



## Teaching Ethics in a Clinical Setting

**Abstract** In this chapter we focus specifically on teaching health care ethics in clinical settings rather than the classroom, through formal courses. The clinical opportunities are diverse, often ad hoc, and usually connected up with current clinical cases. We also discuss the use of formal clinical modules and the role of mentoring as ways of enriching and reinforcing what has previously been taught through formal courses. The discussion here, as in the two earlier chapters on teaching clinical ethics, is centered on efforts to extend and enrich trainees' informal ethical thinking within their respective interpretive communities, as discussed in Chapters 6 and 7.

**Keywords** Health care · Clinical ethics · Implicit ethical framework  
Informal ethical discourse · The self · Interpretive community  
Morality of ordinary practice · Clinical training · Teaching formats  
Case conferences · Formal clinical modules · Reflective practice  
Evidence-based health care · Mentoring · Arts-based learning

### CLINICAL OPPORTUNITIES

The clinical opportunities for teaching ethics vary dramatically from one field of health care to another. What we describe here is a general approach that can be adapted to the particular field of health care and the particular clinical setting. Independent of the field, however,

developing an effective program for teaching clinical ethics is a matter of overriding importance. Since so much of health care is provided in non-institutional settings or behind closed doors or even by sole practitioners, the time of clinical training is, for many health professionals, the only time in their careers when they will be exposed to teaching in a clinical setting.

As noted in discussing the touchstones for learning (see Chapter 8), the central challenge is to identify problems that trainees (or health professionals at any stage) are currently encountering. That's one of the two main uses of the touchstones; the other is to use them to probe thoughts and feelings once a problem has been identified for discussion. In many fields of health care—nursing, social work, psychology, psychiatry, and medicine—such discussions are considered the means of promoting *reflective practice* (Jarvis 1992; Yelloly and Henkel 1995; Morrisson 2005; Senediak and Bowden 2007; Carroll 2009; Mann et al. 2009; Senediak 2014, 2015; Fisher et al. 2015; Bennett-Levy and Finlay-Jones 2018), which is a good characterization of what we're trying to achieve here through clinical teaching opportunities. Reflective practice will, by its very nature, incorporate and promote informal ethical thinking, and generate an ever changing balance of fast and slow thinking (see Chapter 6).

The opportunities for clinical teaching in medicine and nursing are especially rich since so much of the training occurs within institutional settings, such as hospitals and clinics, that might be said to *embody* the goals, values, and practices of various interpretive communities, including those of doctors, nurses, and social workers. All such settings, especially if they are affiliated with teaching programs, include regular meetings of one kind or another, any of which can easily produce cases to discuss. Insofar as teaching programs want to include an ethics component, one practical approach is to schedule, say, a small but ongoing proportion of meetings to address ethical issues (e.g., once or twice a month in the case of a clinical meeting that is scheduled daily). If the trainees are themselves asked to select the case or set of cases for discussion (using touchstone-for-learning questions), it will ensure that the case is relevant to their current experience, and it will also encourage them, more generally, to speak among themselves about what is troubling or bothering them. Over time, that sort of conversation among trainees can serve to legitimate certain types of conversations that would otherwise be lost. Importantly, too, asking and respecting such questions in a clinical setting can help to identify and explore matters that are part

of the informal and hidden curricula—especially those matters that are, on the human level, unacceptable, abrasive, or otherwise not what one would want if given a choice.

Another possibility is for someone savvy in the ways and byways of clinical ethics, *as presented in this book*—potentially (even) a bioethicist or suitably trained and oriented philosopher, psychiatrist/psychologist, other health professional, or mediator<sup>1</sup>—to work regularly (as a team member) with clinical teams of doctors, nurses, and doctors and nurses in training (from students through the graduate level), as well as with, when available, social workers and psychologists. Such persons—we could call them *ethics facilitators* since *ethics consultants* suggests the possession of substantive expertise and the transmission of authoritative judgments—could rotate among teams as a shared resource, beginning with morning work rounds, continuing through the various meetings scheduled throughout the day, and maintaining availability for ad hoc discussions, group or otherwise, whenever needed. This kind of low-key but regular presence has the capacity to change professional perceptions and behavior, improve patient care, reduce conflict of all kinds, and enhance professional satisfaction.

