Providence
Center for
Health Care Ethics

Providence Center for Health Care Ethics

Clinical Ethics Fellowship Program Handbook

SECTION I

Goals of the Fellowship:

The Fellowship in Clinical Ethics and Health Justice provides post-graduate level education for ethicists-in-training. The goal of the Fellowship is to prepare highly-qualified, academically trained ethicists for the professional fields of health care ethics and clinical ethics by providing practical, hands-on experience with dedicated preceptorship.

Our Clinical Ethics Fellowship is designed to:

- provide professional formation through hands-on work in clinical ethics, with a particular focus on consultation;
- actively promote health justice in the work of the Providence Center for Health Care Ethics and the education it provides;
- and contribute to the professionalization of the field of clinical ethics and the development of excellent practices in ethically-challenging patient care situations.

Our Clinical Ethics Fellowship will prepare the fellow to:

- Perform clinical ethics consultation in a variety of hospital settings.
- Contribute to the field of clinical ethics via quality improvement and engagement with scholarship.
- Provide education in bioethics to a broad range of clinicians, for the purposes of continuing medical education and initial competency-building.
- Provide ethical support and insight to organizational ethics discussions and decisions across the healthcare continuum.
- Develop and maintain ethically relevant policy for healthcare institutions.
- Provide support to ethics committees.
- Encourage professional development in the field of health care ethics and promote an environment where the fellow can develop through formation.

Fellowship Timeline:

	1-3 months	3-6 months	6-12 months	12+ months
Call	Shadowing, drafting notes for ethicist edits, chart review and discussion of cases.	Some intake as appropriate, drafting notes for ethicist review and submission, case engagement	Some further consult tasks, draft notes to post with ethicist modifications, simple consults solo	Increased volume of routine consults solo, active participation in complex consults, note writing
Case Rounds	Attendance at Center and System case rounds, present case summaries	Presentation at Center CR following each week on service, attendance at System CR	Yearly System case rounds presentation, continue to present at Center CR	Yearly System case rounds presentation, continue to present at Center CR
Scholarship	Reading and exploring possible scholarship	Identify scholarship interests	ASBH attendance ASBH submission	ASBH submission, One submission for publication
Education	Observe all Center education offered, observe system education as offered. May offer resident education.	Offer at least one educational session per resident rotation w/ ethicist feedback, one noon conference	Continue resident rotation education, present quarterly noon conferences, prepare and offer one Lunch & Learn	Continue resident rotation, offer one additional Lunch & Learn, ongoing noon conferences
Organizational Ethics	Observe Ethics committees & organizational ethics meetings	cont.	Take over 2+ ethics committees, organizational meetings as assigned	cont.
Provider Orientation & Onboarding	Observe provider onboardings and orientations	cont.	Take over at 1+ Ethics onboarding for providers	cont.
HEC-C	HEC-C readings	cont.	HEC-C practice exams	HEC-C certification
Policy	Review ethics stakeholder policies, attend GOP meeting	Head policy review for regional ethics committee meetings	Participate in Ethics-held policy review	Assists with Ethics-held policy review as appropriate
Rotations & Mentorship	Introduction to Providence System Ethicists	Engage in System-level ethics dialogues as appropriate	Identify preferred rotations and mentorship and determine fit	1-2 rotations, Ongoing mentorship

Requirements for Graduation:

HEC-C Certification: Fellows will seek HEC-C certification during their fellowship, including ensuring they meet the hourly contact requirements and study the HEC-C reading list and complete practice tests as indicated by the timeline. In order to graduate the fellowship, fellows must be granted the HEC-C (or have taken appropriate steps towards receiving the certification if timing of completion of the HEC-C is not possible, with approval from program leadership).

Independent Consultation Readiness: Fellows will progress through increasing levels of responsibility for clinical ethics consults, first observing consults, then slowly taking on aspects of consults as indicated by the timeline and by their preceptor's approval. In order to graduate the fellowship, fellows must have the majority of their preceptors sign off that they are capable of providing high-quality clinical ethics consultation on their own.

Independent Education Readiness: Fellows will progress through increasing levels of responsibility for providing education to Providence caregivers moving from smaller audiences to providing education available to all caregivers in Oregon, with frequent feedback, as indicated by the timeline. In order to graduate the fellowship, fellows must have the majority of their preceptors sign off that they are capable of providing high-quality bioethics education to caregivers on their own.

Portfolio Preparation: Fellows will produce a portfolio for clinical ethics consultation to submit in consideration for graduation. This portfolio will include a clinical ethics resume, statistics on consult participation, a write-up of a minimum of 3 cases including a clinical summary, summary of the ethical issue, de-identified chart notes, analysis of any relevant justice considerations for context of the case, and ethical analysis.

Oral Examination: To graduate from the fellowship, fellows must present their portfolio to their preceptors and provide satisfactory answers to examination questions based on the cases in the portfolio and other aspects of their submission. Oral examinations may include one relevant outside examiner.

Upon completion of the two-year period of the fellowship (subject to discussion following completion of 18 months of the fellowship) and the above requirements, fellows may apply for graduation in discussion with their fellowship director.

Embedded ethics personnel across the Providence system:

Throughout your fellowship you will also have the opportunity to collaborate with and learn from ethicists assigned to other states in Providence. These include:


Jordan Mason, PhD, MDiv, HEC-C
Clinical Ethicist, Northern California

Interests: Clinical Ethicist, Ethics, Northern California. Theological bioethics, medical error and moral tragedy, philosophy of medicine, technique and method in clinical ethics consultation, bioethics after the Holocaust.


