

# BEN

## BIO QUARTERLY

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Network of Ohio

### Jacks-and-Jills-of-All-Trades, Experts of Some: Pastoral, Diversity and Inclusion Skills Training for Ethics Consultants



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*The chairs were in a circle for the provider-family ethics consultation meeting. As just over a dozen participants found their chairs, something seemed off and my thoughts rambled to my first observation of a real ethics consult in my career.*

*Many years earlier, an attending physician had me observe a family-provider ethics consultation meeting. The patient was a woman in her thirties who was hit by a car while walking. Multiple opportunistic infections from advanced AIDS exacerbated her injuries. Providers wanted a meeting to break the news by suggesting palliative care rather than aggressive treatment to her sister, her statutory, default surrogate decision-maker. Three chairs were set up in the middle of a medium-sized room. The patient's sister arrived with the patient's two children, about seven-years-old and nine-years-old. All gingerly sat down. I was horrified as the attending left and came back with about twelve residents, all white with white lab coats, who proceeded to file in and stand, surrounding the seated, black family. On a smaller scale to the patient's family members, the rest was a worsening nightmare, from providers talking to, not with, family members to the children's widening eyes, welling with tears, as doctors younger than their mother made an unabridged disclosure, far too blunt for little ears.*

*Why was I thinking about a consult over a decade ago? The patient's situation in the prior consult bore no semblance to the then-current patient's situation. Introductions and the start of the current consult brought me back to reality. The patient's husband and children asked to have a second ethics consult with an expanded group after concerns about providers' advocacy of their, and the patient's, interests in the wake of the first ethics consultation. Were we assuming that her family members couldn't let her go, or did she want continuing, intensive measures, even up to the end of her life? She had been through tough situations before. Why was this time different? Discussion reached a crescendo. As voice volumes raised, the back-and-forth between care team and family members resembled a tennis volley – back-and-forth, back-and-forth.*

*Only then did it occur that the patient's family members, all black, were seated on one side of a huge circle. The caregiver and provider team, all white, were seated on the opposite side of the circle. Chairs in the circle were meant to create closeness, be therapeutic, and remove barriers such as tables. Yet the participants' seating choices made it an oppositional cross-examination. I couldn't find a place to call it out when...*

*Someone else did. A family member rightly called attention to the arrangement. Everyone mixed it up by switching seats.*

#### **Interdisciplinary Field's Inclusivity Blind Spots Equal Lost Training Opportunities**

Ethics consultants can profoundly benefit from having and integrating resources and tools from other disciplines. The field of bioethics is inherently interdisciplinary, assimilating knowledge from medicine, philosophy, law, theology, and more. For example, a key resource for ethics consultants is *Bioethics Mediation: A Guide to Shaping Shared Solutions*

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# President's Greetings

Welcome to the August BioQuarterly.

Having just prepared a kiddo to return to school, I am acutely aware that summer 2022 is almost in the rearview mirror! It seems as though we just finalized the Spring Issue of BioQuarterly and I know before I can blink it will be time to rake and roast marshmallows in the backyard.

Impacting the work we do, this summer has continued to present new developments politically and legally, as well as on-going evolution of global health crises. While BENO will continue to represent a neutral ground as an organization, we are available to support any local needs of our colleagues across Ohio who may be engaged with clinical ethics work.

In this issue, I trust that you will find value in contributions from our members and trustees. There is a general theme around communication, which we all know is often of central importance to ethics in the clinical setting. As always, please do let us know if there are particular topical areas of high value that you would like to see addressed in BioQuarterly.

Last, and certainly not least, I'd like to welcome (in some cases welcome back) those elected to the BENO Board of Trustees. You will find their names and affiliations in this edition.

