


REVIEW ARTICLE

Creating a Multidisciplinary Bioethics Ambassador Program at a Comprehensive Cancer Center

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Abstract

The Ethics Committee at Memorial Sloan Kettering Cancer Center (MSK) developed a Bioethics Ambassador Program (BAP); a yearlong educational program to assist clinical and non-clinical staff develop the skills to identify and address common burgeoning ethical issues that can arise during the provision of care to patients with cancer. The goal was to provide greater awareness of the role and services of Ethics, particularly at the institution's geographically-diverse outpatient care centers and to better instill a culture of preventative ethics. This article discusses the design and implementation of the first two years of the program and analyzes its strengths, weaknesses, and impact on MSK.

Keywords: bioethics; healthcare education; preventative ethics

Introduction

Cancer remains the leading cause of death in the world.¹ Its prevalence and heterogeneity present many unique ethical complications for patients, families, and clinicians. Ethical conundrums manifest themselves throughout the cancer care continuum—from diagnosis to treatment, research, palliative care, mortality, and survivorship—but tend to go unrecognized, particularly in the outpatient setting during the early phases of patient-clinician relationships.² Patient-centered care requires clinicians to pay attention to their patients' unique characteristics. An institution's Ethics Committees (EC) and Clinical Ethics Consultation Services (CECS) are critical components in the effort to elevate the voices and concerns of patients and caregivers to ensure that medical decisionmaking processes integrate their values and preferences.^{3,4}

In an effort to better provide these services, in 2019 the Memorial Sloan Kettering Cancer Center (MSK) EC embarked on a Bioethics Ambassador Program (BAP)—a yearlong educational program to help its staff develop the analytic tools to identify many common burgeoning ethical conundrums that can arise during the provision of care to patients with cancer, particularly in the outpatient setting, and to either mitigate them or call upon institutional resources to address them before they reach a critical stage.

The impetus behind BAP was twofold: The first was a recognition of the geographic limitations of our EC and CECS to deliver real-time, expert ethics services at *all* our institution's locations. MSK has grown from a single campus in Manhattan to more than 12 outpatient care centers throughout New York City (NYC), surrounding suburbs, and New Jersey—sites which are equipped to provide a wide array of

cancer diagnostic and therapeutic services, including clinical consultations, chemotherapy, radiation therapy, interventional radiology, and surgical interventions. MSK's EC and Ethics Consultants are primarily based at the inpatient campus, and although all locations have access to the CECS, the lack of "physical presence" of ethics professionals at these sites can place staff there at a disadvantage in their ability to recognize, name, and address an issue as one that can benefit from ethics involvement. Our concerns intensified as data revealed that more of our patients choose to receive their care at these "closer-to-home" locations, a trend amplified by the COVID-19 pandemic.⁵

Concurrently, we sought to enhance our institutional culture of preventative ethics, particularly at our outpatient sites. The practice of preventative ethics equips staff to recognize and call upon institutional resources to address budding ethical issues *before* they reach a seemingly intractable stage.^{6,7,8,9,10,11} BAP's mission was to educate and empower staff with the skills to identify mounting ethical challenges in real-time and to give them the tools and agency to call upon institutional resources to mitigate and hopefully resolve them before they reach a critical stage. Bioethics ambassadors would serve as "boots on the ground," ready to share their knowledge and experiences to assist their colleagues. As Anita Ho *et al.* and Carol Pavlish *et al.* explain, the key to preventive ethics is access to ethical expertise, ongoing exposure to ethical wisdom, a culture of ethical reflection, and a mechanism for regular team communication.^{12,13} These tools are particularly relevant for our regional sites, as both theory and practice have demonstrated that many ethical challenges often manifest themselves early in a patient's disease trajectory—a period during which patients often receive their care in the outpatient setting.

The goal of BAP was not to recreate or expand our EC or CECS, but rather to build a new, strong, local cadre of professionals and leaders at our regional sites who can enhance our institution's ethical footprint and serve as a bridge to the EC and CECS. Bioethics ambassadors would serve as ethics resources to their colleagues and patients/caregivers at their locations and also possess the confidence and capacity to call upon the EC and CECS for guidance or assistance when necessary.

This article discusses the design and implementation of our Bioethics Ambassador Program, which has educated 56 staff members through two distinct academic years. After describing BAP's design, structure, and teaching methodologies, we will analyze its strengths, weaknesses, and outcomes, as well as plans for both improving the BAP and leveraging its impact going forward.

