WEBVTT

118
00:09:03.210 --> 00:09:06.240
Paul Wolpe: Welcome everybody. I've got 28 people on

119
00:09:07.770 --> 00:09:08.430
Paul Wolpe: Don't know.

120
00:09:09.930 --> 00:09:16.860
Paul Wolpe: People can make sure that they click their participants and their chat functions at the bottom.

121
00:09:19.260 --> 00:09:21.090
Paul Wolpe: My Zoom is spinning right there.

122
00:09:22.590 --> 00:09:27.900
Paul Wolpe: And they can see who's on and you can speak to them privately or in public.

123
00:09:29.280 --> 00:09:30.900
Paul Wolpe: But just make sure that you

124
00:09:32.670 --> 00:09:38.190
Paul Wolpe: speak privately to those who you think you're speaking privately to and publicly to those. You think you're speaking publicly, too.

125
00:09:40.770 --> 00:09:50.850
Paul Wolpe: So I don't know how many of you saw today's email about this. I thought we could do a quick coven check in and then talk about some of the other challenges of

126
00:09:52.710 --> 00:09:53.730
Paul Wolpe: Being a director

127
00:09:54.000 --> 00:09:58.350
Paul Wolpe: And I also suggest that people mute when they're not speaking just

128
00:09:58.800 --> 00:10:00.720
Paul Wolpe: Minimize ambient noise.

129
00:10:02.280 --> 00:10:03.090
Paul Wolpe: And

130
00:10:05.310 --> 00:10:13.020
Paul Wolpe: I'm sure most of you are all of you know that the article from a BP D from animals came out this past week if you don't

131
00:10:14.250 --> 00:10:17.520
Paul Wolpe: Have that if you haven't seen it, you don't have that link.

132
00:10:18.570 --> 00:10:18.960
Robert Klitzman: Certainly.

133
00:10:18.990 --> 00:10:20.730
Paul Wolpe: Email me I'll send it to you. I think we

134
00:10:20.910 --> 00:10:23.190
Paul Wolpe: Sent it to everybody and not hundred percent sure

135
00:10:24.480 --> 00:10:27.660
Paul Wolpe: And there's one for a job that should be coming out shortly.

136
00:10:28.830 --> 00:10:39.990
Paul Wolpe: And I really do encourage if any of you have articles coming out on this issue, you know, we can create certainly we can send those out to the group and create a library.

137
00:10:41.220 --> 00:10:57.000
Paul Wolpe: Around those things. And what is Would anybody like to give us any kind of report or update or say something important about their activities or information about Colvin before we move to other issues.

138
00:11:00.990 --> 00:11:03.420
Susan Tolle: This is Susan hi from Oregon.

139
00:11:04.620 --> 00:11:09.090
Susan Tolle: And I'd be happy to share some of the efforts, we're making

140
00:11:10.320 --> 00:11:13.470

Susan Tolle: One of the things we have done is to

141
00:11:15.090 --> 00:11:19.620
Susan Tolle: Be as responsive as we can to areas of need.

142
00:11:20.670 --> 00:11:25.860
Susan Tolle: By creating webinars, because we can't do the outreach conferences that we normally run

143
00:11:26.250 --> 00:11:26.400
Susan Tolle: And

144
00:11:26.850 --> 00:11:27.660
Susan Tolle: We pulled together.

145
00:11:28.110 --> 00:11:31.440
Susan Tolle: And we have made 10 of them and posted them on their

146
00:11:31.680 --> 00:11:32.580
Susan Tolle: Website and

147
00:11:33.780 --> 00:11:36.330
Susan Tolle: They're in a wide variety of areas.

148
00:11:37.350 --> 00:11:37.950
Susan Tolle: And

149
00:11:39.450 --> 00:11:51.630
Susan Tolle: Some of them have had as many as 4000 views. So it has helped us to connect with our communities, at a time when it's much more difficult to do so.

150
00:11:53.160 --> 00:11:53.700
Susan Tolle: Thank you.

151
00:11:56.130 --> 00:11:56.610
Thank you.

152
00:11:58.350 --> 00:12:13.200

Christine Mitchell: This is Christine from Boston, Massachusetts. We like many, many of you revised crisis standards of care, specifically for code and had a very significant public pushback from

153
00:12:14.520 --> 00:12:29.310
Christine Mitchell: African American and Latino communities and the disability community. Some of us and talking about that in blog posts on various list serves and on various lists or so, at any rate, we revise those and

154
00:12:31.290 --> 00:12:39.630
Christine Mitchell: You know the details are relevant to many but not here. I would just say that the the difficulty and revising those standards.