My Best,

**Josh**



FOLLOW BENO ON:  

*Jacks-and-Jills* continued from page 1...

by Nancy Dubler and Carol Liebman. Their chapter on techniques for mediating bioethics disputes in the revised and expanded edition includes reality testing, reversing roles, allowing silence, and stroking,



These are basic counseling techniques, found in texts such as *Counseling Strategies and Interventions* by Sherry Cormier and Harold Hackney.<sup>1</sup>

Any endeavor, pursuit, or field has its blind spots or less-explored arenas. The bioethics field is not immune. Education, for instance, is a large part of healthcare ethics work, even suggested in influential sources.<sup>2</sup> Yet a dearth of scholarship exists around ethics stakeholder needs (beyond committee members and consultants), educational pedagogy, curricular design (education plans), evaluation and assessment within health care practice, with some notable exceptions around ethics content. Bioethics is a field of nuance and frequently challenges foundational assumptions and presumptions. Yet it lacks self-scrutiny. Its seeming blind deference to academia, including academic medical centers, reveals a commonly used fallacy. Being in or affiliated with higher education does not entail education being good. Nor do recommendations from academia have intentionality and skill with curricula, education, and assessment. Does bioethics uncritically accept this because so many other fields make the same mistake? What are the signs of trickle-down education: ethicists teaching what they were taught to ethics program leaders, ethics program leaders teaching the same to ethics program members, and so on? My experience in academia with multidisciplinary higher education programs, all of them stellar, leads me to assume that programs make a conscious choice in some cases to teach philosophical and justice theories, health

care systems, and ethics and the law. Less attention is paid to basic counseling skills, leadership, organizational and team dynamics, ethics and human behavior, social systems, and development (including family dynamics and systems).

Professionals develop skills on-the-job. Exposure to an ethics topic may only occur in a practice setting because professional curricula with ethics content are inconsistent among healthcare professional higher education programs. Still, having an experience without considering or processing emotions, sensitivities, motivations, or character (resilience) misses the mark.<sup>3</sup> Similarly, some professions and professionals are better than others for shepherding reflections as well as knowing what approaches work better than others. An illustration may assist. The national bioethics professional organization, the American Society for Bioethics and Humanities (ASBH), mentions knowing a clinical context with “awareness of the grieving process and psychological responses to illness” in *Core Competencies for Healthcare Ethics Consultation*, second edition. One can know Elizabeth Kubler-Ross’ stages of grief. There is a difference between knowing what to look for, seeing or recognizing, and experiencing someone going through them. Guidance about what to do or avoid in response is also different, requiring much more subject matter skills such as Mark Moran’s pastoral approaches to the stages outlined in the National Association of Catholic Chaplains (NACC) National Conference in 2013.

#### **Focusing On Prospects From Two Fields – Pastoral Care And Diversity And Inclusion**

Often overlooked fields and approaches include pastoral care skills and cultural sensitivity and competence with their approaches to health care disparities. Arguably, both could have helped the consults

mentioned above. Chaplains and care ministers should be adept at knowing where they are before entering a visit... or an ethics consult meeting in this case.

Emotional checks include:

*How do I feel today?*

*How do I feel about going on this visit today?*

*Do I have any strong feelings about something else that might preoccupy me today? <sup>4</sup>*

Ethics consultants may want to add or adapt questions:

*How might the case context or characteristics remind me of my emotions from similar cases?*

*How does this situation mimic illness narratives and family dynamics with my own friends and family members?*

*What are my feelings when someone already reminds me of an acquaintance?*

After an ethics presentation, a chaplain colleague and CHRISTUS Health pastoral care leader provided candid, and appreciated, feedback around active listening. He said to be careful of formulas – five strategies for..., ten tips to... – without practice and expert engagement. The devil is in the details and attempts to help can quickly become vapid, armchair “how-to” lists. Related to the former point, *appearing* to actively listen and *actual* active listening are lightyears apart. *Looking* present, interested, and engaged versus *being* present, interested, and engaged are sensitivities for chaplains, conceivably after repeatedly witnessing the former, *appearance only*, by healthcare professionals. He referred to a TEDx talk by Celeste Headlee titled “10 ways to have a better conversation” for teaching active listening, conversational competence, and respectful disagreement. At first, his suggestion seemed hypocritical. A list?! A formula??!! Doesn’t this violate the warning about being prescribed or methodical???! Maybe not. Headlee’s modes are for being and doing, not for appearance. Additionally, they are about setting parameters and boundaries rather than regimented prescriptions and methodological edicts.