Design

The institution's EC and CECS were established in 1984 with a primary focus on education, clinical consultation, and policy. In 2004, the CECS began tracking consultations in the hospital's database, and as of 2023, more than 1,400 ethics consultations have been recorded. Over the last 16 years, the CECS has seen a steady increase in requests for ethics from both physicians and nonphysicians.¹⁴ The present day CECS is comprised of 15 ethicists from a variety of professions (Nurses, Nurse Practitioners, Physicians, Physician Assistants, and Social Workers) and medical specialties (including critical care medicine, hospital medicine, pediatrics, psychiatry, and surgery).

A BAP Steering Committee was created and comprised of six members of the EC, including the EC Chair, three Clinical Ethics Consultants, a Research Informationist, and administrative support. Its initial tasks were to formulate course objectives and to create a timeline for planning and implementation. The working group met regularly over the course of more than six months to accomplish the following:

Define the following learning objectives

- Provide BAP participants with analytic tools to help identify (at an early stage) the common ethical challenges faced during the delivery of oncology care in the outpatient setting.
- Educate BAP participants about common ethical frameworks, universal language, and consistent approaches to analyzing complex issues in the oncology setting.

- Create a space for thoughtful, transparent discussions about ethical issues participants may face in their outpatient practice.
- Embed staff with general ethics knowledge in the outpatient setting.

Develop the overall course structure

The Steering Committee's primary goal was to devise a curriculum that identifies and addresses the ethical challenges that commonly occur in any medical setting. However, given the institution's unique position as a tertiary oncology center, they prioritized ethical issues that are more germane to cancer prevention, diagnosis, treatment, and research. To that end, the Steering Committee reviewed institutional ethics consultation data to identify recurring themes and common ethical conundrums faced by patients, caregivers, and staff and developed 12 distinct sessions to cover these topics and themes (Table 1).

Sessions taught early in the year focused on the core principles and foundational underpinnings of bioethics, such as the History of Bioethics, Ethics and the Law, and Healthcare Decision-Making. These early classes were intended to familiarize students with the historical and legal contexts for many of the ethical challenges and themes presented in subsequent sessions, such as Genetics, Pediatrics, and Research. They were also important vehicles for illustrating the importance of humility and the need to recognize one's individual biases and limitations. Foundational sessions were referenced in later classes, with the purposeful intent of encouraging students to apply the central principles and themes of bioethics to later case discussions. This course structure was designed to enhance students' confidence in their ability to analyze complex ethical dilemmas.

This multidisciplinary initiative utilizes the 70-20-10 Model for Learning and Development with emphases on students' unique disciplines, experiences, and training.¹⁵ All sessions aimed to foster interaction/discussion among the students, emphasizing their distinct perspectives. This teaching model helped promote our secondary goal of raising student awareness of the moral distress that routinely impacts healthcare workers.

The Steering Committee embedded fictitious or de-identified cases into each session. Students were encouraged to analyze the cases' ethical issues and discuss approaches for addressing them. Employing "real" and often relatable scenarios allowed students to develop their critical thinking skills, cogently articulate their thoughts and opinions, and acknowledge their personal and professional biases.

Instructors

The Steering Committee agreed that each class would be co-taught by one expert in bioethics and a second instructor with experience and knowledge in specific cancer-related topics. The bioethics experts are trained Clinical Ethics Consultants, some with a Master's degree in Bioethics and most with certification in Healthcare Ethics Consultation.¹⁶ Among the content experts, two were invited lecturers from the community, and the rest were internally sourced. For example, in Year One, a Nurse Ethicist who sits on the Institutional Review Board (IRB) was paired with the Chair of the IRB to teach the Research Ethics sessions (Table 1).

Individual session development

The working group met with each class instructor to discuss salient ethical issues related to their session. The EC's dedicated Research Informationist (Library Sciences) helped identify relevant articles for each session. Efforts were also made to identify topic-specific podcasts, videos, and other modes of learning. An online Library Guide ("LibGuide") was created as a central repository of these educational materials.