155
00:12:39.630 --> 00:12:40.830
Christine Mitchell: Has been that

156
00:12:41.280 --> 00:12:42.990
Christine Mitchell: It really undermines

157
00:12:43.650 --> 00:12:45.840
Christine Mitchell: Need to address vulnerable communities on

158
00:12:45.840 --> 00:12:52.530
Christine Mitchell: The other hand, it undermines the capacity to triage when you eliminate tending to comorbidities and

159
00:12:53.700 --> 00:13:07.500
Christine Mitchell: You no longer term survivability and so forth and so it's been a, it's been an educational and difficult process. I don't. I suspect it shared by many in this group who have served on task forces for their states.

160
00:13:08.850 --> 00:13:14.250
Robert Klitzman: Have you published the or put out the revised version that takes into account the pushback.

161
00:13:14.760 --> 00:13:31.830
Christine Mitchell: Yes, we have. And we eliminated description lists of co-morbidities we changed from maximizing life years to only take into account survivability of this disease and near term survivability and made some very explicit

162
00:13:33.210 --> 00:13:38.340

Christine Mitchell: You know comments about not discriminating and the wrong ways

163
00:13:39.780 --> 00:13:52.140
Christine Mitchell: And yeah, and I think, you know, in some ways, this is really just a preliminary to I what I hope will be future attention to this because we, despite

164
00:13:52.830 --> 00:14:02.100
Christine Mitchell: Our number of cases have not entered into the crisis category. So we're still under contingency and they're not the crisis standards of care are not

165
00:14:03.420 --> 00:14:09.090
Christine Mitchell: Officially activated and there's a reporting requirement for anybody who's using them to let the pH know

166
00:14:16.290 --> 00:14:17.790
Paul Wolpe: Thanks. Anyone else

167
00:14:19.980 --> 00:14:23.010
Jonathan Bolton: Wonder if this experience.

168
00:14:24.510 --> 00:14:35.070
Jonathan Bolton: warrants a follow up article or a review of the article. Since there was only 50% of policies were

169
00:14:36.480 --> 00:14:39.630
Jonathan Bolton: vetted and I wonder if down the road.

170
00:14:41.190 --> 00:14:41.940
sophia: You make sense.

171
00:14:43.290 --> 00:14:43.740
Jonathan Bolton: To

172
00:14:44.580 --> 00:14:45.630
Jonathan Bolton: To offer a follow up.

173
00:14:45.720 --> 00:14:46.050
Here.

174
00:14:58.410 --> 00:15:03.990
Christine Mitchell: We can hear you, Jonathan. It's just a someone else's not muted next

175
00:15:04.230 --> 00:15:05.550
Jonathan Bolton: Though, so it was really

176
00:15:06.600 --> 00:15:16.710
Jonathan Bolton: New Mexico's policy didn't get included in the revisions didn't get included, I think it would be worth the effort to offer a final statements based on

177
00:15:17.760 --> 00:15:18.660
Jonathan Bolton: You know, as many

178
00:15:20.010 --> 00:15:26.370
Jonathan Bolton: Policies as possible. Certainly north of 50 policies. So that was the comment.

179
00:15:27.750 --> 00:15:35.910
Matthew Wynia: Yeah. Essentially, this is Matt essentially very few of the policies, even those that were final at the time, or really final

180
00:15:37.230 --> 00:15:52.050
Matthew Wynia: Because we've seen it. I'll just say in Colorado. We had a final product. But over the weekend. It was revised again. So I'm not sure if we were to do or formal sort of review.

181
00:15:53.220 --> 00:16:07.110
Matthew Wynia: We still wouldn't have the final, final products because my hunch is these are going to continue to evolve. The interesting thing to me at least, is that even in the places that really have been swamped.

182
00:16:08.460 --> 00:16:28.380
Matthew Wynia: No one has admittedly gone into for formal triage processes and my my senses and I would defer to Robert and others in New York and New Jersey. But my sense is that there is an incredibly large barrier.

183
00:16:29.700 --> 00:16:35.040
Matthew Wynia: psychological barrier to accepting the notion that we are in fact

184
00:16:35.130 --> 00:16:36.720
12522580318: In crisis standards of care.