An instance of this involves Headlee’s guidance for authentic listening and conversations. She advises entering every conversation as a continuous learner, assuming that you have something to learn and that you can set yourself aside, in the words of M. Scott Peck.<sup>5</sup> A skilled observer can follow a checklist, noticing an ethics consultant’s eye rolls followed by a vacuous stare, hear the sighs and snorts, and responses with a condescending tone. It

continued on page 5...

# Clinical Combat v. Courage: Meliorism in Medicine



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**In this brief piece, I will evaluate metaphors, especially as they are used in medicine. I will argue that warfare, military, and combat metaphors are problematic for both healthcare providers and patients. I will further suggest we restructure our orientations and obligations in healthcare such that we focus on meliorism achieved through the virtue of courage.**

## Metaphor

Metaphor is an aspect of language that is, arguably, unavoidable in human communication; it helps us understand our world. The history of metaphor can be traced to ancient Greece, when Aristotle defined metaphor as "Giving something a name that applies to something else"<sup>[1]</sup>, now recognized as the "substitution view" of metaphor. Millennia later, Max Black suggests that metaphors create and disclose reality, and "show" things as they actually are<sup>2</sup> now identified as the "constitutive view" of metaphor. In the 1980s, George Lakoff and Mark Johnson published the revolutionary book *Metaphors We Live By*<sup>[3]</sup> and introduced the conceptual view of metaphor; they argue that human concepts are inescapably metaphorical.

Lakoff and Johnson claim that many of our conceptual metaphors arise from our embodied experience. For example, consider the fact that human bodies have fronts and backs, most travel in forward and backward directions, and many move up and down. Our bodies are roughly like the bodies of persons with whom we communicate, and we generally possess the same kinds of sense organs and appendages. Thus, our understanding of time and knowledge, for example, is grounded in the way our bodies generally function and move. Consider metaphors for time such as "Let's move this meeting up," "You can't go back in time," and "Can we push this forward?" all of which are grounded in our bodily orientation and movement. When speaking about knowledge and communication, we might say something like "I see your point," or "I don't think you're hearing me," or "I've not yet grasped that concept." These metaphors, too, are grounded in our bodily experience and arise generally from sense perceptions and the usage of appendages.

## Metaphors in Medicine

Combat, warfare, and military metaphors (broadly construed) are common in our understanding of medicine, both in reference to the provider and the patient. Consider, for example, the following sentences: "That patient is a warrior," "This infection is attacking your kidneys," "The virus has invaded your body," "We will run a

battery of tests," and "Chemo is our best weapon." Any one of these metaphors might be heard in clinics and hospitals, and their usage is common enough that it is usually unremarkable.

The unremarkable nature of the metaphors does not mean they are not problematic, though. Jing-Bao Nie, et al.<sup>[4]</sup>, provide a summary of recent critiques. In terms of the patient's experience, military and warfare metaphors may contribute to a sense of failure—both mentally and physically—when treatments are not successful. Patients may also come to expect or request a constant barrage of more powerful "weapons" when ill. Both healthcare providers and patients may see the body as a "battleground" dissociated from the human being. These metaphors may also reinforce the power differential in provider-patient relationships, insofar as healthcare providers (especially physicians) are seen as "generals" while patients are "soldiers." Lastly, these metaphors can contribute to a feeling that dying is defeat when, of course, death cannot be conquered.

Combat metaphors also carry implications about medicine, broadly understood. Warfare is necessarily a violent endeavor, both literally and figuratively, suggesting medicine, too, will be destructive and violent. Some numbers of soldiers are expected to be wounded or killed in any war, and collateral damage is probable. This implies that we ought to assume some persons will be sacrificed for the larger goals in medicine, too. Importantly, warfare *only* ends when there is a decisive winner and loser. This differs from medicine, which is not a binary practice. We certainly do not think of either patients or providers as victors and the conquered.

