Cambridge Quarterly of Healthcare Ethics (2024), 1–9
doi:10.1017/S0963180124000409

CAMBRIDGE UNIVERSITY PRESS

RESEARCH ARTICLE

Teaching Ethics Consultation Using a Tabletop Exercise

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Abstract
Drawing on pedagogical tools utilized in clinical scenario simulation and emergency preparedness training, the authors describe an innovative method for teaching clinical ethics consultation skills, which they call a "tabletop" exercise. Implemented at the end of a clinical ethics intensive course, the tabletop enables learners to implement the knowledge and practice the skills they gained during the course. The authors highlight the pedagogical tools on which the tabletop exercise draws, describe the tabletop exercise itself, offer how to best operationalize such an exercise, reflect on the method's strengths and weaknesses, and provide insights for others who may want to implement their own tabletop for ethics consultation education.

Keywords: clinical ethics; education; emergency preparedness; ethics consultation

Introduction

The Cleveland Clinic Center for Bioethics offers the Clinical Ethics Immersion Program (CLEIP), an innovative program that provides an immersive educational experience in clinical healthcare ethics.[1] It consists of a three-day preparatory intensive course followed by a two- to three-week immersion in the Center and on the ethics consultation services of Cleveland Clinic's northeast Ohio hospitals. The three-day intensive course engages all learners in the cohort in skill-building workshops and experiential exercises to deepen their understanding of standard ethics consultation methods as well as emerging approaches. They learn organizational strategies for establishing infrastructure and providing institutional leadership for quality benchmarks in information gathering, ethical reasoning, advanced communication skills, and ethics note-writing.

Learners practice these specific skills in a final capstone tabletop exercise, which is the focus of this article. The tabletop exercise is a half-day simulation at the end of the intensive course where participants navigate a realistic clinical ethics consultation, integrating knowledge, skills, and abilities acquired during the intensive. This paper begins with a description of how the CLEIP tabletop exercise combines elements of clinical scenario simulation and emergency preparedness training. The paper then discusses the specific content of the exercise, how it is best operationalized, and its strengths and weaknesses as a form of ethics consultation training. It concludes by offering insights for others who may want to implement their own tabletop for ethics consultation education, including highlighting approaches for fostering a safe learning environment to optimize effectiveness and success.

Learning from Clinical Scenario Simulation and Emergency Preparedness

The tabletop model utilized in CLEIP is an innovative methodology for teaching ethics consultation. Although the exercise is called a "tabletop," it actually incorporates several forms of emergency preparedness training and methods utilized in medical education—namely, simulations, tabletop exercises, walk-throughs, and drills—to create a comprehensive and dynamic educational experience that exposes learners to the complexities of healthcare ethics consultation. Although each of these methods share similarities in their goal of enhancing knowledge and skills, they differ in terms of their format, level of interactivity, and specific objectives.[2]

Simulation involves recreating real-life scenarios in a controlled environment to allow participants to practice and apply their skills in a realistic setting. Simulations often involve roleplaying and may utilize standardized patients or actors to enhance realism. They promote dynamic and interactive learning, allowing participants to experience emotional and interpersonal dynamics they may encounter in actual practice. In the CLEIP tabletop, faculty are assigned roles and given deep background information that only they may know and act on, as well as directions for when to reveal information in the consultation process. These roleplaying faculty are made up of CLEIP leaders (Center for Bioethics faculty who run the CLEIP program and teach much of its content), internal faculty (Center for Bioethics faculty who provide additional teaching during CLEIP), and external faculty (Cleveland Clinic caregivers who do not otherwise teach in CLEIP and are therefore unknown previously to the learners).