Jennifer Dunatov, DHCE, MA
Chief of Integrated Ethics, South Division (California)

Interests: Birth Ethics, Reproductive Justice


Jacquelyn Harootunian-Cutts, MA, HEC-C
Clinical Ethicist, Southern California

Interests: Theological bioethics, Catholic Social Teaching, clinical ethics and nursing


Mark Carr, PhD
Chief of Integrated Ethics, North Division (Puget Sound, Alaska)

Interests: Theory, Method, Virtue ethics, Case study pedagogy, Faith-based Corporate American Healthcare systems


Doyle Patterson, PhD
Senior Director, Texas/New Mexico

Interests: Ethics & medical architecture, Ethics of recruitment of international nurses


Dylan Manson, PhD
Clinical Ethicist, Providence Swedish, Seattle/Puget Sound

Interests: political philosophy, capacity, surrogate selection and responsibility, TA-NRP, ECMO, and medically inappropriate treatment

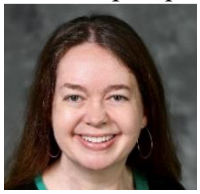

Sara Kolmes, PhD, HEC-C
Senior Clinical Ethicist, eastern Washinton and Montana

Oregon team (on-site with fellows in Portland on the campus of St. Vincent)

Throughout your fellowship you will work closely with and learn from staff at the Providence Center for Health Care Ethics, which provides Providence ministries in Oregon with ethics education, organizational ethics support, and clinical ethics consultation. These include:


Kevin Dirksen, M.Div., M.Sc., HEC-C
Director, Providence Center for Health Care Ethics
Andy & Bev Honzel Endowed Chair, Applied Health Care Ethics
Chief of Integrated Ethics, Central Division (Oregon, eastern Washington, Montana, Texas, New Mexico)
Clinical ethicist, Oregon
Program Director, Fellowship in Clinical Ethics and Health Justice


Kayla Tabari, RN, MBE, HEC-C
Clinical Ethicist, Oregon
Fellowship Supervisor, Fellowship in Clinical Ethics and Health Justice


Kelsi Charlesworth, MS

Senior Manager, Providence Center for Health Care Ethics


Daniel Olson
Administrative Coordinator, Providence Center for Health Care Ethics

Satellite Locations

While the Providence Center for Health Care Ethics is located on the **Providence St Vincent Medical Center** campus, the Center serves all Providence caregivers in the state of Oregon. As such, fellows will find themselves learning at many Providence locations in Oregon. Fellows are expected to work out of these locations when on call with coordination with the on-call ethicist and will be expected at minimum to work out of satellite locations once per month.

Oregon Hospitals with Ethics Offices:

Providence Portland Medical Center: 400+ Beds, located at 4805 Ne Glisan Street, Portland, OR. Colloquially this hospital is known as PPMC, although it is OPH in Epic. This hospital is home to an internal medicine residency for which the ethicists and fellows will provide significant in-person teaching. In addition, the on-call ethicist or the fellow on call typically visit PPMC on average once per week.

Providence Milwaukie Hospital: 74+ Beds, located at 10150 SE 32nd Ave., Milwaukie, OR. Colloquially this hospital is known as PMH, although it is OMW in Epic. This hospital is home to a family medicine residency for which the ethicist and fellows will provide significant in-person teaching. In addition, the on-call ethicist or the fellow on call if relevant, typically visit PMH on average once per week.

Other Oregon Hospitals Served by the Center for Health Care Ethics: Ethicists and fellows will visit these at a more infrequent, irregular cadence, although an effort will be made to introduce fellows to all Oregon hospitals at some point during their fellowship.

Providence Willamette Falls Medical Center, OWF in Epic
Providence Medford Medical Center, OMD in Epic
Providence Seaside Hospital OSS in Epic
Providence Newberg Medical Center ONB in Epic
Providence Hood River Memorial Hospital OHR in Epic
many outpatient clinics and services, designated as PMG (varying location designations in Epic)

SECTION II

Call Expectations:

A fellow's individual call expectations will evolve throughout their learning process. Fellows will be on call both together and separately on a regular basis.

First Month: The fellow will observe all aspects of consults, review patient EMR records and relevant case background, drafting example notes for revision, and review completed ethicist's notes. The fellow will observe and assist with tracking cases in EthicsLabe. The fellow will observe each ethicist for one week as soon as possible. The fellow will be scheduled to be on with the on-call ethicist 1/2 of the time (scheduled by admin).

2-3 Months: The fellow will observe all aspects of consults, review patient EMR records and relevant case background, develop first drafts of notes, review the ethicist's notes, and engage in some intake of cases and consultative activity. The fellow will begin to enter assigned cases into EthicsLabe, subject to ethicist review. The fellow will be scheduled to be on with the on-call ethicist 1/2 of the time (scheduled by admin).

3-6 Months: As appropriate, the fellow will take on some simple intake and chart review and tasks, drafting notes for editing with the ethicist. The fellow will take on responsibility for recording cases in EthicsLabe. The fellow will be scheduled to be on with the on-call ethicist 1/2 of the time (scheduled by admin).

6-12 Months: As appropriate, there will be a slow handoff of more tasks to the fellow in some cases. The fellow will continue to draft notes which will now be reviewed by the ethicist, building to the fellow posting their own notes with ethicist cosign. The fellow will be responsible for tracking cases they participate with in EthicsLabe, and cases they observe as assigned. Fellows may begin to cover simple cases solo. All tasks will be supervised by the ethicist and receive feedback. The fellow will be scheduled to be on with the on-call ethicist 1/2 of the time (scheduled by admin).