As a variation on the above, senior clinicians (e.g., doctors, nurses, or social workers) could be trained to assume the primary responsibility for teaching clinical ethics, patient communication, and shared decision making (potentially in combination with methods of evidence-based health care) and to be available, in real time, to advise trainees on how to address these issues as they work on the wards or in outpatient clinics or on other outpatient rotations day by day. As a complementary, but more formal, approach, the clinical modules discussed in the following section could be used, potentially with the same clinician supervising all the modules for any particular trainee, thus helping the trainee to integrate how the various elements actually fit together in providing care to patients.

In clinical settings, the diverse perspectives and approaches of different fields of health care are potentially a source of enrichment. Although some questions identified (e.g., through the touchstones for learning) may be best discussed by the trainees by themselves (as in the personal doubts of medical or nursing trainees when they first move onto the wards), other questions are ones for which a diversity of perspectives improves the discussion and brings into play matters that one field would recognize but not another. As an example of the latter, the Morbidity and Mortality conferences that are held regularly in hospitals can often

profit from diverse perspectives; given the complexity of hospitals as social systems, understanding what went wrong in anything but the most straightforward medical situation requires input from numerous fields. What did the doctors do (or not do), and why? What did the nurses do (or not do), and why? Why was social work not consulted, or consulted too late? What did the patient and family know or want, or not? What questions should we have asked but didn't? Why not? What information didn't get properly shared? Why not? How can these problems be avoided in the future?

Here's a case from an ethics-oriented Morbidity and Mortality conference that raises many of these questions:

The patient, Mrs. H, was a 78-year-old nursing home resident with a long history of congestive heart failure and slowly deteriorating health, punctuated by occasional visits to the local hospital for acute episodes of respiratory distress. On this visit, unlike previous ones, she needed to be placed on a mechanical ventilator. She and her son (a doctor at the same hospital), daughter, and primary care physician were in agreement that the ventilator support should be considered temporary only. After her medical condition stabilized, the ICU staff attempted to wean Mrs. H from the ventilator, but these efforts, spread over a week, were repeatedly unsuccessful. After consulting with their mother, the son and daughter requested a meeting with the mother's primary care physician and the chief of the ICU. As the daughter explained at that meeting, it seemed clear to her, her brother, and the primary care physician that the mother was not going to be successfully weaned from the ventilator, in which case her clearly expressed desire was to return to the wards and to let nature take its course. But the ICU chief disagreed; in his view, weaning was still a realistic goal, with the consequence that the condition for discontinuing intubation had not yet been met. In response to this sharp rebuke from the ICU chief, the brother noted that the chief had a point and that it would be wrong for the family to intrude into the chief's medical judgment. After another couple of failed efforts to wean the mother, and in light of the ICU chief's refusal to release her short of completely satisfying the relevant physiological criteria, the primary care physician ordered an increase in tidal volume to promote oxygenation and decrease CO<sub>2</sub> retention. After several days of near weaning that generated ever increasing distress from the nursing staff, Mrs. H qualified for independent respiration and was released from the ICU for terminal care. Treated with oxygen and anxiolytics, she died peacefully within 48 hours, with her family around her.

The main story, told by the most powerful actor—the ICU chief—is that he was simply doing his job and following the highest medical standards, as the patient’s son, a doctor at the same hospital, himself finally acknowledged. But there are counterstories aplenty. In brief:

- *From the nurses.* The ICU chief is a hard-core technician, an old-school intensivist, who received his professional training before it came to be accepted that doctors and patients would collaborate in making decisions, who defines the primary goal of his work as saving lives, and who never bought into patients’ rights and the need to work with families, too, in determining appropriate treatment. His insistence that the patient satisfy standard weaning criteria was a form of denial, something that enabled the chief to avoid recognizing that his efforts to save the patient had failed. Instead, we had to deal with the hour-to-hour distress of the patient and family, with the chief checking in only a couple of times a day.
- *From the sister.* My brother has always been an opportunist and ultimately a coward. I had thought that he and I were on solid ground as we worked together—as a family—to ease our mother’s last years and months, and finally her death. But when push came to shove, my brother found himself at odds with the ICU chief, and instead of standing up for himself and his mother, he wimped out, needlessly prolonging our mother’s suffering and spreading distress everywhere else.
- *From the social worker.* I’ve known this family a long time but was never called in near the end, which was too bad. My sense is that the ICU chief got locked into a position where he found it impossible, at least psychologically, to back down. I think that I could have helped the family and the two doctors (the ICU chief and the patient’s son) find some sort of middle ground where the ICU chief could save face. I continue to be surprised at how much inequalities in power influence what happens in hospitals. It’s not just that doctors are the dominant professionals. They act as if they’re the *only* professionals.