Table 1. Bioethics ambassador program topics, content experts and themes

Topic	Content expert(s)	Themes addressed
1 History of Bioethics	Local University History Professor	<ul style="list-style-type: none"> • Experimentation on human subjects – historical examples • Technological advances and ethical implications • Historical contexts for the rise of modern bioethics
2 Ethics & The Law	Attorney from Office of General Counsel	<ul style="list-style-type: none"> • Advance Directives • Surrogate Decision Making • Do Not Resuscitate (DNR) Orders
3 Decision-Making	Psychiatry Attending Physician	<ul style="list-style-type: none"> • Frameworks for decision making • Decisional Capacity Assessment • Informed Consent & Informed Assent • Deciding for others/Surrogate decision making
4 Patient & Family Values	Senior Clinical Social Worker	<ul style="list-style-type: none"> • Complex family dynamics • Relational Autonomy & Truth-Telling • Cultural Considerations • Incivility
5 Patient & Provider Rights	Medical Oncologist	<ul style="list-style-type: none"> • Patient Autonomy • Right to Decline Treatment • Requests for Nonbeneficial Treatment
6 Research	Medical Oncologist and Chair of Intuitional Review Board (IRB)	<ul style="list-style-type: none"> • Clinical trials 101 – Guiding Principles • Informed Consent • Therapeutic Misconception • Pediatric Research
7 Ethics Issues in Pediatrics	Senior Pediatric Clinical Nurse	<ul style="list-style-type: none"> • Psychosocial impacts of pediatric cancer • Autonomy and pediatric patients • Consent and Assent in pediatrics • Truth-Telling • Cultural Humility
8 Symptom Management	Palliative Care Physician	<ul style="list-style-type: none"> • Pain & symptom management across disease trajectory and setting • Obligation to Attempt to Alleviate Pain and Suffering • Communication Skills
9 Economics of Cancer Care	Medical Oncologist and Director of Clinical Value & Sustainability	<ul style="list-style-type: none"> • Economic costs of cancer care • Financial hardship • Drug pricing • Insurance
10 Genetics	Clinical Genetics Service Physicians and Genetic Counselor	<ul style="list-style-type: none"> • Genomic Data and Cancer 101 • Informed Consent and genetic testing • Incidental Findings • Privacy and Confidentiality
11 Clinical Ethics Consultation	Clinical Ethics Consultant/Advanced Practice Provider	<ul style="list-style-type: none"> • The process of an ethics consultation • Roles & responsibilities of Ethics Consultants • Mini Ethics Consultations: group discussions using short cases to examine approaches to a variety of common bioethical challenges
12 Real Ethical Conundrums	Ethics Committee Chair	<ul style="list-style-type: none"> • Case discussions, critical thinking and analysis • Public health ethics • Social determinants of health

Subsequent meetings were held with each session's two content experts to discuss relevant themes, questions, teaching tools, and class structure. Many of the instructors had extensive experience in teaching and/or speaking on their subjects. Given the wide range of clinical knowledge among BAP students, care was taken to deliver clinical material in a manner that all students could digest. BAP administrators reviewed all slides and content prior to each session.

Execution: Delivering the product

Logistical considerations

Scheduling: The Steering Committee decided that 12 monthly sessions taught over one year would keep the students engaged and not overtax their other professional responsibilities. Each month's session was taught twice to accommodate the participants' schedules and allow for smaller group discussions. Online, live sessions were two hours in length, and the BAP Administrator carefully ensured that each class had a relatively even number of students. Students were expected to attend at least 11 of the 12 scheduled sessions, although the nature of an acute hospital setting required us to afford students some leeway.

Platform: BAP was always intended to be a fully remote, online program to encourage a geographically diverse array of participants. The shift to remote work and education necessitated by the COVID-19 pandemic only served to enhance our participants' comfort level with our tele-digital classes. The virtual platform allowed for breakout rooms, chat, and poll questions. Students were asked to keep their cameras on and actively participate in the discussions.

Continuing Education: BAP was certified for physician Continuing Medical Education (CME) and nursing Continuing Education Units (CEUs).

Recruiting and selecting BAP students

Ethics leadership prioritized recruiting a professionally and geographically diverse cohort of Bioethics Ambassadors, and all staff were eligible to apply. Program information was posted on the internal ethics webpage and widely distributed to hospital leadership at all locations. BAP planners also conducted virtual information sessions.