By the start of year two, the fellow as appropriate may be handling simple consults with supervision and assisting in elements of more complex consultations. Fellows will demonstrate an awareness of and ability to deploy in-person case analysis via the Providence Ethical Decision-Making Model (facilitation of a group exercise centered on four fundamental questions of i) what is the **honest** practice of medicine or quality health care for my patient (*clinical integrity*), ii) how can we demonstrate **dependability** to benefit my patient (*beneficence*), iii) what is **fair** to my patient in the circumstances (*respect for patients and their autonomy*), and iv) how can we be **accountable** to other obligations especially regarding our commitment to *justice* and the duty of *nonmaleficence*.

Case Rounds:

First 6 Weeks: Fellows will attend weekly Center ethicist case rounds and observe case presentations and discussions. Fellows will attend monthly System ethicist case rounds and observe case presentations and discussions.

6 Weeks-3 Months: Fellows will present a brief case overview and clinical summary of one case they were involved in at Center ethicist case rounds and observe ethics presentations and discussions. Fellows will attend monthly System ethicist case rounds and observe case presentations and discussions.

3-6 Months: Fellows will begin to present full cases at Center case rounds, with the goal of one or both fellows presenting a case and receiving feedback at each case rounds following a week when fellows were on calls. Fellows will attend monthly System ethicist case rounds and observe case presentations and discussions.

6-12 Months: Fellows will continue to present at Center case rounds. Fellows will present once at System ethicist case rounds.

12+ Months: Fellows will continue to present yearly at System ethicist case rounds and present weekly at Center case rounds.

Case Rounds at Providence locations

Ethicists will join ICU rounds at Providence locations in Oregon. Some of these rounds will recur weekly, whereas others outside of the Portland Metro Area are on a less frequent basis. Fellows will be expected to participate in ethics rounds during weeks on call and as needed.

Members of the clinical ethics team will occasionally travel to other locations in the Providence network. Fellows may be encouraged to accompany team members on these trips as appropriate.

Scholarship:

Fellows will be expected to contribute to the field by engaging in scholarship with colleagues, via conference presentations and developing scholarship. The specific topic of scholarship will be expected to be broadly related to bioethics with a suggestion that the fellow consider a relevant emphasis on justice, but will be determined by the fellow based on their existing interests, experiences, background, and expertise. Fellows without a research background will be provided with significant mentorship; for basic resources on writing abstracts, research, and the Providence Library resources see the ‘Additional Resources’ section in part III of this handbook.

During their first year, fellows will draft and submit one commentary or letter to the editor on an article to a major journal, either in collaboration with ethicist colleagues or with approval of the

submitted draft. For example, a submission of an Open Peer Commentary to the American Journal of Bioethics would fulfill this requirement.

During the second year, fellows will draft and submit one work of publishable quality to a major journal in collaboration with or guided by ethicist colleagues.

Fellows will submit at minimum one solo or co-authored presentation to ASBH both years of the fellowship and attend the conference during at least one year of the fellowship.

Fellows will remain engaged in monitoring and reading scholarship in their chosen specialties and in clinical ethics in general as assigned.

Organizational Ethics and Ethics Committees:

First 6 months: Fellows will observe and participate in as many ethics committees and organizational ethics meetings as possible. Fellows will debrief these meetings with preceptors, with a particular emphasis on the organizational ethics issues raised, possible justice considerations which might be addressed within these structures, and operating in organizations effectively.

6-12 months: Fellows will take over 2 ethics committees as assigned.

12-24: Fellows will take over 2-3 ethics committees as assigned and may take point in organizational ethics meetings as assigned.

First 6 months: Fellows will observe all possible onboardings for clinicians, availability permitting.

6-24 months: Fellows will take over onboardings for one category of clinicians, assigned by interest.

First 6 months: Fellows will observe all possible organizational ethics meetings.

6-24 months: Fellows will continue to observe organizational ethics meetings and take over assisting organizational ethics meetings as assigned.

First 3 months: Fellows will review policies in which ethics is a stakeholder and attend relevant GOP meetings.

3-6 months: Fellows will head policy review segments in Regional Ethics Committee meetings, and continue to attend GOP meetings.

6-12 months: Fellows will continue to head policy review segments in REC and attend GOP meetings and will participate in and observe Ethics-led policy review. Policy development will be accompanied by education on practical, ethical, medical, and any particular justice-oriented considerations on appropriate policy in the relevant areas.

12+ months: Fellows will continue to head policy review segments in REC and attend GOP meetings and will assist with ethics-led policy review as appropriate.

Education:

First 3 months: Fellows will observe all ethics education for medical residents and, during this time, they will produce an education session or present an existing offering intended for the residents. Fellows will offer logistical support to the program coordinator during Lunch and Learns.

Starting in the first three months, fellows are also encouraged to draw upon their theoretical knowledge of bioethics to develop a novel resident education session on a topic of their choosing. The topic must fall under the wider clinical ethics umbrella; however, the fellow should feel free to educate the resident on their specialty or interest so that the resident acquires a broader snapshot of the world of clinical ethics during their rotation. The fellow will meet with the educational coordinator to discuss developing this and begin presenting it to residents when it is approved.

3-6 months: If applicable, fellows will continue to offer their novel session and begin to offer additional standardized clinical ethics education to resident physicians on an ethics elective rotation. They will begin to prepare a noon conference for one resident rotation, presenting it at some point during this period. Fellows will offer logistical support to the program coordinator during Lunch and Learns.

6-12 months: Fellow will continue to offer resident education once per rotation and one noon conference per quarter. Fellow will begin to prepare a lunch-and-learn presentation. They will first present this to a resident physician while they are on ethics elective rotation with observation by a precepting ethicists. After feedback, the fellow may repeat this process several times before the formal Lunch & Learn is scheduled.

In the second year the fellow will present an additional lunch and learn presentation, continue to offer quarterly noon conferences, and rotation resident sessions as assigned.