What one sees here is that when anything has gone wrong in the care of a patient, there are almost always diverse perspectives, different stories and counterstories, that capture the forces at work in the situation. When seen together these different sets of perceptions, woven into

stories, provide a way of understanding what happened and why, and point to a way of moving forward so as to avoid the same sort of problem in the future.

## FORMAL CLINICAL MODULES

In addition to the clinical opportunities discussed above, which build upon existing formats, establishing dedicated clinical modules for ethics is a potentially attractive option. As background for our discussion, we draw on the clinical modules that are used for teaching evidence-based clinical practice skills as developed by Per Olav Vandvik and colleagues at the University of Oslo Faculty of Medicine (Vandvik et al. 2013; Kongerud and Vandvik 2013). Such clinically integrated teaching in evidence-based clinical practice has been shown to be effective, for medical trainees, across the domains of knowledge, skills, attitudes, and behaviors (Coomarasamy and Khan 2004). Other structures have also been used for such modules. In a module that has much in common with what we describe in this section, students at Albany Medical College in New York “were assigned to write an essay about an episode on the rotation that taught them something about professionalism, and then later [met] with a preceptor in a small group to discuss their experience” (Dexter and Mann 2013, p. 422). Another type of module, quite different from what we describe in this section, is the Peer Experiential and Reciprocal Supervision model, which aims to promote self-awareness and reflective practice. This model requires paired clinicians (genetic counselors in the published study) to observe and comment on each other’s performance in actual sessions with patients/clients (Sexton et al. 2013).

We focus here on the approach used at the University of Oslo because it can be so easily adapted to a wide range of clinical contexts and problems. We present modules for clinical ethics, patient communication, and shared decision making. As noted in the preceding section, these modules could potentially be integrated into real-time clinical practice, under the supervision of senior clinicians, for further enhanced learning and impact on patient care.

### *Clinical Ethics Module*

In the University of Oslo modules, which are incorporated into broader clinical rotations, students are asked to move through four steps—

(1) formulation of questions, (2) searching for relevant research evidence, (3) critical appraisal, and (4) application and evaluation of new knowledge in practice—and to memorialize those efforts through an online *work file* incorporating answers to each of these four questions (Vandvik et al. 2013; Kongerud and Vandvik 2013).

Since the goal of the above modules is to promote and assess each student's individual skills in evidence-based medicine, the students choose their own specific questions and then also proceed through the other three steps on their own. For an ethics module, it's not possible to justify decisions by consulting scientific evidence. Some other method needs to be used to generate an evidence base. Here's what we propose as a reasonable process for challenging students to develop these skills at ethical reasoning through formal clinical modules. Like the strictly evidence-based practice process, our suggested process has four steps, which we have tried to keep as close as possible to the ones used for medical decisions.

1. *Formulate a question.* The formulation of a clear, precise question is essential, as it is with the medical process. Just how to identify the questions to be used will be up to the specific training program (which could be in any field of health care, not just medicine). There is surely, too, going to be a learning curve here. The questions obviously need to be open-ended rather than calling for a yes/no or single determinate answer, but just how broad or narrow a question should be will need to be worked out with experience. The range of possible questions should be defined broadly and include matters of professionalism and the work culture (e.g., bullying, harassment, abuse of power/authority, limits of one's professional obligations).
2. *Informal ethical analysis.* On one's own, and consulting any sources deemed to be useful from sociology, history, and anthropology/psychology,<sup>2</sup> trainees should analyze the question in (1) as thoroughly as they can (within the range of time/effort allocated for preparation and for the presentation itself, and also in accordance with what the program or the module director considers "thorough").
3. *Critical appraisal: Presentation to group.* Each trainee should present, either orally or in writing, a summary of the informal ethical analysis above in an effort to solicit different perspectives, identify points of agreement and disagreement, and determine what points need further thought or clarification.

4. *Application and evaluation of new knowledge in practice.* Trainees each consolidate steps 2 and 3 to generate the final analysis of their own initial questions (which have potentially been sharpened or adjusted in response to those two steps), and they submit the analysis in writing to the module director (= the work file).

An easy way of understanding the above steps in relation to the original four steps (which were for medicine) is that the evidence base is, in effect, the informal ethical discourse of persons (in general) and health care trainees (in particular): step 2 helps trainees to gain access (which may be difficult at first) to their informal ethical reasoning regarding the particular question identified; step 3 puts that reasoning to probing examination; and step 4 provides the opportunity for each trainee to put everything together into a well-reasoned, and tested, analysis of the original question.