We have employed a new set of combat metaphors in the wake of COVID-19, especially pertaining to healthcare providers. For example, consider the following: "Healthcare workers are on the front lines," "Healthcare providers have been redeployed outside their areas of specialization," "PPE is necessary armor," "Providers should combat their own compassion fatigue," and, more broadly, "We are mustering all of our forces against the disease." Again, these metaphors are most likely so commonplace that they go unnoticed. However, healthcare workers are no more soldiers than they are generals. They have neither been drafted nor have they enlisted in the military. Instead, healthcare providers have voluntarily chosen their professions, which they may change or leave at any time. Further, combat metaphors may increase the sense that individual doctors and nurses are responsible for "losing" patients. Death, however, is not an enemy that can be conquered.

*In terms of the patient's experience, military and warfare metaphors may contribute to a sense of failure—both mentally and physically—when treatments are not successful. Patients may also come to expect or request a constant barrage of more powerful "weapons" when ill.*



*Jacks-and-Jills* continued from page 3...

takes a specialist to meaningfully dialogue with the consultant after the consult about these behaviors and why they are occurring.

Another pastoral care skill is appreciating the toll that pain and illness take on the mind, body, and spirit.<sup>6</sup> This applies to family members and friends with the dimension of accompanying someone who is suffering. Other skills are knowing what not to say and do as well as what to say and do:

*People in pain don't need to hear: "It can't be that bad, can it?" "Don't worry, everything will work out." "I know what you are going through." "I had that operation once, too." "I've had a really bad day." ...*

*When working with people in pain, remember: Don't touch without permission. Don't lecture. Don't back away. Don't try to make it all better.<sup>7</sup>*

Yet another common pastoral skill is processing encounters for content, process, and feedback as well as emotionality. This merits further discussion within ethics.

Ethics colleagues express a range from moral distress and moral injury to burn-out, or nearly so, with the pandemic. Observationally, clinical ethics consultants have embodied the pandemic's stressors, whether first-hand or secondary to others' trauma; keeping in mind that many consultants are frontline health care professionals. The same ethics consultants may also facilitate moral distress and moral injury interventions. Possessing knowledge and assisting others in a topic does not make one more likely to embody the needed qualities (akin to "do as I say and not as I do").<sup>8</sup> Ethics consultants can use help processing. Chaplains have tools to help, such as the verbatim, a reflection format for after visits (consult meetings in our case), and processing, which may include journaling, making notes, taking quiet time, and spending time with family and friends.<sup>9</sup>

The following true story highlights the need for equity, diversity and inclusion training for ethics consultants:

*Susan Moore, the patient, said the white doctor at the hospital in suburban Indianapolis where she was being treated for Covid-19 had downplayed her complaints of pain. He told her that he felt uncomfortable giving her more narcotics, she said, and suggested that she would be discharged. "I was crushed," she said in a video posted to Facebook. "He made me feel like I was a drug addict." In her post, which*

*has since circulated widely on social media, she showed a command of complicated medical terminology and an intricate knowledge of treatment protocols as she detailed the ways in which she had advocated for herself with the medical staff. She knew what to ask for because she, too, was a medical doctor. But that was not enough to get her treatment and respect she said she deserved.*

*"I put forth and I maintain if I was white," she said in the video, "I wouldn't have to go through that." After Dr. Moore, 52, complained about her treatment, she received care that she said "adequately treated" her pain. She was eventually sent home, and on Sunday, just more than two weeks after posting the video, Dr. Moore died of complications from Covid-19, said her son, Henry Muhammed.<sup>10</sup>*

As a hypothetical, assume that Dr. Moore requested an ethics consult when she first experienced a care disparity. The on-call consultant would need recognition, skill, and comfort working with the patient and providers on this overt issue that is intensely uncomfortable to discuss.

Not all diversity and inclusion issues in ethics are as overt. Some are subtext within other discussions. Consider the patient who moved to the U.S., could not access appropriate healthcare, and then once accessed, the level of care appeared different from others. These narratives may not have occurred in the present setting, but they impact current perceptions and plans nonetheless. Physician ethicist Kelly Stuart's simple and helpful rubric is that less has always been less for people who have experienced health disparities.<sup>11</sup> In other words, clinicians and ethics consultants often express the view that less (invasive treatment) is more (better for the person).