Didactic Sessions:

Fellows will have didactic sessions assigned with ethicists, with assigned readings for discussion. Sessions may be focused on specific readings, on specific topics of interest, or on fellow-identified readings from this list. Fellows and faculty may also determine that a specific focus for

alternative reading assignments is appropriate.

Health Justice

Consistent with a core bioethical principle of justice, fellows will be expected to demonstrate an advanced understanding in and application of concepts like social medicine, structural competency, and global health equity. Fellows will be able to extend a clinical ethics case analysis approach (e.g., Providence Ethical Decision-Making Model) to a structural competency assessment (e.g., Structural Competency Working Group arrow diagram) on a given case.

HEC-C:

First 6 months: Fellows will review the HEC-C reading list, becoming familiar with all required HEC-C material. The HEC-C reading list can be found in this handbook.

6-12 months: Fellows will begin to participate in HEC-C practice tests and continue to review HEC-C material. Residents will ensure they meet the other requirements for HEC-C certification.

12-24 months: Fellows will be expected to pass the HEC-C certification and be awarded it during their second year.

Clinical Rotations:

During the first three months of their fellowship, a fellow will be assigned a number of rotations with allied clinical services, the details of which will be determined with clinical services and the fellowship supervisor based on the fellow's background and goals.

Rotations may include:

Shadowing palliative care at PPMC or PSV for a week

Shadowing bedside nurses at PPMC for three full 12-hour shifts

Shadowing care management at PPMC, PMH, or PSV for a week

Shadowing behavioral health at PMG for three days

Shadowing internal medicine residents visiting OHR on their geriatrics rotation patient visits and didactics for one day

Fellows may elect to request to repeat these rotations or other rotations later in their fellowship based on their interests and goals, subject to availability of clinical services and fellowship leadership.

Partner Rotations:

During the first three months of their fellowship, a fellow may be assigned a rotation with an allied service. The details of this rotation will be determined with the relevant service and the fellowship supervisor based on the fellow's background and goals.

Example rotations include:

Shadowing risk management virtually for a week

Shadowing legal virtually for a week

Shadowing the pediatric palliative care team and clinical ethics service at OHSU for a week

Shadowing mission integration for a week

Fellows may elect to request to repeat these rotations later in their fellowship based on their interests and goals, subject to availability of clinical services and fellowship supervisor approval.

External Ethicist Rotations:

In discussion with ethics preceptors, fellows will mutually discern an interest and fit for a potential rotation with System ethicists during the advanced phase of the fellowship. Opportunities to rotate with System ethicists as appropriate will be available to fellows during their second year. Several possible modalities are listed below, subject to resource availability and fit:

Modality: Virtual, optional hybrid visit

- **Duration:** 8 months – 1 year
- **Preparation:** Shadowing educational programming, reading education curricula
- **Check-ins:** monthly
- **Responsibilities:** Curation/improvement of Ethics Liaison training material, development/improvement of ELC materials, host monthly support calls, attend monthly rotation meetings
- **Observation:** Shadow initial support calls, attend organizational meetings

Modality: In-person, *condensed*

- **Duration:** Two weeks
- **Preparation:** assigned reading, shadowing ethics committees
- **Check-ins:** shadow full workdays for duration of rotation
- **Responsibilities:** Prepare/facilitate one ethics committee meeting, some consultative responsibilities as appropriate, present large-group capstone presentation, capstone article/project as discussed with preceptor
- **Observation:** shadow all consults and organizational meetings

Modality: In-person event with virtual preparation

- **Duration:** 1 year
- **Preparation:** Conceptualize an educational or other community event with ethicist, production of materials and assistance with logistics for said event
- **Check-ins:** Meet hosting ethicist bi-monthly for event design check-ins. Meet with other event stakeholders as needed.
- **Additional responsibilities:** Attend and assist with event in-person.
- **Observation:** If relevant, observe hosting ethicist meetings with stakeholder groups ahead of and during event.

Modality: In-person, virtual, or hybrid

- **Duration:** variable
- **Preparation:** determine appropriate activities and modality with preceptor
- **Description:** Loosely-structured, case-by case rotation not covered by previous rotation descriptions. Details should be decided on in conversation between preceptor and fellow.

Modality: virtual

- **Duration**: ~8 weeks
- **Preparation**: listen to several released episodes, attendance at season planning meeting
- **Check-ins**: 2 virtual meetings; updates via email as needed

- **Responsibilities**: serve as host/producer for one episode (includes content planning, recording, and making editing decisions); may be an interviewee for an additional episode, depending on season needs and fellow's expertise; be available to support other episode activities as requested.
- **Observation**: shadow the making of an episode from start to finish (review preparation materials as developed, be present for a recording, review editing decisions).

An external rotation must have the following structures at minimum, regardless of the modality chosen:

- Rotation preceptors must identify the goal of the rotation. Goals can be targeted to a specific topic within clinical ethics, or something as simple as exposing the fellow to clinical ethics practices at a different location.
- Preceptors must create a schedule of events ahead of the fellow's arrival to the rotation. Some leeway will be given for consult scheduling, due to their more chaotic nature in terms of scheduling. However, blocked periods of time, specific meetings, educational offerings, and anything else that can be scheduled in advance must be placed on Outlook calendars at bare minimum. Preceptors are also encouraged to create a separate document with the schedule laid out in a clear manner, but this step is not strictly necessary.
- Preceptors must acknowledge and respect the autonomy of the fellow and their learning progress in the clinical ethics fellowship. Preceptors must abide by the same pedagogical standards that the Ethics Center staff abides by with regard to teaching the fellow. They must also allow for ample opportunity for experiential learning, respecting the autonomy the fellow has earned for themselves in their particular stage of the fellowship.