The four steps might seem daunting for trainees with little or no previous course work in ethics (either during their professional training or earlier), but the four steps merely demand that the trainees undertake, in a structured way, something that they do all the time—and that people are capable of doing earlier than one might think. An impressive example of just how early can be seen in the elegant, probing essay written by fourth graders from the Friends Seminary in New York City—ten-year-old students!—regarding the controversy over American football players kneeling, rather than standing, when the U.S. national anthem was being played. The essay, reproduced in a January 2018 *Washington Post* article (Strauss 2018), presents a remarkably balanced and thoughtful response to the controversy.

### *Patient Communication Module*

In the ethics module the emphasis was on presenting an informal (versus formal) ethical analysis of a particular problem or question. The emphasis in patient communication is different in that there isn't a question to answer. Instead, there's a process to understand and potentially master. For those purposes, some adjustments to the ethics module are required. The first step, as we have formulated it, requires the availability of live (e.g., acted or role played, including videos) or written (e.g., drama, literature, or clinical vignettes) examples of communication with patients



or, let's add, families. For teaching purposes, these examples should generally involve problems of one kind or another that trainees need to be able to identify, analyze, and determine how to address.

This preliminary step will require some additional effort by the module's director, but once a set of examples has been prepared, they can be used again and again with each new batch of trainees. It's also worth noting, though, that rich, engaging examples, if using clinical vignettes, are not hard to come by; a group of seasoned professionals could likely generate a list of cases just by summoning up difficult cases from their past practice. Here are two clinical situations from the experience of the first author (SS):

A 60-year-old woman with advanced ovarian cancer was asked by a group of medical residents on morning work rounds whether she wanted to undergo surgery, already scheduled, to remove the visible tumors from her abdominal cavity. This surgery, if she survived the surgery itself and the immediate postoperative period, would give her a chance to live for several more months instead of days or possibly weeks without surgery. While expressing a vehement desire to leave the hospital and revisit a city in which she had had an especially pleasant time ten years previously (which she might be able to do if the surgery was successful), she also expressed a strong, unqualified opinion that she did not want to undergo surgery. The residents were outraged at what appeared to them to be the oncologist's blatant disregard of the patient's clearly expressed wishes. After being informed of the resident's concerns, the oncologist accompanied the residents back to the patient's room and proceeded to discuss the scheduled surgery with her. He explained the operation (and its risks) to her; asked her about what she wanted to do with her remaining days, weeks, or months; made sure that she realized that there was no guarantee whatsoever that she would leave the hospital again or be capable of making her trip; and assured her that he was quite willing to accept whatever option she chose. At that point, he asked her whether she wanted the surgery, and she expressed the same strong, unqualified opinion that she had given to the residents. But then the oncologist added one more piece of information that the residents had neglected: she would almost certainly die very soon, and in no more than a few weeks, without surgery. The patient then said, quite emphatically, "That's exactly why I want the surgery!!"

What we see in this first case is, in part, the inexperience of the residents. What they saw was a very sick, dying patient whose life was limited in time and scope, and who could scarcely be expected to have any

interests beyond her present circumstances. Instead, the patient was able to identify her own desires, acknowledge her strong, conflicting impulses (between avoiding surgery and extending her life), speak about them with clarity and even elegance, discuss her own death, and make a decision about what care, if any, she wanted. And it is also important to note that it was only the skills and patience of the oncologist that enabled the patient to obtain the particular care that she wanted. The less experienced, though equally concerned, residents were unable to present or elicit the full range of considerations that the patient deemed relevant to her decision.

The second vignette is as follows:

A cardiologist had scheduled a meeting with the available family members of a patient who, he wanted to inform them, was dying after a long series of medical and surgical interventions. The cardiologist, feeling uncomfortable with the situation, asked the first author to join the conference. When the family was assembled, the cardiologist went through a long series of past interventions and noted, in turn, that they had each worked for a time but were now, for one reason or another, no longer having the desired effect. As the cardiologist was going through what he had done and why, it was clear that the family were becoming more and more uncomfortable. The cardiologist ended by saying, "So, I don't know what else to do." The family, at that point, were quiet, obviously anxious, likely puzzled by the last comment, and literally sitting on their hands. The first author then asked the cardiologist if he (the first author) could say something, which was fine with the cardiologist. The first author then noted to the family that the cardiologist had not mentioned something important: their father was *dying*. Two things then happened: the family immediately relaxed, and the cardiologist sent the first author a remarkably dirty look, clearly communicating his view that something horrific had been said.