185
00:16:36.990 --> 00:16:39.690
Matthew Wynia: With regard to ventilators and critical care.

186
00:16:39.750 --> 00:16:55.590
Matthew Wynia: Resources and that we would much much rather talk to patients as though what we are doing is just making a rational decision about non beneficial treatment and most people in your condition in your mom's condition.

187
00:16:56.070 --> 00:16:59.340
Matthew Wynia: will not survive and therefore we don't think it's wise to

188
00:16:59.430 --> 00:17:02.730
Matthew Wynia: Take her to the ICU or to put her on a ventilator.

189
00:17:04.110 --> 00:17:13.590
Matthew Wynia: Which, by the way, is very reminiscent of years ago in the 80s. Some of you will remember that National Health Service used to not cover.

190
00:17:15.750 --> 00:17:18.660
Matthew Wynia: Treatment with dialysis for patients first over 50

191
00:17:21.000 --> 00:17:21.420
Matthew Wynia: And

192
00:17:21.840 --> 00:17:24.030
Matthew Wynia: And when people survey doctors and patients.

193
00:17:24.030 --> 00:17:24.210
About

194
00:17:25.290 --> 00:17:33.270
Matthew Wynia: Not say we're not doing this because it's a scarce resource, they said we're not doing it because dialysis doesn't work for people over 65

195
00:17:34.830 --> 00:17:40.830
Matthew Wynia: And I think we're seeing the same dynamic play out. Now that we have a very, very hard time

196
00:17:42.000 --> 00:17:44.430
Matthew Wynia: saying we're not doing this because there's not enough.

197
00:17:46.140 --> 00:17:46.440
hannah lipman: I will

198
00:17:47.010 --> 00:17:48.000
Robert Klitzman: Say, Oh, go ahead.

199
00:17:48.720 --> 00:18:02.730
hannah lipman: I was just gonna say I will add from New Jersey that another barrier was that the New Jersey Department of Health put out their own policy on April 11 and at least in northern jersey. That was when we were you know

200
00:18:03.600 --> 00:18:14.220
hannah lipman: About to hit peak and coming down. So we didn't have the legal authority to implement triage before that the executive orders and the legislation, we're done between

201
00:18:15.000 --> 00:18:29.790
hannah lipman: April 11 and April 14 and that that was a major barrier, the public discourse has really impacted in, in some cases, the way that families are approaching decisions we've been asked. Not a few times.

202
00:18:30.390 --> 00:18:40.680
hannah lipman: are you recommending withdrawal of life sustained treatment because you don't have the resources and that's contributed to an uptick in our patient specific bioethics consultations and talking

203
00:18:41.310 --> 00:18:49.620
hannah lipman: Teams through how to manage in their, you know, ethical dilemmas because of looming scarcity and frustration that there wasn't

204
00:18:51.120 --> 00:18:56.910
hannah lipman: The legal basis for triage and staying patient focused, but in a really authentic way. I mean, the mortality is so high.

205
00:18:57.840 --> 00:19:08.820
hannah lipman: Of older patients in our ice us that it isn't inauthentic to stay patient centered. Many of our patients will die and you know that has been a challenge for our bioethics consultation.

206
00:19:10.050 --> 00:19:18.360
Robert Klitzman: So I would say that for us. What's happened is because of the kind of pushback or potential pushback that Christine was mentioning

207
00:19:18.900 --> 00:19:33.210
Robert Klitzman: There's been an effort to just build more and more ICU workers and, you know, convert more and more rooms to ICU facilities and get more and more ventilators, so we wouldn't have to make the difficult triage decisions.

208
00:19:35.760 --> 00:19:46.920
Robert Klitzman: I think because of the concerns, it was less sort of directing families away from ventilators and more just sort of increasing the supply it quote for costs, so to speak.

209
00:19:49.320 --> 00:20:03.060
Kelly Michelson: This is Kelly in Chicago. I'm wondering if people can comment on modifications in unilateral DNA are throughout all this because we've we in Illinois. We are like

210
00:20:04.080 --> 00:20:12.960
Kelly Michelson: Everyone has been describing haven't quite reached that crisis standard in our sort of ticking by in terms of ICU resources, but I am hearing from

211
00:20:13.620 --> 00:20:31.140
Kelly Michelson: various institutions that they've shifted how they do DNA are and unilateral DNA are and those kinds of things, which is particularly thorny in Illinois, because of our laws. So I'm curious what people are seeing around the country in that regard.