It may be helpful to design a rotation to support scholarly collaboration with the hosting ethicist, either to fulfill the scholarship requirements of the fellowship or for work outside of this structure. Please discuss this with your hosting ethicist if you are interested.

Other Policies:

Device Policy

The Ethics Center policy regarding personal devices used for work is the same as the PSJH policy for personal devices. Ethicists and other Center staff must protect protected health information (PHI) even when using their personal devices for non-work reasons. Lost devices should be reported to IS as per PSJH policy, and any confidentiality breaches or HIPAA violations will be addressed according to the law and company policy.

PHI Compliance and Ethicist Pagers

Ethicist pagers may contain protected health information pertaining to ethics consultations. As such, pagers should be treated pursuant to PSJH policy regarding personal devices. The fellow will be responsible for maintaining HIPAA compliance and protecting patients' health information, as well as maintaining confidence with providers reaching out for consultation.

If the ethicist/fellow misplaces their pager or if the pager is stolen, then they should report the missing device to IS and their supervisor as per the PSJH policy regarding missing personal work devices. Any breach of HIPAA compliance resulting from misplacing the pager will fall under PSJH policy and HIPAA law, as will any disciplinary actions that follow said breach.

Other Responsibilities:

Fellows will also participate in the organization and coordination of ethics education and lectureships. This may include, for example, as assigned:

- Assisting with identifying future lectureship speakers through research and developing summaries of the work and presentation style of suggested lecturers for review by the team.
- Assisting with development of presentation titles, descriptions, and learning objectives for presentations and lectures.
- Assisting in the process of making educational content eligible for CME/CNE credit.
- Assisting with lectureship logistics, including transportation of speakers, tech checks for lectureships, review educational material, managing Q&As after lectureships, and drafting lectureship schedules based on past schedules.
- Produce presentation aids for regularly scheduled organization meetings based on templates.

Intellectual Property Guidelines:

Educational and policy materials created for the Providence Center for Health Care Ethics are the purview of the Center. Specific exceptions to this may be made in conversation with

preceptors, but in general, educational and policy materials a fellow assisted on should be heavily modified before being used in other institutional settings.

SECTION III:

Reading List

Bioethical Theory and Theoretical Considerations

Sorajjakool, Siroj, Mark F. Carr, and Julius J. Nam, eds. “From Conceptual To Concrete” from *World religions for healthcare professionals*. New York: Routledge, 2010.

Jonsen, Albert R. "Of balloons and bicycles—or—the relationship between ethical theory and practical judgment." *Hastings Center Report* 21.5 (1991): 14-16.

Arras, John D. "The way we reason now: reflective equilibrium in bioethics." in *The Oxford Handbook of Bioethics*. Oxford University Press. (2009).

Wailoo, K. (2022). Patients Are Humans Too: The Emergence of Medical Humanities. Daedalus, 151(3), 194-205.

Pellegrino, E (1994). Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship. Journal of Contemporary Health Law and Policy.

Isasi-Díaz, A. M. (2010). Justice as reconciliatory praxis: A decolonial mujerista move. International journal of public theology, 4(1), 37-50.

Metzl, Jonathan M., and Helena Hansen. "Structural competency: theorizing a new medical engagement with stigma and inequality." Social science & medicine 103 (2014): 126-133.

Religion and Bioethics

Sorajjakool, Siroj, Mark F. Carr, and Julius J. Nam, eds. “Religion and Public Health” from *World religions for healthcare professionals*. New York: Routledge, 2010.

Bibler, Trevor M., Myrick C. Shinall Jr, and Devan Stahl. "Responding to those who hope for a miracle: Practices for clinical bioethicists." The American Journal of Bioethics 18.5 (2018): 40-51.

Clinical Ethics

Steinkamp, N. et al (2008). Debating Ethical Expertise. Kennedy Institue of Ethics Journal.

La Puma, J., and Schiedermayer, D. (1991). The Clinical Ethicist at the Bedside. Theoretical Medicine.

Kockler, N., and Dirksen, K. (2015). Competencies Required for Clinical Ethics Consultation as Coaching. CHA.

Jonsen, Albert R., Stephen Toulmin, and Stephen Edelston Toulmin. The abuse of casuistry: A history of moral reasoning. Univ of California Press, 1988.

Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. Oxford University Press, USA, 2020.

Agich, George J. "The question of method in ethics consultation." *American Journal of Bioethics* 1.4 (2001): 31-41.

Kuczewski, M. (2002). Two Models of Ethics Consensus, or What Good Is a Bunch of Ethicists? Cambridge Quarterly of Healthcare Ethics.

Zaner, Richard M. "Listening or telling? Thoughts on responsibility in clinical ethics consultation." *Theoretical Medicine* 17 (1996): 255-277.

Clinical Considerations

Pavlish, Carol. "A culture of avoidance: voices from inside ethically difficult clinical situations." *Number 2/April 2015* 19.2 (2015): 159-165.

Kon, A., et al. 2017). Shared Decision Making in Intensive Care Units: An American College of Critical Care Medicine and American Thoracic Society Policy Statement.

Ganzini, L. et al (2005). Ten Myths About Decision Making Capacity. JAMDA.

Allison, TA. (2013). Disregard of Patients' Preferences Is a Medical Error. JAMA Internal Medicine.

End of life/ ACP

Jansen, L., Sulmasy, D. (2002). Sedation, Alimentation, Hydration, and Equivocation: Careful Conversations about Care at the End of Life. American Society of Internal Medicine.

Tonelli, M. (2005). Waking the Dying: Must We Always Attempt to Involve Critically Ill Patients in End of Life Decisions? CHEST.

Lo, B et al (2002). Discussing Religious and Spiritual Issues at the End of Life: A Practical Guide for Physicians. Journal of the American Medical Association.