Applicants completed a short Research Electronic Data Capture (REDCap) survey collecting career demographics (discipline/department, years of experiences, years at current institution) and Ethics-specific interest and experiences (open-ended questions included: 'Please tell us why you would like to participate in the Bioethics Ambassadors Program' and, 'What has your experience been with clinical ethics consultation?'). The applications were reviewed by the BAP working group with special attention towards assuring a diverse cohort of clinical and nonclinical professionals representing a variety of specialties, departments, levels of experience, and hospital sites, with an emphasis on outpatient locations (Table 2).

Information on the number of applicants, accepted students, and those who completed the program are presented in Table 3. Attrition for both years stemmed from participants who left our institution before the completion of the program. From the beginning, our goal was to have a maximum of 25–30 participants per year, which we believed would allow for a robust, relatively "intimate" online experience. Each subject was taught twice per month, and we strove to have a roughly equal number of students per session so that participants (15–20 students, 2 instructors, and 2–3 BAP directors) would all fit on one Zoom screen.

Metrics/Data collection

In an effort to evaluate BAP's impact on students, we administered core bioethics competencies surveys and validated tools—Interpersonal Reactivity Index (IRI)—assessing empathy and leadership skills^{17,18} at both the onset and at the conclusion of the course. The core competency survey included 20 multiple-

Table 2. Bioethics ambassador program graduates by discipline

Program graduates N = 56			
Clinical		Non-clinical	
Advanced Practice Provider	9	Administrator	7
Chaplain	1	Environmental Services	1
Genetic Counselor	2	Medical Interpreter	1
Nurse	14	Patient Advocate	1
Physician	8	PFACQ ^a Member	2
Social Worker	2	Pharmacist	1
		Recreation Specialist	1
		Security Guard	1
		Other (Admin Asst, Project Coordinator, Unit Assistant)	5
Total:	36		20

^aMSK Patient and Family Advisory Council for Quality

Table 3. Bioethics ambassador program applicants and acceptance

	# of applicants	# of staff accepted	BAP graduates
Year 1 (2021–22)	37	28	28
Year 2 (2022–23)	66	32	28

choice questions gauging students' general ethics knowledge, while the IRI focused on perspective taking, empathy, and personal distress.¹⁹

Educational sessions

The classes were organized by theme/topic with secondary emphases on role modeling, critical thinking, and analysis. Planners strove to create a balance between the didactic components of each session and opportunities for open discussion, debate, and question & answer periods between instructors and students. Fictitious ethics cases were employed to facilitate group discussions. Most classes included moderated breakout sessions inviting students to critically examine a complicated case or situation in small groups before sharing with the class at large. Poll and chat functions also drew on students' personal experiences and opinions. Confidentiality of the participants' comments, personal experiences, or descriptions of patient cases were emphasized to ensure open and honest discussions and to protect participants' and putative patients' confidentiality and privacy.

Each session's content and ethics experts conscientiously prepared and presented their materials in manners that acknowledged the BAP students' highly diverse professional experiences and clinical knowledge. This approach offered the students an opportunity to gain familiarity with a sundry of disciplines and operations within the institution, including clinical care, research, supportive services, and administration. It also underscored how the institution's CECS strongly relies on a multidisciplinary approach.

As Table 1 illustrates, BAP planners tailored session themes, cases, and discussions to topics prevalent in an oncology setting. For example, the Ethics and the Law session focused on the juxtaposition between

local, state, and federal laws and hospital policy. The discussion was led by a Psychiatrist/Ethics Consultant and the hospital's Chief Legal Counsel and addressed issues related to advance directives, surrogate identification, guardianship, Medical Aid in Dying (MAiD), and Do Not Resuscitate (DNR) orders. The Clinical Ethics Consultation session offered a general overview of consultation and presented a series of "mini" ethics cases to engage students in discussion and deliberation about how best to approach these complex situations.

Analysis: Considerations for future years and recommendations for others embarking on an ethics education program

Institutional buy-in is necessary

An effective ethics training program requires significant institutional support through the allocation of dedicated resources, time, and faculty training.²⁰ Leadership support for the Bioethics Ambassadors Program was instrumental in securing access to prominent content experts and raising general awareness of the Program and its benefits. Students were required to receive their supervisors' approval, be guaranteed time off from work to attend class, and, in some cases, be provided with a quiet space within their work environment and the necessary technology to participate. BAP required minimal capital expenditures: Its virtual platform ensured that expenses for the program were low and able to be absorbed through the EC's annual budget. Nevertheless, BAP success did rely on leveraging many of our institution's world-renowned clinicians and senior staff to donate countless hours of valuable time and expertise. The two external lecturers were offered small honoraria.