What we see in this case is a well-intentioned cardiologist who recognized the need to talk to the family, who understood that having the first author in attendance would be helpful and supportive, but who then couldn't quite get himself to say what needed to be said and then, even at the end, still found the outcome unsettling. We also see that the cardiologist's circumlocutions left the family confused and in discomfort, and that they were well able to understand and appreciate that even the efforts of this dedicated cardiologist could not, in the end, save the life of their father.

The number of cases (of whatever type/format) needed for the patient communication module will depend, of course, on various factors, to be decided by the clinical program, and it may be that different modules would be used in different years. It is also possible that the trainees could take some important role in designing the vignettes. Our overall idea, though, is that the module would run for four to twelve sessions, roughly once a month, with a different clinical case used each session.

Once the cases have been chosen, we suggest the following structure for the module:

1. *View or read the clinical situation selected for each session* (for trainees to do on their own).
2. *Background reading and analysis.* On their own, and consulting any sources deemed to be useful from sociology, history, and anthropology/psychology, trainees should analyze the clinical situation in (1) as thoroughly as they can (within the range of time/effort allocated for preparation and also in accordance with what the program considers “thorough”). At the discretion of the module director, a selection of relevant readings could be made available for trainees to consult. Just for a start, readings in this module could include, on the patient side, studies and analyses of the “sick role,” of how patients respond to illness of various kinds, of how being sick affects how patients communicate, and of how families respond to the illness of a family member. On the caregiver side, readings could include studies and analyses of the caregiver’s role, of how health professionals deal and communicate with very sick patients and their families, of how health professionals deal with patients who resist treatment, and of the nonverbal communication between health professionals and patients.
3. *Group discussion.* Trainees meet together to discuss their perceptions of the case, of what went wrong and why, and of how things could have been done better. If the clinical situation lends itself to counterstories, they should be presented/formulated and discussed. The module director (or whoever is leading the discussion) should also present minor variations on the facts of the case to give trainees an opportunity to work through exactly what they think and why. In this context, possible variations include factors that would be considered under cultural competence (extended) (see Chapter 9).

4. *Application and evaluation of new knowledge in practice.* Trainees each consolidate steps 2 and 3 to generate their final analysis of the clinical situation and its possible variations, and submit the analysis in writing to the module director (= the work file).

The rationale and steps here are very similar to the clinical ethics module. The main difference is that the ethics module presents an unfamiliar, potentially uncomfortable challenge: setting forth, in writing, a thorough, but informal, analysis of a particular ethical question or situation. There's real value in pinning down what one thinks and seeing how others react. By contrast, the patient communication module deals with much more familiar material. Leaving oneself open to, and seeing the situation from, a diversity of perspectives (and counterstories) is the fulcrum for learning.

### *Shared Decision Making Module*

As noted in Chapter 9, shared decision making should be considered the central mode of decision making in health care. As such, it should have an important place in any series of formal clinical modules used in training programs.

In lieu of repeating ourselves, we suggest that the four-part structure of the patient communication module would also be appropriate here for shared decision making. Likewise, the clinical situation presented in that module of the 60-year-old woman with advanced ovarian cancer could also be used to explore the process of making decisions.

## MENTORING

Mentoring is one of the most powerful and lasting modes of teaching, and with regard to the teaching of ethics, it is surely one of the most important. Mentoring is a form of personal contact that is different from any other form of teaching. Even when the mentoring occurs in a small group rather than one-to-one, a mentor's impact can be profound.<sup>3</sup> And it is a form of teaching that is basically as good as the mentor himself or herself. For our purposes, a richly human mentor leaves one legacy through teaching, a narrowly focused mentor quite another. And universities do not necessarily reward only the former. Mentoring is, indeed, more or less irrelevant to career advancement within universities, including professional schools. Consequently, those in a position to be mentors are not necessarily well suited for that particular role.