Jimenez, G (2018). Overview of Systematic Review of Advance Care Planning: Summary of Evidence and Global Lessons. Journal of Pain and Symptom Management.

Catholic Bioethics

Hamel, R. (2010). Thinking Ethically About Emergency Contraception. Health Progress.

A Colloquium Organized by Ascension Health (2014). Medical Intervention in Cases of Maternal-Fetal Vital Conflicts. The National Catholic Bioethics Center.

Finnis, John, Germain Grisez, and Joseph Boyle. "" Direct" and" Indirect": A Reply to Critics of our Action Theory." The Thomist: A Speculative Quarterly Review 65.1 (2001): 1-44.Baumann, P. (2018). An Unhealed Wound: Commonweal and Humanae Vitae. Commonweal.

Catholic Bioethics & Social Justice. Edited by M. Therese Lysaught and Michael McCarthy. Liturgical Press Academic: Collegeville, MN. www.litpress.org. 2018.

Lysaught, M. Therese, and Michael McCarthy. "A social praxis for US health care: Revisioning Catholic bioethics via Catholic social thought." *Journal of the Society of Christian Ethics* (2018): 111-130.

McCarthy, Michael. "Beyond a Bourgeois Bioethics." *Journal of the Society of Christian Ethics* 41.1 (2021): 73-88.

Bishop, Jeffrey P. "Technics and liturgics." *Christian bioethics: Non-Ecumenical Studies in Medical Morality* 26.1 (2020): 12-30.

Tuohey, J (2011). A Fatal Conflict: Can Catholic Hospitals Refuse to Save Lives? Commonweal.

Cases

Luce, J. (2015). The Uncommon Case of Jahi McMath. CHEST.

Malone, Jay R., Jordan Mason, and Jeffrey P. Bishop. "Ritual and Power in Medicine: Questioning Honor Walks in Organ Donation." *HEC Forum*. Dordrecht: Springer Netherlands, 2024.

Emmanuel, E., Wendler, D., Grady C. (2000). What Makes Clinical Research Ethical? JAMA.

Kockler, N. (2017). Caring for Patients with a History of Illicit Intravenous Drug Use: Ethical Obligations from Bedside to Boardroom. CHA.

Kolmes, S, Ha, C, and Potter, J (2022). Responding to Cultural Limitations on Patient Autonomy: A Clinical Ethics Case Study. HEC Forum.

Tabari House, K, et al (2021). Ending Restraint of Incarcerated Individuals Giving Birth. AMA Journal of Ethics.

Macauley, Robert C. "Covert Medications: Act of Compassion or Conspiracy of Silence?." The Journal of clinical ethics 27.4 (2016): 298-307.

Data and Machine Learning

Big Data, Health Law, and Bioethics. Edited by I. Glenn Cohen, Holly Fernandez Lynch, et al. Cambridge University Press, 2018.
Ho, Anita, et al. "Multi-Level Ethical Considerations of Artificial Intelligence Health Monitoring for People Living with Parkinson's Disease." AJOB Empirical Bioethics (2023): 1-14.

McCradden, Melissa D., et al. "A research ethics framework for the clinical translation of healthcare machine learning." The American Journal of Bioethics 22.5 (2022): 8-22.

Birth Ethics

Lori d'Agincourt-Canning, Carolyn Ells, editors. Ethical Issues in Women's Healthcare: Practice and Policy. 2019. Oxford University Press: New York, NY.

Deborah Kuhn McGregor. From Midwives to Medicine: The Birth of American Gynecology. New Brunswick, NJ: Rutgers University Press, 1998

Garcia, Lorraine M. "Obstetric violence in the United States and other high-income countries: an integrative review." Sexual and reproductive health matters 31.1 (2023): 2322194.

Moral Distress and Resilience

van Dernoot Lipsky, L. (2010). Trauma stewardship: An everyday guide to caring for self while caring for others. ReadHowYouWant. com.

Jameton, A (2017). What Moral Distress in Nursing History Could Suggest about the Future of Health Care. AMA Journal of Ethics.

Fourie, C (2017). Who Is Experiencing What Kind of Moral Distress? Distinctions for Moving from a Narrow to a Broad Definition of Moral Distress. AMA Journal of Ethics.

Hamric, A., Arras, J., Mohrmann., M. (2015). Why Must We Be Courageous? Hastings Center Report.

Public Health

Berlinger, N. et al (2020). Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2. The Hastings Center.

Galea, S. Annas, G. (2016). Aspirations and Strategies for Public Health. JAMA.

Piñones-Rivera, C, et al (2023). Global Social Medicine for an Equitable and Just Future. Health and Human Rights Journal.

Anti-Racism

Wilson, Y (2022). Is Trust Enough? Anti-Black Racism and the Perception of Black Vaccine "Hesitancy". Hastings Center Report

Villarosa, Linda. *Under the Skin: The Hidden Toll of Racism on American Lives*. Anchor, 2022.

Berger, Jeffrey T., and Dana Ribeiro Miller. "Health disparities, systemic racism, and failures of cultural competence." The American Journal of Bioethics 21.9 (2021): 4-10.

Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. American journal of public health, 90(8), 1212.

Disability Studies

Reyonds, JM, Binkley, C, and Shuman, A (2021). The Complex Relationship between Disability Discrimination and Frailty Scores. The American Journal of Bioethics.

Ho, A (2022). Disability Bioethics and Epistemic Injustice. The Disability Bioethics Reader.

Guidry-Grimes, Laura, et al. "Disability rights as a necessary framework for crisis standards of care and the future of health care." Hastings Center Report 50.3 (2020): 28-32.