Resource and labor-intensive process

To our knowledge, BAP is the first, year-long comprehensive ethics education program for multidisciplinary clinical and nonclinical staff in a healthcare setting and specifically the field of oncology. As such, BAP was a time-consuming labor of love. The Steering Committee spent more than 6 months planning all aspects of BAP—objectives, priorities, recruitment, marketing, and administrative responsibilities—prior to its launch. Moreover, curriculum development with our instructors required multiple preparatory sessions in addition to the two, 2-hour live sessions per year. This labor-intensive, hands-on approach was necessary to accommodate the varying degrees of foundational ethics knowledge and educational needs of our diverse cohorts of students. We recognize that not all institutions, their clinicians and staff, and ECs have the financial/operational resources or the time necessary to create and successfully execute an ethics educational program.

The Pros and Cons of teaching clinical and nonclinical students together

Since its inception, BAP was intended to be available to all hospital staff—both clinical and nonclinical. Inclusiveness offers more opportunities to foster a humanistic culture and patient-centered care while also raising awareness of and avenues for remediating ethical dilemmas.²¹ Nonclinical staff, including hospital administration, environmental services, security, and patient advocates, constituted 36% (N:20) of the BAP's student body (Table 2). To some degree, the class makeup mimics our institution's multidisciplinary teams and exemplifies our diverse professional perspectives and opinions.

At times, however, instructors struggled to communize course content in their efforts to teach physicians, nurses, unit assistants, and security guards alike to understand and appreciate the nuances of decisional capacity, adolescent truth-telling, and informed consent. The course materials and discussions were curated to assure accessibility for all students. The program directors and instructors accomplished this intricate goal by balancing didactics with case-specific open debates/deliberations where students were encouraged to share challenging personal and professional experiences related to the topic at hand. The team worked diligently to focus the didactic materials and discussions on the

ethical dilemmas and less on their technical or clinical nuances. This approach sometimes proved difficult for some of our expert instructors with more experience teaching medical residents and fellows, but we found the method invaluable for BAP students.

Despite these difficulties, we believe the professional diversity of our student body proved to be an overwhelmingly positive experience. Our students and instructors all benefitted from exposure to a wide range of experiences and viewpoints, which, we surmise, enhanced both their critical thinking and empathy skills. For example, in the session examining ethical challenges related to decisional capacity and discharge Against Medical Advice (AMA), a “clinical” student expressed her frustrations in witnessing an elderly patient demand discharge before resolution of atrial fibrillation. A “nonclinical” student countered by sharing a personal story of local police performing a welfare check after he had left a local emergency room AMA. This led to a lively discussion highlighting the important balance between duty to care and dignity of risk.^{22,23} Not surprisingly, the nonclinical staff elevated the voice of the patients and caregivers in most discussions.

Keeping students engaged and active during classes can be difficult

Materials for certain sessions were heavily didactic, leading to concerns that students were less engaged. These reservations were compounded by the online nature of BAP. Although online education allows for greater participant diversity, it unfortunately lacks the intangible benefits of in-person learning and interaction. Multi-tasking and other distractions have become a byproduct of our remote work/education world, making it more difficult to keep our students fully engaged during the sessions. Students were encouraged to remain “camera on” and to be ready to participate in discussion, but there were always 1–2 students who did or could not comply, either for personal, professional, or technological reasons. We acknowledge that it is worth exploring other strategies and class structures that would allow us to engage a diverse cohort of students in an in-person setting.

Assessing student accountability is challenging

Aside from the pre- and post-Program assessments and witnessing active participation in BAP sessions, there were no formal means to assess how much participants were learning. Other than attendance and the required 2–4 articles or resources per class, we placed no additional work requirements on our students. The program directors considered instituting some form of “homework,” but ultimately decided that this might deter participation. Throughout the two years of BAP, the assigned materials were seldom referenced during class by either instructors or students, and we are unsure whether the students reviewed/read them fully. We acknowledge the shortcomings of not incorporating the readings in either the didactic teachings or discussions in our classes. These materials provided excellent foundations for each session’s specific subject, and we should have both encouraged our instructors to reference the readings and provided opportunities for the students to discuss them either during the class or in reflections following the sessions. This will be a priority for future years of BAP, in addition to periodic written assignments and/or a capstone project to better assess each student’s ethics proficiency.