That said, good mentoring is a gift to any student, and most trainees in health care can point to certain teachers who made an important difference for them. One example (from the first author's ongoing experience of fifteen years) comes from observing Shelly Greenfield, a professor at Harvard Medical School who is also the Editor of the *Harvard Review of Psychiatry*. As background, the journal's editorial staff includes roughly a dozen Assistant Editors who have been drawn from the medical school's training programs in psychiatry. At the journal's weekly editorial staff meetings, it is common for questions to arise that concern the ethics of publication, what can be reasonably expected (or not) of authors, what safeguards are needed to ensure the integrity (defined in several ways) of the journal's articles, what needs to be done to ensure that the Assistant Editors understand their work and have time to do it, and so on. What has always been so impressive, in the first author's experience, is how Professor Greenfield has, in such situations, always stopped any discussion of business as usual to discuss the ethical/publication matter at hand. If the issue has been addressed in the past, she explains to the Assistant Editors how and why the decision was made. If the issue is still open, she explains why things used to be handled in a certain way and why that way no longer works, and then she solicits, against that background, input and advice. What emerges from these discussions is a richer sense of the past and present, an understanding of the many facets of current policies, and, perhaps most importantly, an overarching sense of how to function both humanly and intellectually at one's highest level.

To take a step back from this example, what mentors can communicate, and literally give, to trainees is part of themselves. What they know, who they are, what they care about, how they feel—these are the gifts that mentors can provide. Importantly for our purposes, what they also have, as we saw above, is institutional knowledge, and in conveying that to trainees, mentors move them closer and more intimately into the institution itself, into the interpretive community. So, when senior health professionals realize that it wasn't always this way, or that certain questions need to be rethought, an opportunity for mentoring is at hand. It shouldn't be lost.

### MAINTAINING THE SELF

At the end of Chapter 8, we mentioned the importance for trainees to maintain their well-being, mental and physical health, and sense of self-respect. We reiterate that point now but also mention that, especially because of the stresses involved in clinical training, some formal

interventions should be considered. In this context, and as one type of intervention oriented toward learning by doing, we mention the *Performing Medicine* program created by the Clod Ensemble, a UK theater company. In developing programs for professional training, *Performing Medicine* “uses methods found in the arts to develop skills essential to clinical practice and healthcare.” The range of skills is impressive: “non-verbal communication, self care, resilience, vocal clarity, leadership, teamwork, appreciation of diversity and difference, reflective practice, observation skills and anatomy.” What’s at stake in such interventions is of paramount importance for trainees: protecting and maintaining the self, both short and long term, not to mention better patient care and more awareness of the values and ethics of professional practice. And with its learning-by-doing approach to their material, *Performing Medicine* is able to deliver all this in a week (e.g., the program developed for medical trainees in their first clinical year takes the equivalent of seven days’ time, with seven weekly sessions).<sup>4</sup> We can almost hear program directors saying that they would love to do such things, but where do you find the time. Our guess is that any time lost will easily be regained by the many efficiencies generated by better-adapted, more reflective, more self-aware trainees.

But we are just using *Performing Medicine* as an example—in two respects. First, programs in the arts, especially those that adopt a learning-by-doing approach, can do much to supplement and advance the approach to health care ethics that we are presenting in this book. Second, the conception of health care ethics that we have presented here is one that is intertwined with the self and with each health trainee’s and each health professional’s personal history, in all its facets. Learning by doing, especially in the ways that have been advanced by groups such as *Performing Medicine*, connects up directly with these personal phenomena.

For ethics teaching, the clinical setting has a unique position. In the move to the clinic from the classroom, trainees engage the real world, begin to have an actual stake in, and responsibility for, patient outcomes, and have the opportunity to interact with, and learn from, senior clinicians—some or even many of whom will have gained, through their own thought and experience, what we can call *ethical wisdom*. Altogether, the clinic is a setting in which health care’s various interpretive communities intersect; it provides a singular opportunity for trainees to observe, act, learn, and grow.

## NOTES

1. A potential problem with using psychiatrists or psychologists is that the main phenomena to be examined are ethical, institutional, and various sorts of goal-directed and pragmatic reasons, as well as how those phenomena are interconnected with how people feel about, or respond to, particular clinical situations; the “why do you think/feel” questions would need to look mainly for such factors rather than the standard, more personal and idiosyncratic matters addressed in psychiatric/psychological encounters. A potential problem with using mediators is that they often are satisfied with consensus—the elimination of conflict—without trying to understand and sort out the underlying reasoning of the people involved. These underlying reasons are important, both individually and institutionally, for growth and stability.
2. Just what to do with materials from the bioethics literature is discussed in Chapter 11.
3. See Appendix 8.1, A Young Doctor’s Reflection.
4. For more information on *Performing Medicine*, readers can contact Bella Eacott, Research Manager, at [admin@performingmedicine.com](mailto:admin@performingmedicine.com).

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