The CLEIP tabletop exercise differs from a standard simulation in medical education in its length and complexity, as multiple different skills are required along an extended narrative trajectory. Although there are opportunities for faculty to provide feedback, debrief with learners, or respond to requests for information or guidance, the scenario proceeds without the frequent planned debriefing intervals that often take place during simulations. This momentum provides some of the sense of urgency or immediacy inherent in disaster management. Although many, if not most, clinical ethics consults do not rise to the level of a disaster, often the consult request is made due to the need for timely decisions in a setting of heightened emotions and distress.[3]

Tabletop exercises are typically group-based discussions that involve presenting hypothetical scenarios or case studies for participants to analyze and discuss. Tabletop exercises have been utilized in disaster management in multiple settings. Most commonly, they are used in planning for natural disaster response, mass casualty or trauma events, terrorism threats, and pandemic preparation.[4] They bring key players together in a pre-crisis, safe environment to talk through various scenarios and brainstorm potential responses. Tabletop exercises are often conducted in a setting such as a conference room or command center, where participants discuss and strategize without performing physical actions. They differ from walk-throughs or drills, which are discussed below, in that much of the activity in a tabletop occurs in discussion and may happen remotely or virtually.

The CLEIP tabletop exercise, which was designed pre-COVID, capitalizes on the use of virtual and remote access to gather information and convene stakeholders by incorporating both in-person interactions as well as telephone conversations with roleplaying faculty. This dual approach reflects a realistic situation, as many of the interactions and action steps in a clinical ethics consultation do happen via telephone in a large academic medical center. Additionally, video conference for convening family meetings or multidisciplinary conferences have emerged as key components of contemporary telehealth and offer opportunities for expanded family involvement in decision-making or decision-making support. Post-COVID, this model offers even greater applicability with increased remote ethics support and remote learning as key markers of the current era.

A **walk-through** is a step-by-step exploration of a process, policy, or protocol, with participants physically moving through the actual or simulated environment. A walk-through may involve observing and analyzing the steps involved in conducting an aspect of emergency preparedness or other healthcare endeavor. It allows participants to gain a practical understanding of a process and identify potential challenges or areas for improvement. The CLEIP tabletop exercise incorporates elements of a walk-though in that learners physically engage in the ethics consultation process from start to finish.

Drills are structured, repetitive exercises designed to test specific skills, protocols, or emergency response procedures. Drills provide a means for participants to reinforce specific competencies and

identify areas that require further development. Although commonly associated with emergency preparedness, drills can also be adapted to healthcare ethics consultation. In this context, a drill may focus on practicing communication skills, decision-making under time constraints, or adherence to established protocols or approaches to ethics consultation. Each of these aspects of repetitive skills practice are incorporated into the CLEIP tabletop exercise.

When considering their use in teaching healthcare ethics consultation, simulation, tabletops, walk-throughs, and drills all have the potential to serve distinct purposes: simulations offer realistic and immersive experiences; tabletops facilitate group discussion and ethical analysis; walk-throughs provide practical understanding of the consultation process; and drills focus on skill reinforcement and adherence to protocols. By combining elements of all of these tools, the CLEIP "tabletop" creates a comprehensive and dynamic educational experience that exposes learners to the complexities of healthcare ethics consultation.

Content of CLEIP Tabletop Exercise

Because the tabletop exercise takes place on the last day of the CLEIP intensive weekend,[5] the goal is for learners to experience a consult from beginning to end and to implement all the ethics consultation skills they have learned throughout the weekend. To meet this goal, the exercise takes learners through the stepwise processes of intake, fact-gathering (in multiple iterations, given that many clinical ethics cases unfold over days to weeks), ethical analysis, and note-writing. There are built-in periods for feedback and group reflection throughout the exercise as well. Instructions, phone numbers, and other information are generally provided in written form throughout the exercise. Faculty roleplay as stakeholders throughout the exercise and have additional information to inform their interactions with learners.

