to a particular patient's care within the time frame optimal to the patient's needs. Having the bioethicist see her/his role as serving the patient by serving the clinicians also sets what we consider the optimal psychological framework for the bioethicist—that the bioethicist is there to assist others in thinking through the issues, not there as judge or ethics expert. Accordingly, the concept of "train the trainer" is an ideal filter for conceptualizing the bioethics service of rounding. If a physician, particularly a unit attending, increases her/his skills in ethical analysis, then the rounding bioethicist will have succeeded in advancing the ethical care of the hospital's and unit's patients.

Another way in which having a bioethicist join regular unit work rounds enhances clinical care is by clarifying that rounds is an appropriate place for moral discourse, contributing to strengthening the moral climate of the unit.[5] Hospital units are organismic. They respond to changes in activity level, personnel mix and other staffing pattern characteristics, and personality dynamics. Each unit will have its own culture and feel. Much of the emotional climate of a unit will be attributable to the degree to which a unit is a morally safe environment. That is, the degree to which all members of a unit, from desk clerks to clinicians, feel comfortable enough to speak up and raise difficult and/or complex ethical issues will contribute to the moral climate of a unit. Where clinicians are disinclined to speak up, errors are more likely to occur.

That is the second way in which the rounding bioethicist fulfills the purpose of enhancing the quality of clinical care, by modeling behavior that strengthens the moral courage required to speak up. Medical hierarchy based on knowledge and ethical and legal obligation is appropriate. But because medicine is so hierarchical, it is often difficult for clinicians to learn that optimal moral discourse requires flattening traditional power hierarchies during moral discussion and ethical argumentation. This may be the most important lesson the advent of ethics committees has to teach. One of the primary reasons the ethics committee has become such a ubiquitous addition to the medical terrain is the appreciation, articulated or intuitive,

that diversity of views and voices in the consideration of complex medico-moral discussions is an ethical advance over outdated practices of medical paternalism. But because the care of most hospitalized patients does not involve ethics committees, this notion of diversity of moral perspective needs to be brought to the patients. By having a bioethicist articulate a reasonably complete range of ethically permissible actions, offer ethical justifications for various points along that continuum, and then, as appropriate, make and justify recommendations for one or more of the ethically acceptable options, the bioethicist models how to engage in ethical argumentation without being argumentative. As the clinicians perfect this skill, the level of moral discourse in the unit is elevated, moral distress declines, and patients can be expected to receive better and safer clinical care.

Adding a bioethicist to regular work rounds can—and ultimately should—have profound effects on unit processes around medico-moral decision-making. This prospect, however, should give the bioethicist pause. Because the environment of any hospital unit is fragile and susceptible to responding to subtle changes, one wants to be careful that the introduction of the bioethicist to rounds produces positive and not negative outcomes. Thus, we underscore our recommendation that the bioethicist who rounds see him/herself as one who serves and educates. Being perceived as a "know-it-all" in ethics will be the kiss of death.

This is especially critical to the success of the rounding bioethicist who is trained (and perhaps still licensed) as a clinician, particularly a physician bioethicist. For the clinician–bioethicist, especially the physician–bioethicist, it is all too easy to fall back on old habits and slide between roles of bioethicist and clinician. Whether the bioethicist was originally trained as a philosopher, social scientist, or physician, the bioethicist function is not responsible for direct patient care. This is a fact that must always be front and center in the rounding bioethicist's self-awareness.

Also, timing is everything. A bioethicist joins rounds by invitation of the unit chief. Invitations can be extended more or less enthusiastically. Once on rounds, unless the bioethicist gains credibility as a useful member of the group, the invitation will not last long. It is important that the bioethicist learn to negotiate the fine line between raising ethical issues that need attention and knowing which ethical issues are better postponed. The rounding bioethicist must learn to disagree forcefully if need be, but simultaneously in a way that builds trust and respect, without embarrassing or intimidating others—including, and sometimes especially, the attending physician.

Take, for example, the problem of informed consent. It is difficult to know how much a patient and/or his/her family has actually absorbed. Often patients and their families build walls of psychological denial to protect themselves from the misery and sadness that information about poor health brings. To expect perfect understanding is unrealistic. Where ethical judgment is needed is to determine at what point one's obligation to make an ethically acceptable effort has been met. Finding this set point for each patient every time requires thought and may produce disagreement among the team. Ethically and legally, what is enough informing and enough understanding for satisfactory consent is going to be a moving target; there is no formula for finding just the right spot to call the job well done. But the skilled bioethicist can facilitate a discussion on rounds detailed enough to produce a

reasonable level of confidence that a good faith effort has or has not been made. Ordinarily, handling these routine ethical aspects of care on rounds will prevent this kind of situation from going from bad to worse, resulting in so much conflict that an ethics committee consultation is called to handle a problem that, if it had been handled early on, might not have become a problem at all.