Responding to overt or implicit care disparities in a consult is awkward. Such situations bear a remarkable resemblance to engaging patients around adverse events such as errors, especially for clinicians,

lawyers, and risk managers. Respecting autonomy through disclosure, addressing inequities, is balanced by organizational nonmaleficence, or the risk of institutional harm by addressing the disparity. Do ethics consultants have the tools and training to effectively navigate situations? What are the ways the organization helps consultants process their anxieties and fears around these tough topics? Professionals in Health Equity, Diversity and Inclusion (HEDI) have the skills and training to help.

### **Ethics Consultant Continuing Training at CHRISTUS Health**

Ethics consultants appreciate and invite periodic skills retraining, especially if consultants are the point person for only a couple to a half-dozen consultations per year or experience long intervals between consults. After reformatting initial ethics consultation training, a small planning team's attention went to skills retraining for consultants who have taken the initial training, which focuses mainly on process and basic skills. Two key questions emerged: Can content, methods, and skills from other fields and professions benefit CHRISTUS Health ethics consultants? Can involving experienced, talented professionals and leaders from those fields and professions benefit CHRISTUS Health ethics consultants by their involvement in ethics consultant training? The answer to both questions was yes.

Why does priority go to pastoral and diversity and inclusion skills when compared with other fields and their content and skills? The planning team considered when and how healthcare and ethics consultations can go wrong. A litmus test for technological and treatment appropriateness developed by a famous neurologist was employed in a different manner to sort issues. Anything inappropriate may be unnecessary, unsuccessful, unsafe, unkind, or unwise.<sup>12</sup> Consultants frequently deal with the unnecessary and the unsuccessful with advanced treatments and interventions. Issues about safety fall under the auspices of compliance and risk

*continued on page 6*





*Jacks-and-Jills* continued from page 5...

management, not ethics. Endorsed and authorized, technically and procedurally flawless patient treatments, and even ethics consults, can otherwise fail because someone is unkind. The mode of delivery and how it made the patient and family feel can range from dismissive to cruel. Bryan Jennett's definition of unwise involves justice, which is another area where healthcare delivery and ethics consults may fail. Dr. Martin Luther King inherently linked unwise and unkind in a press conference outside the second convention of the Medical Committee for Human Rights in 1966 with, "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman." Chaplains and HEDI professionals have unique skills and resources to bolster ethics responses to what is unkind and unwise.

A case in point encompasses a helpful way to respond in situations when a patient experiences care disparities. An approach resonating with HEDI professionals was introduced by Kelly Stuart during Awkward Moments in Ethics Consultation training in 2019 at a different organization. Namely, invite a patient or their family members to the table with something such as, "We know healthcare doesn't always meet everyone's needs. Please share any concerns if you have any. It helps us meet your needs better."<sup>13</sup> This short script addresses the needs of individuals while still being comfortable for the organization. The focus is on problem-solving for all stakeholders.

A mid-sized workgroup of chaplain leaders, HEDI professionals, and ethicists are currently designing the training; the same persons will be in the rollout. Involving human resources and the experts mentioned above in the training's construction and practice increases the chances of identifying and attending to root problems rather than masking their signs and symptoms. An observant PhD ethicist, for instance, could assess if training participants use the five r's of effective listening – repeating, restating, reflecting, responding, and respecting.<sup>14</sup> Seasoned chaplains, chaplain leaders, or clinical pastoral education (CPE) supervisors are more likely to evaluate the totality of active listening and learn why a consultant is not listening.

We are also leveraging the rarest of healthcare professionals, those who have expertise in two professions. CHRISTUS Health has an exemplary chaplain ethicist, Jeff Matsler, who was the only uniformed ethicist in the Department of Defense for around 15 years. Some HEDI professionals have experience with ethics, and are uniquely suited for this work. Social worker ethicists also have knowledge and experience with diversity and inclusion issues in addition to their ethics expertise. Those with feet in two professional worlds as experts are helpful guides for others with feet in a single professional world... or different professional worlds from the topics (ethics, pastoral care, diversity and inclusion). One of their gifts is insight into simple ways to avoid role confusion. Ethics consultants are unlikely to consider themselves as chaplains. They are more likely to want to know their limits around being pastoral when patient conversations venture into fear of rejection by God. How does a consultant accomplish a warm handoff to a chaplain while not losing ground or momentum in an ethics consultation? Dual experts are crucial for design and rollout.