The tabletop is based on a real case, with certain elements changed for anonymity. The case centers on a patient in her 30s. After undergoing cardiac surgery, her recovery is significantly slower with more complications than expected. Her family requests an ethics consultation and expresses their concerns that the patient would not want to continue the current, aggressive care path. Specifically, they seek withdrawal of life-sustaining treatment. Several members of the care team, including the cardiac surgeon and intensivist, believe that more time is needed because the patient could still make a full recovery. Several nurses and social workers appear to be experiencing moral distress due to the perceived disconnect between patient wishes (as expressed by the family) and plan of care (as driven by certain physicians). The case unfolds as follows.

First, although learners are assigned to small groups, they start out all together for initial intake. One of the CLEIP leaders receives a page from the consult requestor—a critical care nurse calling on behalf of the family—and conducts intake over speakerphone. Learners are directed to utilize an intake form throughout the conversation and take notes on key facts as presented by the nurse. This step kicks off the fact-gathering process. At the end of the intake conversation, the nurse indicates that the family would like to speak with the ethics team right away.

Groups then receive confirmatory and additional facts in written form, which instructions indicate are pulled from the electronic medical record. They designate one individual from each small group to participate in the requested meeting with the family as members of an ethics consultation team. It is worth noting that this initial interaction with the family is akin to speaking with an initial consult requestor, rather than participating in a traditional "family meeting," which typically includes several members of the healthcare team. Several faculty roleplay as family members. Learners not engaged in the conversation with the family observe and may support those participating with suggestions if requested.

In the next step, groups engage in fact-gathering with care team members, including the roles of cardiac surgeon, intensivist, neurologist, and a social worker. Before reaching out to these individuals, learners are prompted to consider (1) who they want to speak with next (and in what order); (2) what they want to ask each stakeholder; and (3) what they want to communicate to each stakeholder, including how they plan to summarize their meeting with the family. Groups are provided with a list of phone

numbers—the cell phones for the various faculty playing each role. Armed with a robust set of information, each group is then prompted to collaboratively draft a single placeholder note. Faculty debrief with learners over lunch.

After lunch, groups are informed that the ethics team participated in another family meeting, this time with both the family and several other care team members. This is an example of how the tabletop is designed to "fast forward" temporally within the consult, to optimize teachable moments in a time-conscious manner. The discussion and outcome of this meeting—including that a do-not-attempt-resuscitation order was placed and a plan for non-escalation was implemented—are summarized in written form in the instructions. Groups are prompted to brainstorm in bullet point form what information they would include in a note documenting this family meeting.

The next step again fast forwards—to ten days later. Learners are informed that, based on current electronic medical information, the patient is septic and in multi-system organ failure. The care team provided multiple blood transfusions to the patient and started continuous dialysis. Learners are prompted to consider what concerns these development raise. They are also asked to create a list of stakeholders they would like to contact and to make those phone calls, and they are directed to speak with the family in-person again. During this step, the cardiac surgeon maintains her belief that the patient can still recover back to her baseline, without dependence on either a ventilator or dialysis, and says that, based on her preoperative informed consent conversation with the patient, the patient understood that difficulties were possible in the postoperative period. However, the surgeon does concede that if other consultants judge the patient to be ventilator or dialysis dependent, then the patient would not want to live that way and withdrawal of life-sustaining treatment would be indicated. Learners are nudged to speak with both the pulmonologist and the nephrologist. Ultimately, the nephrologist confirms dialysis dependence.

Finally, learners are encouraged to discuss the ethics recommendations they would make to the team and instructed to draft an ethics consultation note that includes these recommendations. They are told to utilize various resources they have learned about and practiced with throughout the program, including a note template, smartphrases, and other tools. Groups share their notes in a report-out format and a final debriefing commences.

Operationalizing the Tabletop

The tabletop requires significant preparation to operationalize successfully. A number of written materials are needed. For learners, materials should include a clear narrative of the consult—separated into phases or different discrete time periods—as well as contact information for various stakeholders, especially those stakeholders who will only be available by phone or virtually. The written consult narrative should strike the balance of having enough information to indicate that there is a clear ethical issue while not including everything needed to conduct an ethical analysis or make recommendations; gaps in the information are necessary so that conversations with stakeholders/actors must take place. For faculty, materials must familiarize them with the full case, faculty role descriptions and a mechanism to track who is filling each role, and what information each faculty member—roleplaying a particular role—seeks to provide to the learners during certain phases.