Does BAP make a difference? Are its impacts quantifiable?

It has been difficult to quantitatively measure the impact of BAP upon participants themselves and/or the institution at large. Colleagues at another institution theorized that their bioethics training program might encourage ethics consultations to be initiated earlier in a patient’s hospitalization and therefore measured the point/day in a patients’ hospitalizations at which ethics consults had been requested, an outcome that they “quickly found challenging to evaluate.”²⁴ We agree that this metric is problematic: one can argue that an increase in ethics consultations signals a greater awareness and responsiveness to ethical issues; conversely, a decrease could be interpreted that our staff have been successful at

Table 4. Bioethics ambassador program post-graduation student activities

Bioethics ambassador program post-graduation student activities	
Became clinical ethics consultants	Internal promotions & job advancement
Requested and/or participated in ethics consultations	Joined existing institutional committees:
Led/participated in institutional initiatives	<ul style="list-style-type: none"> • Medical Aid in Dying (MAiD) Advisory Council • Ethics Committee • Institutional Review Board (IRB) • Women on the Move Employee Resource Network
<ul style="list-style-type: none"> • Increasing patients’ completion of advance directives • Review of institutional regulations on use of herbal products • Creation of institutional standards on caregiver presence at bedside during clinical procedures 	Led/participated in ethics-related education
Ethics-related publishing and speaking engagements	<ul style="list-style-type: none"> • Developed and conducted topic/site-specific ethics education • Designed/taught external ethics classes • Joined BAP faculty
<ul style="list-style-type: none"> • Presentations at national and international conferences • Published ethics relevant articles 	

recognizing and mitigating burgeoning ethical challenges before they become critical, thereby nullifying the need for an ethics consultation.

Preliminary evaluation of the core bioethics competency surveys revealed that 74% of BAP students increased their bioethics knowledge, with scores improving the most for questions pertaining to decisionmaking (capacity) and clinical ethics consultation. As for the IRI, it was theorized that this tool would evaluate vital personal attributes that would help determine the efficacy and impact of BAP on participants. Analysis of the IRI survey revealed no statistically significant difference following BAP. We theorize that BAP students were a self-selecting group and came into the program already possessing high levels of these attributes, particularly empathy and perspective taking, and that BAP served to reinforce participants’ already-existing strengths.

In our estimation, the most relevant indication of BAP’s impact is how the graduates have incorporated their experiences into their professional practices and enhanced the ethics “landscape” of the entire institution. Participants are empowered to convey their bioethics training to their specific departments, services, and locations, to support and advise peers in real-time, and to harness the resources of the CECS. BAP students are the “bridges” to the main EC and CECS.

When we ask the question, “how have the BAP participants applied their knowledge to the betterment of the institution?” we conclude that BAP has been a success. Over 41% of our graduates have meaningfully participated in *documented* ethics-related activities that have benefited staff, patients, caregivers, and the institution at large. As described in Table 4, they have led numerous ethics-related educational initiatives, trained to become clinical ethics consultants, joined BAP faculty, represented Ethics as members of institutional committees and working groups (such as IRB and Medical Aid in Dying Advisory Council), and have initiated or been involved in ethics consultations. We also surmise that many BAP graduates have leveraged their knowledge and experiences “under the radar” through undocumented conversations and guidance to patients, caregivers, and other staff members. Furthermore, several BAP graduates have assumed leadership positions within their departments or have advanced professionally within the institution. While these promotions cannot be attributed solely to BAP, we do submit that through BAP, many participants gained the confidence and skills to better advocate for themselves, their coworkers, patients, and caregivers and to serve as dependable representatives of our institution.

Conclusion

For healthcare organizations that operate geographically diverse patient care centers, the Bioethics Ambassador Program offers clinical, nonclinical, and administrative staff remote education on relevant and critical aspects of Bioethics. Embedding staff throughout the institution with a base knowledge in ethics invariably raises awareness not only to the Ethics Committee and Clinical Ethics Consultation Service, but also of the ethical dilemmas faced by our patients, caregivers, and staff. Future analysis of the

collected data from our first two years will help verify the ongoing and direct impact of the Bioethics Ambassador Program on participants, patients, other staff, and the institution at large.

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Notes

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