HEC-C Reading List:

American Society of Bioethics and Humanities. (2011). Core Competencies in Healthcare Ethics Consultation (2nd ed.). Chicago, IL

American Society of Bioethics and Humanities. (2017). A Case-Based Study Guide for Addressing Patient-Centered Ethical Issues in Health Care. Chicago, IL

American Society of Bioethics and Humanities. (2015). Improving Competencies in Clinical Ethics Consultation: An Education Guide (2nd ed.). Chicago, IL

Applebaum PS. Clinical Practice. Assessment of Patients' Competence to Consent to Treatment. N Engl J Med, 2007 Nov 1; 357(18); 1834-40.

Beauchamp, T., Childress, J. (2019). Principles of Biomedical Ethics (8th ed.). Oxford: Oxford University Press

Berlinger, N., Jennings, B., Wolf, S. (2013). The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life. Oxford: Oxford University Press

Danis, M., Wilson, Y., & White, A. (2016). Bioethicists Can and Should Contribute to Addressing Racism. The American Journal of Bioethics, 16(4), 3-12. doi:10.1080/15265161.2016.1145283

Diekema, D., Mercurio, M., Adam M (Eds). (2011). Clinical Ethics in Pediatrics: A Case-Based Textbook. Cambridge: Cambridge University Press

Dubler, N. N. (2013). The Art of the Chart Note in Clinical Ethics Consultation and Bioethics Mediation: Conveying Information that Can Be Understood and Evaluated. The Journal of Clinical Ethics, 24(2), 148-155.

Fiester, A. M. (2015, March 1). What Mediators Can Teach Physicians About Managing 'Difficult' Patients [Editorial]. The American Journal of Medicine, 128(3), 215-216. Retrieved from https://doi.org/10.1016/j.amjmed.2014.09.017

Ford, P. (Ed.), Dudzinski, D. (Ed.). (2008). Complex Ethics Consultations: Cases That Haunt Us. Cambridge: Cambridge Press.

Hester, DN and T. Schonfeld. (2012) Guidance for Healthcare Ethics Committees. Cambridge: Cambridge University Press

Jonsen, A., Siegler, M., Winslade, W. (2015) Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine (8th ed.). New York: McGraw Hill

Kon AA, et al. Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee. Crit Care Med. 2016 Sep; 44(9); 1769-74.

Lo, B. (2020). Resolving Ethical Dilemmas: A Guide for Clinicians (6th ed.). Philadelphia: Lippincott Williams & Wilkins

Marcus, L. J., Dorn, B. C., & Mcnulty, E. J. (2012). The Walk in the Woods: A Step-by-Step Method for Facilitating Interest-Based Negotiation and Conflict Resolution. Negotiation Journal, 28(3), 337-349. doi:10.1111/j.1571-9979.2012.00343.x

Morreim, H. (2018). Mediating Healthcare Disputes More, Earlier . . . And Differently: Mediating Directly in the Clinical Setting. The Health Lawyer, 31(1), 18-29.

Reynolds, J.M. (2018). Three Things Clinicians Should Know about Disability. AMA Journal of Ethics, 20(12):E1181-1187.

Saltman, D. C. (2006). Conflict management: A primer for doctors in training. Postgraduate Medical Journal, 82(963), 9-12. doi:10.1136/pgmj.2005.034306

Sherwin, S., & Baylis, F. (2003). The feminist health care ethics consultant as architect and advocate. Public Affairs Quarterly, 17(2), 141-158.

Stramondo, J.A. (2016). Why Bioethics Needs a Disability Moral Psychology. The Hastings Center Report, May-June, 22-30.

Wahlert, L., & Fiester, A. (2014). Repaving the Road of Good Intentions: LGBT Health Care and the Queer Bioethical Lens. The Hastings Center Report, 44(S4). doi:10.1002/hast.373

Useful Policies:

The Center manages a number of policies in the Oregon region which are ethically relevant. This is a sample of the most-utilized policies. When used on Providence intranet, these links will take you to the policystat pages for review:

Statement on Abortion

Physician-Assisted Suicide

Immediate Donation after Circulatory Death

Determination of Death by Neurologic Criteria in Adults & Children

Organ Donation for Patients Determined to be Dead by Neurological Criteria

Notification of Mental Illness

Physician Orders for Life-Sustaining Treatment (POLST)

Resuscitation and Emergency Interventions During Hospitalization

Determination of Death by Neurologic Criteria in Adults & Children

Substitute Decision-Making for Clinical Interventions on Behalf of Incapable Adults without Alternative Decision-Making Mechanisms

Guardianship Policy Oregon Region

Consent and Refusal of Consent for Procedures

Advance Directives

Transition (Discharge) Planning Process

Patient Choice: Post-Acute Care Services [note that this link is not currently live]

Clinical Ethics Consultation

Regional Ethics Committee Charter

Restraint for Non-Violent Non-Self-Destructive Behavior

Restraint for Violent/Seclusion/Self-Destructive Behavior

Procedure for Potentially Futile Treatment

Useful Medical Acronyms and Technical Terms:

Technical Terms:

- Acute: Of short duration and/or severe intensity
- Benign: Will not cause cancer; not cancerous
- Biopsy: A tiny tissue sample used for testing purposes
- Chronic: An enduring, long-term illness
- Defibrillator: A device that restores a normal heart rhythm
- Edema: Excessive fluid in the body tissues
- Embolism: An arterial blockage of blood flow
- Fracture: Broken cartilage or bone tissue
- Hypertension: High blood pressure
- Intravenous: Fluid or medication delivered through a vein
- Malignant: Cancerous
- Metastasis/metastases: Growth of a malignant cancer to other sites
- Prognosis: The predicted result of a disease's progression
- Trach: Tracheostomy
- Vent: Ventilator

Acronyms:

- 2/2: Secondary to (or derivative from)
- ACL: Allen Cognitive Level score
- AKA: Above knee amputation
- AKI: Acute kidney injury
- AMA: Against medical advice
- AND: Allow Natural Death
- ANH: Artificial Nutrition & Hydration
- A&O: Alert and oriented
- B/L: Bilateral
- BKA: Below knee amputation
- BMI: Body mass index
- BP: Blood pressure
- CAD: Coronary artery disease
- CHF: Chronic heart failure, congestive heart failure
- COPD: Chronic obstructive pulmonary disease
- CPAP: Continuous positive airway pressure
- CPR: Cardiopulmonary resuscitation
- DM: Diabetes mellitus (type 1 or type 2)
- DNR: Do not resuscitate
- DOB: Date of birth
- ECMO: Extracorporeal Membrane Oxygenation (heart and lungs life-sustaining treatment)
- ED/ER: Emergency department/emergency room
- EKG: Electrocardiogram
- ESRD: End-stage renal (or kidney) disease
- ETOH: Alcohol
- GCS: Glasgow coma scale
- H&P: History and physical
- ICU: Intensive care unit
- LST: Life-sustaining treatment
- MICU: Medical intensive care unit
- MRN: Medical Record Number
- NCCU: Neurocritical Care Unit
- NICU: Neonatal intensive care unit
- NG: Nasogastric (ie, NG tube)
- NPO: Nothing by mouth
- PEG: percutaneous endoscopic gastrostomy feeding tube (permanent)
- PMH or PMHx: past medical history
- P.O.: per oral by mouth
- PT: Physical therapy

- Rx: Prescription
- SICU: Surgical intensive care unit
- SLUMS: St. Louis University Mental Status exam
- s/p: Status-post (occurring after)
- STAT: Immediately
- TBI: Traumatic brain injury
- TPN: Total parenteral nutrition

Additional Resources:

It is important for clinical ethics fellows to 'speak the language of medicine', or be clinically competent in conversation. This may require additional resources beyond researching medical details as they become relevant to cases and reading the EMR. Some other resources include:

Inside The Boards, a podcast intended to assist students in studying for board exams, with short episodes on various relevant specialty topics.

Uptodate, a resource for clinical updates and medical information.

The Nocturnists, a podcast focused on experiences of healthcare workers, focusing on difficult experiences surrounding burnout, moral distress, and the human difficulty of providing healthcare.

Fellows without a research background will be offered significant mentorship on this aspect of the fellowship. For some basic research resources at Providence, please see the following online courses. Please note that in order to access these courses you must be logged in to your Providence account:

Library Resources 101, a 90 minute introduction to the library resources available at Providence, which will cover how to access academic materials and best practices in searching for relevant papers, as well as other ways the library at Providence can be of assistance.

Writing an Abstract 101, a 90 minute course focused on the basics of what should be included in an abstract for conference submission, paper submission, or short-form commentary.

Writing A Winning Abstract, further materials on very basic best practices in writing an abstract, including further resources.

Research Basics 101, an introduction to some forms of research in a clinical setting and how it is performed and designed.

One Week On The Ethics Service; A Snapshot

When a clinician consults ethics, they highlight an ethical concern impacting patient care or causing provider distress and receive advice, support, and clinical involvement from an ethicist. Clinical Ethics Consultation can have a different pace, a wider subject matter, and more irregular volume than other consultative services. This is a view of the consultative side of the work of a clinical ethicist in one week.

☐ **1. Ongoing outpatient case:**
Patient **not able to comply** with INR monitoring, on Warfarin, remains unreachable. Ongoing discussions with PCP: should we grant the next refill request, if it comes?

☐ **2. Ongoing outpatient case:**
Patient at end of life, family bought an oxygen tank online and requested the PCP manage, do not want to pursue referral to appropriate service due to previous bad experiences. Provider concerned about **scope**.

☐ **3. Monday Consult:**
Patient requesting outpatient provider fill out documentation attesting to provision of care which raised **professionalism** concerns for the provider.

☐ **4. Tuesday Consult:**
Request to review whether a particular treatment is offered at Providence in light of our **Catholic Identity** from leadership in outpatient clinic.

☐ **5. Wednesday Consult:**
Patient without capacity **expressing distress** at the care they are receiving; interdisciplinary disagreement regarding the need for ethics involvement results in Ethics consultation, cancellation of this consultation, and subsequent offline conversations between ethicist and providers.

☐ **6. Wednesday Consult:**
Patient with no capacity and no surrogate decision-makers, but a "fixed delusion" that he has a wealthy girlfriend who will help him. Request for assistance in guiding physician engagement in **surrogate decision-making**.

☐ **7. Wednesday Consult:**
Patient whose NMI was nullified by misfiling and who **does not demonstrate capacity requests to leave the hospital** while critically ill. Team requests help navigating discharge/care options.

☐ **8. Wednesday Consult:**
Patient is in denial about their end of life status and is requesting **potentially futile treatment**, provider concerned with how to respond.

☐ **9. Thursday Consult:**
Patient with advanced dementia and **no access to adequate outpatient resources is requesting to discharge** and has previously eloped from adult foster home. Team requests help moving forward.

☐ **10. Thursday Consult**
Patient who is **not a candidate for an intervention**, team requests help communicating with PCP who would like more details on why this is the case and whether it is due to patient's ongoing substance use.

☐ **11. Thursday Consult**
Patient's **advance care planning** request is that her children *not* be involved in surrogate decision-making, but has no replacement surrogate. Team requests assistance determining how to reflect this in documentation in the chart and advance directive.

☐ **12. Friday Consult**
Patient is **sexually inappropriate** with team and consistently **does not meet behavioral expectations**. Participate in scheduling large interdisciplinary meeting with care team to determine plan going forward.