Separating information about the consult into phases in the written materials serves several purposes. First, it allows the case information to be disseminated in parts, ensuring that learners cannot circumvent the information-gathering process by reading ahead, as well as allowing for some conceptual time-travel, to mimic a real-life, real-time complex ethics consultation. Second, it creates the opportunity to reconvene the large group as needed to debrief and share approaches that worked well and those that fell short of what learners desired in terms of information and outcomes, and to confirm that each group continues to work with the same basic set of facts. Finally, it prompts breaks, physical movement, and lunch. All of this needs to be organized in a way that allows adequate time for each phase with breaks and keeps the tabletop exercise moving forward on time.

Roleplaying faculty should be empowered to parse out information in a natural, conversational way, which is to say, they should refrain from automatically sharing every detail right away. Learners should be encouraged to ask questions to obtain the information they need; if a tabletop team appears to be struggling with the conversation, faculty are empowered to provide prompts, such as asking, "What do you need to know from me? Is there something you need me to do right now?" Depending on the role they are portraying, faculty may present in a range of ways, from appreciative and ready for a lengthy conversation to a professional but impatient or hurried approach; they may also match the conversational tone of the learner/ethics consultant. This last variable may result in some teams having more information than others. Despite the potential for variation, this approach mimics a real consult experience, in which ethics consultants face sometimes unpredictable responses to their involvement. If needed, a team of learners can be given missing information when the larger group reconvenes, so that everyone continues to work with a sufficiently complete set of facts.

In an effort to mimic a real consult, during which an ethics consultant may face challenges reaching a stakeholder at any given time, some faculty should only be available by phone and some not at all (with written materials for faculty specifying as much). Those faculty who are not available at all should allow any calls to go to voicemail and simply not return the call. Those roleplaying faculty who are not on-site but are available may also allow the call to go to voicemail, with a plan to call back within 20-30 minutes. These details may appear to be unnecessary, but feedback from faculty over the years has indicated that such clear instruction is appreciated.

CLEIP leaders often are assigned roles in the tabletop, which is necessary due to constraints in available staffing. In addition to these assigned roles, CLEIP leaders also periodically check in or listen in on a group, providing support when requested or needed, and real-time guidance.

In disaster management, conducting a tabletop exercise often involves compressing time and condensing the course of events to fit within a shorter period, typically a single day or a half-day. This compression is necessary due to the complexity of the scenarios, which in real-life may unfold over several weeks or longer.[6] The same concept applies in a tabletop exercise for teaching ethics consultation. Written materials should indicate the specific time that each phase is supposed to end. Skilled facilitators must help participants stay focused and prioritize their actions within the time allotted for each phase.

Of note, when designing a time-compressed tabletop exercise, careful selection of the scenario is crucial. The chosen scenario should capture the essential elements, challenges, and decision points that participants would encounter in a real-life situation. However, certain non-essential, less critical, routine, or time-consuming aspects may be excluded or simplified to ensure the exercise can be completed within the designated time, with written materials simply reflecting this fact.[7] The exercise's narrative should be structured to prioritize key events and critical decision-making moments, condensing the timeline to include the most significant developments. This allows learners to engage with the core ethical dilemmas and practice their problem-solving skills efficiently. In addition to highlighting high-yield aspects of the ethics consultation, these elisions also draw attention to the cognitive and emotional changes inherent in healthcare crises that may happen more slowly or may happen abruptly but only after some time.[8] This deepens the experience of the CLEIP tabletop by allowing learners to re-encounter stakeholders at distinct phases of the consultation and encounter a wide range of emotional responses, similar to a real-life scenario.