The team looks forward to piloting and receiving participants' feedback for refining and improving this training. It is our hope to report back about this intervention's effectiveness. We also look forward to hearing about different cross-disciplinary and interdisciplinary ethics trainings that others develop.

*A similar article will likely appear as: Steven Squires, Andrea Thornton. "Jacks-and-Jills-of-All-Trades, Experts of Some: Process Skills Training for Ethics Programs." Health Care Ethics USA 30, no. 2 (2022).*

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COVID-19 has led to an increased association of healthcare workers with heroes. It is true that we have seen many heroic acts from many healthcare providers. Catriona Cox, though, suggests the ongoing and sustained association of physicians and nurses with heroes is problematic and even harmful<sup>5</sup>. In ethics, heroes are defined by their consistent supererogatory behavior. That is, healthcare workers are recognized as heroes because they behave in ways that surpass normal ethical obligation. We all are capable of these superhuman feats occasionally, and healthcare providers certainly do perform supererogatory acts at times. Few people are capable of this kind of behavior all the time; it's simply impossible. It's unfair to label healthcare workers as heroes when the title implies they *regularly* go above and beyond the ethical expectations of their field.

Healthcare providers who do wear the label of hero may have a disproportionately amplified sense of their *individual* responsibility for the successful treatment of patients. First, what counts as a positive outcome is not determined solely by the healthcare provider, nor can they successfully provide treatment in the absence of a team of healthcare providers, a stable and functioning healthcare system, the cooperation of the patient herself and a number of other factors including luck (or at least chance). When we equate our healthcare workers with heroes, it deemphasizes the obligations of others, including healthcare institutions and even the society at large.



### Medical Meliorism and Clinical Courage

I am not condemning all combat metaphors in medicine. Good patient-provider communication incorporates patient values, background, and context. Warfare metaphors may be helpful in some situations, such as when treating combat veterans. However, I am suggesting that we rethink medicine in terms of meliorism. Meliorism is the slow process of making things better without thinking we can make them perfect, since perfection is unattainable in any field insofar as humans are imperfect. Perfection is particularly unattainable in healthcare given our mortality. Meliorism does not easily support binary thinking, given that there are few clear "victories." The art and science of medicine is better framed through meliorism rather than militarism.

Virtue ethics, which is fundamentally about developing an ethical comportment and good character resulting in excellence and human flourishing, is compatible with a melioristic worldview insofar as virtue is a gradual and lifelong project. We must be taught what is virtuous, practice virtuous actions, and develop a habitually and consistently good character. Virtue is compatible with meliorism and parallels the practice of medicine.

Elsewhere<sup>6</sup> I have argued that the virtue of bravery has itself been militarized and that we should reorient at least some of our training in virtue toward courage. Specifically, I argue that courage as comportment has two components: first, one must recognize the interrelated suffering of all humans and second, one must respond to this suffering in a way that alleviates it in some way. In other words, courage requires both empathy and action. Virtuous behavior is always relative to the agent and so these criteria must necessarily, and perhaps frustratingly, remain vague. The way in

Healthcare providers who do wear the label of hero may have a disproportionately amplified sense of their individual responsibility for the successful treatment of patients.

which one empathizes and acts is determined contextually, within the given situation, and cannot be dictated from without.

Nonetheless, I argue that a conscious reorientation toward meliorism through training in virtue, and specifically courage, may be beneficial to both patients and healthcare providers by providing a more realistic vision of medicine. A framework in which improvement is possible, but absolute solutions are not, eschews binary thinking. Victories and losses are understood along a continuum, as is the quality of life and health itself.

Further, healthcare workers are not solely responsible for courageous acts. Patients, too, are charged with developing virtue and acting courageously. Perhaps more importantly, individuals who might not think themselves involved in healthcare must become empathetic and learn to respond with empathy. Thinking in terms of courage provides space to begin dialogues whereas predetermined mandates may serve to shut down discussion before it begins.