To master the art of ethical negotiation, the bioethicist has to build the respect and trust of the team while allowing the morning's set of regular work rounds to progress in a timely manner. In the consent example just given, the skilled bioethicist will be able to quickly elicit from various members of the team whether or not there is consensus that the job has been done satisfactorily or if there is more work to do and with whom. Sometimes it will emerge that the work left to do is primarily with the patient and/or with the family. Just as often, however, it will become explicit (perhaps for the first time, although it may have already been well recognized in silence or in hushed tones) that the senior treating physicians still need to work out their own judgments so a clearer message can be given to the patient and family. This requires give and take, and most likely it is the rounding bioethicist who serves as traffic cop in the intersection.

This default position as ethics discussant fulcrum has its own set of justifications and benefits. The group will naturally and appropriately look to the bioethicist to model refined communication skills in ethical analysis, especially in discussions that might be a bit uncomfortable. In addition to neutral facets of these interchanges, such as communication skills, this process involves more emotionally charged undercurrents, most notably power issues. To do this in a way that not merely surfaces disagreement, but also makes everyone feel respected and more comfortable working together after the discussion is over is the key to the rounding bioethicist's success. Being successful at this kind of communication interchange and power differential management requires that the bioethicist has already built strong trusting relationships. The rounding bioethicist must be a moral model in bringing up the difficult issues and challenging barriers. Success requires that the rounding bioethicist, over time, be seen as someone who provides wise and practical counsel in nonpunitive ways and, when the situation calls for it, acts with moral courage.

Practical Considerations

Personnel

We recommend that only well-qualified and experienced persons participate in clinical ethics rounds. Because bioethicists who round are going to have to earn the trust and respect of the most senior physicians, and be able to do so in a reasonably short time frame (or the bioethicist will be labeled unhelpful and quickly marginalized), we recommend that the rounding bioethicist have a terminal advanced degree, that is, Ph.D., MD, or JD, to better ensure developing the trusting relationships with the attendings that are critical to success. We recommend also that the bioethicist be highly experienced in the clinical medical setting. That is not to say that the rounding bioethicist needs to be a trained and/or licensed clinician. Sometimes it is to the rounding bioethicist's advantage not to be a clinician by previous training. But the rounding bioethicist must be knowledgeable of the clinical setting and understand enough medical terminology to grasp what is going on with the patient. On rounds, dis-

cussions of a patient's condition will be presented fast, in technical, medical language. There is no time for translation. Slowing down rounds is something to be avoided. Having a substantive ethical discussion about a particularly complex medico-moral aspect of a patient's care that has immediate relevance for medical decisionmaking is the only acceptable reason to slow down rounds. A bioethicist's ignorance of the medical facts is never acceptable.

Logistics

The logistics of rounding will have to be worked out in ways that are most appropriate to each practice setting in which they arise. There may be minimum requirements, however, to assure that the purposes of having a bioethicist can be achieved through the means proposed in this paper. Concerning where in the hospital to start rounding, we recommend intensive or critical care units (ICUs or CCUs), medical and surgical, adult, pediatric, and neonatal, first, covering geriatric and obstetrical units next. These are the busiest, have the sickest patients, and present the most ethically complicated cases in the hospital. Decisions often have to be made hourly because the patient's clinical status is changing that fast or faster.

Frequency of having the bioethicist on rounds should be at least once a week. Attending regular unit rounds once a week assures that the bioethicist gets to know everyone. Familiarity with unit processes assures comfort but, by being there only weekly, assures, also, that nobody becomes dependent on the bioethicist for routine ethical analysis. Being available by beeper increases unit comfort. Also, it does not appear necessary to set a rigid schedule as to what day of the week the bioethicist will round. In fact, it may be better to set a default day but run a schedule where some weeks the bioethicist rounds on a nondefault day, rounding occasionally on each day of the week, including weekends. That way the bioethicist learns how the unit's functioning fluctuates throughout the week and, as long as the bioethicist is faithful to once weekly, the staff grows comfortable with him/her coming on and off the unit.

Being there when rounds start is the goal. But because different attendings have differing schedules and emergencies occur regularly, making a good faith effort to be there when rounds start, and hitting the mark with reasonable frequency, is an acceptable standard to set. But once there, the bioethicist needs to stay through rounds. Ordinarily, there is a rhythm to rounds and one can estimate what the general length of rounds is going to be. But codes and other interruptions will simply mean that rounds will last longer. The bioethicist will need to keep her/his schedule flexible on the day she/he rounds so that once on rounds, the bioethicist stays to the bitter end.

Costs

Rounding is not going to be cheap. Hospitals have been trying to shoehorn the costs of ethics services into invisible crevices since ethics services started appearing in hospitals. Often there is no explicit line item in a hospital's budget for an ethics committee. They are a virtually unfunded mandate.