212
00:20:31.650 --> 00:20:33.030
aderse@mcw.edu: So Kelly, this is art.

213
00:20:34.050 --> 00:20:44.010
aderse@mcw.edu: In Wisconsin. We don't have a restricting law. We don't also have a law that aids in this, but we've had a futility policy for about 20 years

214
00:20:44.400 --> 00:20:57.450
aderse@mcw.edu: And futility in resuscitation even longer than that need to physicians to be able to make that determination for everything but Crisis Standards, there has to be communication with the family. The

215
00:20:58.500 --> 00:21:08.130

aderse@mcw.edu: Chief Medical Officer has to be notified but doesn't have to give permission. That's actually been used successfully over the past 23 years or so.

216
00:21:08.790 --> 00:21:16.080
aderse@mcw.edu: It's not used a lot, but it might be used once or, you know, twice, maybe in a month, at most, which may sound like a lot for everyone, but

217
00:21:16.650 --> 00:21:24.960
aderse@mcw.edu: Bottom line is the response to that has usually been half the time is people saying, Oh, so you really don't think it's going to work and

218
00:21:25.290 --> 00:21:32.460
aderse@mcw.edu: The other half the time people perhaps pushing back against it for crisis standards, which we haven't reached we are

219
00:21:33.180 --> 00:21:48.510
aderse@mcw.edu: Giving that authority to one physician, the attending physician. In that case, but we do not have a unilateral DNR policy for all coded patients. Each one has to be based on the clinical circumstances.

220
00:21:51.330 --> 00:22:00.330
Susan Tolle: This is Susan and we've been particularly concerned about any potential for the misuse of post in the context of

221
00:22:01.500 --> 00:22:12.930
Susan Tolle: Discrimination of bias of all persons in group homes with developmental disabilities should have a poles, those kinds of things have been where we've been.

222
00:22:13.380 --> 00:22:37.710
Susan Tolle: particularly aggressive to be certain that there isn't an overreach in a climate of promoting pulls us for high risk categories. Does it become obligatory is there undue pressure, we do not have an overreaching futility policy and require ongoing

223
00:22:37.740 --> 00:22:48.780
Susan Tolle: Negotiation and almost all of the time, it works out. We have about three a year where there is general unhappiness with the insistence on aggressive treatment.

224
00:22:49.920 --> 00:22:53.190
Susan Tolle: But I've taken a different approach than what art is doing.

225

00:22:54.180 --> 00:23:04.320
Denise: And this is Denise that you did medicine in Seattle like art has described, we've had it for a very very long time, the possibility for use of a unilateral DNA are

226
00:23:05.040 --> 00:23:17.550
Denise: With consensus among the treating providers in this case for coven 19 RE. RE emphasize emphasize the need for another attending physician, it sort of implied. Otherwise, but we really emphasized it

227
00:23:18.120 --> 00:23:32.970
Denise: And the first version of our coven 19 guidance around CPR was written in a way that some, I think we're interpreting it that if somebody comes in and who who's sick with with coven 19 they should be DNR

228
00:23:33.480 --> 00:23:47.940
Denise: So we revised it and included some FAQs to be very clear that both coven 19 and non coven 19 patients need to be evaluated. Similarly, and unlike arts description we still require to

229
00:23:48.390 --> 00:23:57.060
Denise: attending physicians and our policy and FAQs are online. So if you'd like those. I can provide those for folks.

230
00:23:59.040 --> 00:23:59.370
Ty Gibb (WMed): Yeah.

231
00:24:00.480 --> 00:24:15.510
hannah lipman: That would be great. We, we have a legal environment in New Jersey, that's a little bit murky and seems to be interpreted differently. Some families. Some hospitals have them and some don't unilateral DNR we wrote a very narrow based on

232
00:24:17.160 --> 00:24:25.140
hannah lipman: CPR wouldn't work or the patient with rearrest and made it temporary only and for all patients. I'm not just coven

233
00:24:27.480 --> 00:24:29.100
John Carney: Or any of those modified by

234
00:24:30.420 --> 00:24:38.220
John Carney: Availability of PPP or plastic sheeting it either in the in the acute for advanced cardiac life support or for BLS

235
00:24:38.970 --> 00:24:52.980
hannah lipman: What we wrote into our policy was that it was it for all patients, but that the clinical team and in making their judgment that CPR would not achieve return of spontaneous circulation or the patient would rearrest shortly, they could