Strengths & Challenges

This pedagogical model of ethics consultation education has both strengths and challenges. The ability to weave together multiple components of skills-practice (fact-gathering, communication, ethical analysis, note-writing, etc.) makes the tabletop exercise an effective all-in-one training tool. The opportunity to practice communication skills through roleplay is particularly robust in the tabletop. In-person communication brings the immediacy of face-to-face conversation with people who may be very stressed or otherwise not at their best, allowing practice of advanced skills like therapeutic silence and reframing, as

well as more basic communication skills like appropriate body language. The telephonic component introduces the very realistic elements of phone tag, crossed wires, and cross-covering or changing staff. It also illustrates the challenges inherent in undertaking value-laden high-stakes topics without the benefit of body language. In this way, and in that it simulates a real case, it also offers a realistic approximation of applied practice.

Moreover, a tabletop exercise for ethics consultation can be adapted in various ways to meet the needs of a particular educational or training program, allowing for operational flexibility. For example, if a program has an entire day to devote (or multiple days), it could be extended; if there are very few faculty available to roleplay, they can be assigned multiple roles (although this is not ideal, as discussed below); the consult scenario can also be changed depending on learners' needs and practice gaps. Additionally, the tabletop is an overall cost-effective exercise. It utilizes a single pre-designed scenario that can be replicated again and again. Indeed, CLEIP leaders have used the same tabletop scenario for several years now. Although costs include the labor necessary for preparation and the time investment of faculty, it allows a group of learners—even a large group—to all benefit from the same exercise without duplicating initial investment costs.

In terms of challenges, the multiple moving parts and different stakeholders in the exercise can be hard to control or choreograph. It requires careful balance of "who knows what when" and anticipated responses. One bad element (e.g., a skeptical learner, a disruption to the decision tree) can corrupt a significant portion of the exercise. Strategies to course-correct in the event of such a derailment should be developed in the planning phase.[9] Another notable challenge or limitation is the lack of interval debrief and replay, which has been demonstrated to be one of the highest-yield aspects of simulation education. This element was deliberately omitted from the CLEIP tabletop exercise as a matter of scope, scale, and time and in favor of prioritizing longer feedback and reflection cycles, which offer the opportunity to observe how one strategy unfolds over time, something that potentially is lost in the shorter cycle model. But this approach does sacrifice shorter cycle debriefings, which help learners assess immediate responses and change course in the moment.

Insights for Implementation

The experience of developing and implementing a tabletop for ethics consultation education has revealed several insights for other educators seeking to develop similar activities or exercises. First and foremost, successful implementation depends on the ability to create a safe learning environment in which controllable environmental risks are minimized to empower learners to engage as fully as possible. Many learners resist participating in roleplay because it makes them feel exposed and vulnerable. There are several strategies employed during CLEIP to help promote a safe learning environment. First, the tabletop occurs at the end of the intensive course after learners have had several days to know each other and learn material and skills in a supportive environment. Additionally, the CLEIP intensive course starts with a faculty-only roleplay, during which learners observe, ask questions, and offer constructive feedback to faculty.[10] In this way, faculty model comfortability with roleplay and normalize it as part of the learning process. Having most or all faculty engage in roleplay during the tabletop reflects an effort to minimize the perception of an audience of non-participants or critics. The simulation and emergency preparedness literature offer a number of other strategies that can be adapted by educators to the clinical ethics tabletop model.[11]

Another key component for implementation is that the tabletop should involve an adequate amount of complexity, especially if the exercise is intended as a culminating activity through which learners demonstrate the skills they have learned over the course of an educational program. At the same time, learners should have a clear picture of what they ought to recommend and where they ought to end up. That is, the tabletop should not be a "choose your own adventure." Instead, the scenario should be appropriately designed such that the steps taken and recommendations made by learners are relatively consistent across each small group.[12]