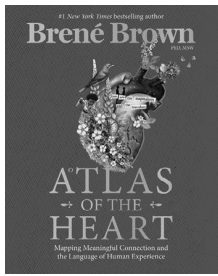
Courage may also undermine the enemy/ally binary implied by warfare metaphors. In the pandemic, persons who willfully refused to mask or vaccinate were one of the sources (along with limited supplies, unrealistic expectations, and other factors) of compassion fatigue and moral distress among healthcare providers. These unvaccinated persons were rightly seen as directly, causally connected to the spread of the pandemic, but we need not necessarily think of them as enemies who must themselves be defeated. We might also view these suffering individuals empathetically. I am not suggesting that healthcare workers are currently unempathetic, and I am not naively suggesting an appropriate response would be simple or straightforward. Nonetheless, an intentional re-orientation is a worthy goal.

### Conclusion

I have not universally condemned the usage of combat metaphors in medicine although I have critiqued them and argued that we should explore additional meaning-making conceptual frameworks in medicine. Medical practice cannot be reduced to binary narratives of victory and defeat or allies and enemies. Further, it is unfair to expect healthcare providers to heroically shoulder the burden of healing and wellbeing, and it is impossible to think of public health without the participation of society. I've offered meliorism as an alternative conceptual framework and shown that it may provide a more realistic understanding of healthcare. Lastly, I've suggested the virtue of courage is a means to meliorism. Via courage, we may lessen the compassion fatigue and moral distress of healthcare providers, ease the angst and emotional weariness of patients while reemphasizing their active role in medicine, and motivate others (individuals, communities, institutions, governments) to recognize their role in healthcare.

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# BOOK REVIEW

## Atlas of the Heart Brené Brown, PhD, MSW

Reviewed by *Kathy Grannan, RN, MSN, CNL*

**H**ealth care professionals navigate a sea of emotions in everyday patient care. Ethical decision making requires insight into the human heart as well as communication skills that assist all parties involved to navigate that sea. Brené Brown has spent two decades researching the human experience and its impact on who we are and how we communicate. Working with professionals from a variety of disciplines, she has examined a variety of human experiences and the impact they have on human emotions, thoughts and actions. *Atlas of the Heart* presents Brown's framework for understanding each of the experiences, the impact they have on human interaction, and the language we use to communicate about these experiences. In her words, "Language is our portal to meaning-making, connection, healing, learning, and self-awareness." (p. xxi). Building on the work of Harvard psychologist Susan David, Brown argues that learning more nuanced emotional vocabulary leads to greater emotional regulation and psychological wellbeing amid the ups and downs of life.

Brown categorizes 87 emotions and experiences into 13 categories based on the way we interpret the experience. Examples include: "Places we go when we compare", "Places we go when we fall short", "Places we go when we search for connection", and "Places we go when we feel wronged". In each chapter, the impact is discussed from a variety of perspectives, including our biology, biography, behavior, and our own "back story". (p. xxix). This "mapping" allows the reader to understand their emotional responses in a way that gets to the heart of the matter. Brown asserts that investing in this internal "connectedness" allows us to form more meaningful connections with others and grounds us throughout life.

Brown openly admits that no single theory of emotion and human experience will be relevant to all people or all scenarios. She has structured this book well to acknowledge that point and diversify opinion. In each of the 13 categories, Brown uses a combination of research, data, art, storytelling, and philosophy to examine each experience in depth. As an example, the chapter "Places we go when we are hurting" reviews the experiences of anguish, hopelessness, despair, sadness and grief. The discussion differentiates these experiences, what leads to them, and possible ways to cultivate a practice of hope. This chapter is particularly enhanced by the inclusion of a photo of a gripping sculpture piece called *Dark Elegy*, born out of the grief when 270 people were victims of a terrorist plane crash in Lockerbie, Scotland. Art examples in many of her emotion categories broaden the readers' perspective on the experience.

Brown approaches in several chapters our desire for human relationships, asserting that humans are not meant to be lonely or independent but need each other to survive. In her chapter on "Places we go with others: Compassion and Empathy" Brown differentiates compassion from different types of empathy. She describes compassion as the practiced art of being with other people in their pain, of "sitting in the dark" with them as an act of shared humanity allowing for human connection. She differentiates this from empathy, or the skill of understanding another person's pain, through recalling a similar experience or experiencing the pain with them.