236
00:24:54.180 --> 00:25:04.890
hannah lipman: Include in that evaluation, the time it would take to put on pee pee that we made it clear that pp was a priority and that if you know, given the time to take with

237
00:25:05.580 --> 00:25:11.790
hannah lipman: To put it on would diminish the patient's chance of survival, they could use that in their assessment and we required to physicians also

238
00:25:13.890 --> 00:25:22.140
Matthew Wynia: Do just to be sure I understand my understand my sense has been nationally that every policy. I've seen

239
00:25:22.530 --> 00:25:36.480
Matthew Wynia: Has said that you don't do CPR without adequate pee pee already gone, even if that delays initiation of PP of CPR. Is that the case is anyone aware of a facility that has not adopted that as a standard

240
00:25:39.840 --> 00:25:41.190
Susan Tolle: That's the standard in Oregon.

241
00:25:42.030 --> 00:25:42.390
Yeah.

242
00:25:43.650 --> 00:25:53.430
John Carney: I think it's a standard in the acute care setting. I'm not sure it is in there for Basic Life Support in the, in the long term care setting just because of lack of availability of

243
00:25:54.810 --> 00:25:56.520
John Carney: Gowns and plastic sheeting.

244
00:25:58.590 --> 00:26:00.300
Robert Klitzman: I don't know if it's a written process.

245
00:26:02.160 --> 00:26:11.400

cgrady: I find in talking to people. This is Christine from NIH, I find in talking to people health care providers around, there's confusion about unilateral

246
00:26:12.000 --> 00:26:27.360
cgrady: DNA ours and universal DNA ours. And to my knowledge, although there's some crisis standards that have built in the possibility of a universal I haven't found any other than that in that case is, is that true mean your experience.

247
00:26:29.280 --> 00:26:34.050
Matthew Wynia: Yeah, I sent my my read of the policies that we've reviewed our that

248
00:26:35.220 --> 00:26:51.000
Matthew Wynia: None of them endorse and many specifically counter contradict the idea of a universal DNR on the same grounds, by the way, as many reject any kind of sort of categorical exclusions.

249
00:26:52.020 --> 00:27:01.710
Matthew Wynia: So the idea that, you know, you don't get access to this because of the category you sit in, as opposed to a more individualized assessment of risks and benefits.

250
00:27:03.000 --> 00:27:03.900
Amy McGuire: From this is our

251
00:27:03.990 --> 00:27:04.560
Gathering

252
00:27:05.910 --> 00:27:19.380
aderse@mcw.edu: So I just wanted to answer john to say we actually now do have something that the resuscitation does take into account, rest of the team that was originally put in the crisis standards area and our medical Executive Committee.

253
00:27:19.800 --> 00:27:33.150
aderse@mcw.edu: Pull that out to now be part of the policy only because we haven't hit crisis standards but i i have to say i think universal DNR coven policies are

254
00:27:34.200 --> 00:27:43.470
aderse@mcw.edu: Not supportable because I think it really does have to take into account the clinical possibility that in some cases for solicitation will work for patients.

255
00:27:48.300 --> 00:27:56.580

hannah lipman: Came up for us was that we were asked by our nursing homes, whether all the patients who had DNR is in place should be have not hospitalized and how they

256
00:27:56.940 --> 00:28:06.060
hannah lipman: Could should appropriately care for patients in the nursing home that had DNR orders, knowing that sending them to overburden hospitals in our system would also

257
00:28:08.130 --> 00:28:12.510
hannah lipman: You know wouldn't provide them an optimal level of care. So they have to rethink sort of how to

258
00:28:13.770 --> 00:28:23.970
hannah lipman: Reach reason you know shift care models. And I was very opposed to making all DNR is equal to DNA, just because the nursing home may not have the resources, obviously, to do any care, including

259
00:28:24.660 --> 00:28:34.350
hannah lipman: Purely palliative in a nursing home. So they didn't. They didn't do that. But there were a lot of questions about how to optimally manage patients and what location based on their code status.

260
00:28:35.220 --> 00:28:35.820
Susan Tolle: And that's what

261
00:28:35.970 --> 00:28:38.250
Susan Tolle: I was conscious. We have been facing

262
00:28:38.250 --> 00:28:39.150
Susan Tolle: An Oregon.