To replicate the fullness of the healthcare environment, it is best to have a rich cohort of faculty well-versed with the case who are able to play the responsive roles. Although one individual can play multiple roles, this approach can thin the experiential nature of the exercise and lead to confusion. Such thinning would be particularly noticeable if a faculty member plays roles on both the provider and the patient side of the story. Having faculty play their own professional roles in the simulation can increase the verisimilitude and create a higher fidelity simulated experience, but "casting against type" may sometimes be necessary or desirable depending on the circumstances.[13]

When structuring opportunities for debriefing and feedback, points of discussion should include not only the ethical relevance of certain information or why certain process steps were appropriate, but also how different approaches to conversing with actors may have resulted in slightly different information or at least a different tenor of conversation. One of the core competencies for ethics consultation identified by the American Society for Bioethics and Humanities is interpersonal skills.[14] This skillset includes listening well, attending to relational barriers like strong emotion, effectively eliciting the moral views of others, and helping stakeholders be heard by other parties. As commentators have noted in the literature, cultivating and assessing interpersonal skills are important components of ethics consultation simulation trainings.[15] Unpacking with learners how different communication approaches and styles resulted in more or less effective communication with stakeholders helps promote this competency. Another opportunity for future expansion of the tabletop exercise is to incorporate parallel enactments of different scenes with subsequent comparison and group reflection. Such expansion would require more time than the half-day currently allotted in CLEIP.

Past learners in CLEIP have included members from various disciplines in healthcare—nurses, physicians, social workers, advanced practice professionals, chaplains, as well as administrators and scholars with backgrounds in law, business, philosophy, and translational research. All participants have some current or future role in ethics in their sponsoring institution and thus almost all participants have a hybrid professional identity. This hybridity is a strength, and the tabletop enables learners to practice wearing their ethics "hat" in addition to their primary role without risk to reputation or a patient.[16] However, one of the most difficult things for new (and sometimes experienced) ethics consultants is working in a hierarchical environment in which traditional power structures are rarely challenged. This power tends to accrue to specific roles, positions, and identities and ethics consultants often need to raise concerns or question decisions, either subtly or overtly challenging that power structure.[17] An individual in a traditionally lower power position in the healthcare environment may need to learn how to negotiate in a higher power role as ethics consultant. An ethics consultant with an identity or position outside the clinical care environment, such as law or philosophy, may struggle to define their role and legitimacy at the bedside. These aspects of wearing a dual "hat," and the growth edges that come with that experience, should be emphasized by facilitators and incorporated into group discussions and feedback during breaks or at the end of the exercise.[18]

Lastly, timing should be reevaluated each time the tabletop exercise is conducted, with realistic assessment of where participants needed more time or less time during certain phases, so that timing can be adjusted in future iterations. Faculty should also be prepared to make spontaneous adjustments during the tabletop itself if indicated.

Conclusion

The CLEIP "tabletop" creates a comprehensive and dynamic educational experience that exposes learners to the complexities of healthcare ethics consultation by combining elements of several tools from emergency preparedness and medical education. In addition to allowing learners to practice the requisite ethics consultation skills in a manner that reflects a real ethics consultation, the tabletop exercise can be replicated and adapted to the needs of different healthcare environments to best reflect the organizational culture and practice approaches among healthcare ethics consultants in that organization. The greatest challenge of the CLEIP tabletop exercise is the significant time required to develop and operationalize it; nevertheless, even with this investment of time, it remains cost-effective, as it draws on the expertise of

healthcare professional colleagues rather than paid actors and can be used repetitively with different groups of learners without significant additional investment. The strengths of this educational approach outweigh the challenges. This innovative pedagogical methodology for teaching ethics consultation as a culminating exercise after learning and practicing relevant component elements of excellent ethics consultation successfully fosters a supportive learning environment in which professionals who excel in their discipline can practice new skills in a new role, or try "wearing a different hat," without risk to reputation or a patient.

Notes

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Cite this article: Mabel H, McCammon S and Eves MM (2024). Teaching Ethics Consultation Using a Tabletop Exercise. *Cambridge Quarterly of Healthcare Ethics*: 1–9, doi:10.1017/S0963180124000409