Although we strongly urge not connecting cost cutting with quality in healthcare, we recognize that for non-income-generating activities to be sustainable, they need to contribute to sound resource management. We predict that having a bioethicist on rounds will make this kind of contribution.[6]

That we predict having rounding bioethicists will save costs does not mean that the service will be inexpensive. Bioethicists should be paid respectably. If one calculates the salary for one bioethics FTE (full-time equivalent position) at 40 hours per week for 52 weeks per year, that equals 2080 hours annually. The time for bioethics professionals as voluntary addendums to a clinical ethics service is over. Less than fair compensation will inevitably result in undercutting the professional standing of the bioethicist as an integral part of the team.

Limitations of the Rounding Model

Having a bioethicist on rounds is not, however, a panacea. Perhaps the most obvious and significant limitation of the rounding model is that it is heavily skewed towards physician training. In the standard process of rounds, the case is presented to the supervising attending by the responsible resident (or other clinician in hospitals without resident training programs). Thus, the bioethicist's focus is most heavily on the clinician presenting the case and the attending. Depending on institutional custom, rounding may or may not include clinicians/managers from nursing, social work, and other disciplines. If not, supplemental ethics education by other mechanisms designed to engage these disciplines will be needed. A related point is that this model does not include much, if any, interaction with patients and/or surrogates. This may or may not be a limitation of the activity.

Another limitation is the prospect for having the rounding bioethicist co-opted by the clinicians, that is, simply becoming a parrot of the recommendations and decisions most preferred by some or other members of the team. This is akin to the problem that the mediation model of consultation is designed to avoid, that the process lacks formalized due process and is therefore open to problems of bias of the rounding bioethicist. Having the bioethicist co-opted by the physicians and/or perceived by others (patients, families, other providers) to have been so co-opted will be damaging to the credibility of the bioethicist and have negative spillover onto other bioethicists and/or bioethics activities in the hospital. Also, were co-opting to occur, problems such as the bioethicist being used as a front for shielding *sub rosa* fiscal reasons for limitations of care could emerge. Relatedly and more commonly, however, is the concern that having a bioethicist on rounds is biasing in the same way as having a "lone ranger" ad hoc clinical ethics consultant can be biasing. Any time only one voice is heard the potential for swaying others based on bias rather than well-articulated and full argumentation is a disturbing possibility.

The final limitation we readily see, however, will come out of an embarrassment of riches rather than as a result of flaws in the model, itself. That is, if, as we suspect, rounding becomes a more widely offered and utilized clinical ethics consultation and training service, there may not be enough bioethicists to go around.

Next Steps

It will be important to begin shaping the model so it can be replicated and tested. To do so, we recommend placing it into the context of the notion of treatment fidelity.[7] Shaping the rounding model in this direction requires decisions about its "active ingredients" or core elements, and their dosage, that is, what elements of rounding, in what amounts, are optimal for producing the desired outcomes? Components thought to be important include (1) regular consideration of routine eth-

ical issues; (2) goals of care congruent with a patient's clinical status and prognosis; (3) ability of caregivers to identify, analyze, and address situations that are potentially or actually ethically problematic; (4) follow-up and revision of previous plans as conditions dictate; and (5) reflection as a team on the accumulating consensus in the unit for handling ethical issues. Dosage refers to the number, frequency, and length of contact. Weekly rounding assures that most patients will be seen and most residents will be exposed to explicit ethics discussions. Amount of discussion on each patient will reflect time needed to resolve medical and ethical questions for a satisfactory plan of care.

Much work remains to be done to optimally develop "rounding" as an ethics service and to test the most efficient use of resources to yield important outcomes. For example, more work is needed to fully flesh out the outcomes so that they can be better quantified and evaluated. These are anticipated to include the following:

1. Ethical conflict avoided as evidenced by decreased numbers of nondilemmatic ethics committee consults, legal actions, and reduced moral distress
2. Ethically appropriate care of patients—such outcomes as having reasonable patient preferences actually enacted and consent be informed
3. Ethically appropriate involvement of patients' families/significant others—their understanding of surrogacy sufficient to play supportive role to patient
4. Development of ethical analysis skills in staff
5. Ethically supportive institutional policies and climate, and self-efficacy on the part of all parties in carrying out their practice
6. A sense of shared history in consensus about appropriate resolution of paradigm cases and accumulation of resolutions reflecting reasonable laws and institutional policy/practice.

In summary, we have argued that it is now time to focus more attention on rounding as the preferred model for routine ethics case consultation and professional training for a number of reasons. Having bioethicists integrated into regular unit rounds can be expected to (1) advance the goals of the field to strengthen ethical patient care practices; (2) teach bioethics to clinical professionals more effectively on a routine, day-to-day basis, than does the ethics committee case consultation model; (3) avoid or reduce the conflict that is the trigger for most ethics committee consultations; and (4) allow the present model of ethics committee consultation to be applied more judiciously, targeting full committee and/or subcommittee case consultation to only the most complex cases. Rounding is tied to the care of real patients in real time and promises to address routine ethical issues early in a patient's stay, well upstream of problems that could generate the kind of conflict resulting in downstream logjams of repetitive, after-the-fact, less than effective ethics committee consults.

Notes

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