263
00:28:39.990 --> 00:28:51.390
Susan Tolle: The tendency to think that do not resuscitate on a pulse form means do not treat and that is something all of us need to be incredibly vigilant about

264
00:28:51.930 --> 00:29:12.450
Susan Tolle: Because as you have widespread use of excellent documents that record do not resuscitate across settings of care. They can be misused to deprive people of comfort measures to deprive people have more simple treatments and as a basic primitive form of rationing and misuse.

265
00:29:13.950 --> 00:29:30.540

Armand Antommaria: So I was surprised that the thing piece now with a company to publication of the policy article, it talks about universal do not resuscitate orders, but has no reference to suggest that they were actually occurring in practice, which, from which sets up a strong person.

266
00:29:37.380 --> 00:29:47.220
Paul Wolpe: Alright, this seems to be a good natural pausing moment I'm in my email. Everybody I suggested that we might use some of this time since the last

267
00:29:47.880 --> 00:30:02.580
Paul Wolpe: Three calls I forget how many we've had so far have all been about coven and nothing but coven to talk about some of the other challenges that many of us are facing around being directors, I sent a list of possible topics.

268
00:30:03.750 --> 00:30:18.450
Paul Wolpe: That included things like how we engage, staff, faculty postdoc trainees graduate students or whoever you know other clinical ethicists who bill. I assume that engaging them as a lot easier.

269
00:30:20.130 --> 00:30:37.410
Paul Wolpe: Issues about budget and economics. Many of us are are already or soon will feel the enormous economic strain remote teaching and how we're doing that and any sort of best practices, keeping one center coherent while we're sheltering in place.

270
00:30:38.430 --> 00:30:41.670
Paul Wolpe: How we're using faculty and staff and

271
00:30:43.410 --> 00:30:51.300
Paul Wolpe: We're all of junior faculty in continuing mentoring and, you know, being of service to our communities, any of these are all of these are

272
00:30:51.930 --> 00:31:04.230
Paul Wolpe: Worthy topics of conversation and discussion. And so I will open it up for people who have questions or comments that they want to make about any of those issues or others around running our centers.

273
00:31:14.130 --> 00:31:14.490
Christine Mitchell: Well,

274
00:31:15.750 --> 00:31:17.490
Christine Mitchell: At the risk of

275
00:31:18.270 --> 00:31:19.800
Christine Mitchell: Saying something everybody else.

276
00:31:19.800 --> 00:31:27.990
Christine Mitchell: already knows. Let me just say that we have for you know the five years of our existence, put a big premium on

277
00:31:29.010 --> 00:31:31.620
Christine Mitchell: Being a very personally delivered

278
00:31:32.820 --> 00:31:45.420
Christine Mitchell: Graduate Program tailored to specific students interests, including their field experience and so forth and so shifting to

279
00:31:45.870 --> 00:31:52.950
Christine Mitchell: Teaching not only teaching remotely but expecting in the fall to have some of our courses actually offered online.

280
00:31:53.430 --> 00:32:06.990
Christine Mitchell: Is what led me to compliment mark before we started in already having a program that is way ahead in doing online teaching, I found zoom to be more

281
00:32:07.800 --> 00:32:29.940
Christine Mitchell: Capable of engaging students interests or students in being able to use it effectively than I would have expected. So it's been not as bad as I thought. But I am not looking forward to putting most of our curriculum online and I can't help but wonder why anyone would pay so much money.

282
00:32:31.020 --> 00:32:33.900
Christine Mitchell: To to not have the kind of

283
00:32:35.160 --> 00:32:48.270
Christine Mitchell: In person mentoring network building colleague, creating environment that has been for us kind of a hallmark of what we're doing at the Masters level.

284
00:32:50.400 --> 00:32:58.020
aderse@mcw.edu: So Christine, having worked with Mark when he moved our program online at the Medical College of Wisconsin.

285

00:32:58.560 --> 00:33:10.110
aderse@mcw.edu: I can tell you that not everybody wants to move to Milwaukee for a year and a half, more people probably want to move to Boston, but at a certain point, you do have the ability to reach

286
00:33:10.140 --> 00:33:14.580
aderse@mcw.edu: Out to students that you would never come, including international students so

287
00:33:14.970 --> 00:33:29.100
aderse@mcw.edu: There, I think there's a lot of benefits to it. I have to say I was not particularly convinced initially, but I still think it's suboptimal to the real thing. But when the real thing is impossible. It's the next best thing.

288
00:33:30.540 --> 00:33:39.810
David Doukas: And one thing that all add is I believe we're than the newest master's program in bioethics medical humanities.

289
00:33:40.650 --> 00:33:48.390
David Doukas: We actually encoded this into the DNA of our program that we would offer live video conferencing.

290
00:33:48.690 --> 00:33:57.570
David Doukas: For all of our classes, not only the required, but also the electives. So our first students because of the way it's structured with an MD MS program.

291
00:33:57.870 --> 00:34:07.500
David Doukas: Our first students arrive may 18 they'll be arriving through the electrons and phosphorus through the, through the teleconferencing

292
00:34:08.160 --> 00:34:25.920
David Doukas: Work that will be doing. But the biggest challenge that I'm having the the daunting part is the marketing aspect of it when we are trying to sell a program which was originally hybridised as in person and teleconference to now say okay

293
00:34:26.610 --> 00:34:36.540
David Doukas: You know, for instance, mid career professionals like live video conferencing, because whether they're in California or even across town.

294
00:34:36.900 --> 00:34:49.560
David Doukas: It's easier to be able to go ahead and do live teleconferencing rather than shuttling on over to the campus or in the case of somebody who is out of state, so the hard part is the vagaries of

295
00:34:50.100 --> 00:35:01.320
David Doukas: What's going to happen when so I imagine it's causing a pause where we're managing to hit what my expectations of numbers are and our budget.

296
00:35:01.710 --> 00:35:17.430
David Doukas: But it is concerning for me and concerning for all programs. I think we should be there should be a shared concern for all of a VIP day for all of the graduate programs that we have students who are who are interested still

297
00:35:18.390 --> 00:35:34.320
David Doukas: Being able to register into programs locally, but also for those programs that allow for one form of either a synchronous or asynchronous delivery of content so that they can go ahead and attain either a Masters or a PhD.

298
00:35:39.870 --> 00:35:50.640
cgrady: This is Christine grading from NIH. I think it's interesting the teaching seems possible on zoom and actually I like what both of you just said about reaching people at different places.

299
00:35:51.780 --> 00:35:53.520
cgrady: What I'm worried more about is the

300
00:35:54.600 --> 00:36:04.980
cgrady: You know, sort of teaching people the hands on stuff you know how to do clinical consultation or and and we have a we have a fellowship program.

301
00:36:05.730 --> 00:36:14.880
cgrady: Which technically has an end to it. And people are saying, well, we're not going to be, you know, there aren't going to be any jobs aren't going to be any there isn't gonna be a place to go for a while. Could we stay

302
00:36:15.390 --> 00:36:29.820
cgrady: And so then we have this you know dilemma of how to accommodate people who are already here. And we've already accepted people for next year. So we're sort of trying to figure out how to do all that. I don't know what people are doing regarding those issues.

303
00:36:33.090 --> 00:36:37.470
Christine Mitchell: I just taught my first clinical ethics simulation program online.

304
00:36:38.730 --> 00:36:41.850

Christine Mitchell: And I was surprised that it was possible.

305
00:36:42.870 --> 00:36:49.200
Christine Mitchell: And, you know, students really felt like they learned a lot still, you know, it's hard for me to believe

306
00:36:50.640 --> 00:36:58.620
Christine Mitchell: That provide me. There's so much apprenticeship training in that particular specialty and bioethics that

307
00:37:01.290 --> 00:37:06.030
Christine Mitchell: Yeah, I don't know what it would be like when these people try to get jobs and

308
00:37:08.370 --> 00:37:15.390
Christine Mitchell: And are you doing, you're going to do your fellowship. Man, I can't even see patients, how will they collect data.

309
00:37:18.840 --> 00:37:19.590
aderse@mcw.edu: So are staying

310
00:37:20.820 --> 00:37:33.990
cgrady: Home for, you know, since early March, I guess, and looks like they're going to be for least another. I mean, they they're working on research projects, to the extent that they can. Some of them are actually doing interviews over the phone, which is pretty good.

311
00:37:35.010 --> 00:37:35.340
cgrady: But

312
00:37:36.720 --> 00:37:39.540
cgrady: Yeah, it's different, obviously different for everybody.

313
00:37:41.370 --> 00:37:46.680
aderse@mcw.edu: So Christian. This is our that I think one of the things that has been successful for us.