This book is well organized, well written and provides a compilation of emotion research that can enhance any health care professional's insight into their own journey as well as the journeys of their patients. Brown's ability to tell a story and then bring to light the variety of dynamics in that situation makes the read engaging and, at once, both personal and professional. Her inclusion of a variety of professions and their research data, a variety of artists and their portrayal of human experience, and true stories from everyday life make the study of this topic a memorable experience. *Atlas of the Heart* is perhaps even better in its audiobook format, which Brown herself narrates in an often delightfully conversational manner. Whether in print or audio, I recommend this book to all health care professionals of all disciplines; Brown's work is not merely a map, but itself a journey worth taking.

## CONGRATULATIONS TO OUR NEWEST BENO BOARD MEMBERS:

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**Christina Namakydoost, MA** - Director of Mission for Mercy Health Fairfield Hospital

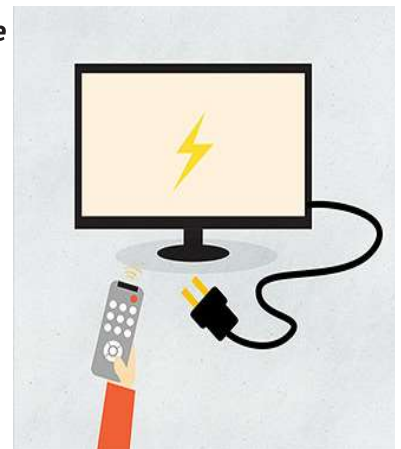
**Keren Tanguay, HEC-C** - Director of Clinical Ethics at Kettering Health

## STAYING ON AS TREASURER:

**Amy Patterson, RN, MA** - Nursing Professional Development Specialist at University Hospitals Cleveland

## HUMOR

*A man and his wife are sitting in their family room. He says to her, "Just so you know, I never want to live in a vegetative state dependent on some machine. If that ever happens, just pull the plug." His wife gets up from her chair and unplugs the T.V.*



## MEMBER SPOTLIGHT



Meet Cristie Horsburgh, JD. At the Cleveland Clinic, she fulfills many roles: Staff Clinical Ethicist; Co-Director, Cleveland Fellowship in Advanced Bioethics; Associate Director, Nursing Ethics Program (NurseE); Associate Director, Clinical Ethics Immersion Program (CLEIP); Regional Bioethicist (East); Center for Bioethics. Cristie has been a BENO member for 9 years.

### What is the proudest moment in your career so far?

I'd have to say the work and work products my colleagues in the Center for Bioethics and I produced early in the pandemic. We were able to work as a team to develop and put out a lot of materials, innovate services and contribute to organizational needs in a short period of time. However, it may be that my biggest professional achievement is still ahead of me!

### What was your professional pathway to becoming an Ethicist?

Author Lurlene McDaniel wrote several novels centered on teens with cancer. Reading about the impact illness had on the protagonist's lives and the decisions that they had to make taught me that I wanted to help those impacted by illness in some way. My first healthcare ethics course in undergraduate studies sparked my interest in the ethical dimensions of care, so I pivoted my major to focus on bioethics and healthcare ethics. I subsequently went to law school, focusing my coursework on health law and bioethics. I thought I would pursue legal academia but found it to be a bit removed from the type of direct impact I desired. At the same time, I found and was accepted to the Cleveland Fellowship in Advanced Bioethics. During my fellowship, I received training in clinical ethics consultation and was hooked. I have been doing clinical ethics work ever since then.

### Current initiatives / committees you serve on and why these are meaningful to you:

Because I have several to choose from, I'll just highlight a few initiatives. One of the larger initiatives I am working on with my colleagues in the Center for Bioethics is a new program structure to engage healthcare professionals and the community in ethics work. It has two components: (1) a development pathway for healthcare professionals with an interest and passion for ethics that includes structured curriculum/education and clearly identified opportunities/roles that can be integrated into their primary job roles and (2) a community-facing body that is comprised of individuals from the communities that our organization serves to inform ethics work within the organization and also take education and support back out to the community. Both of these programs have been in development for some time and we have recently launched them. I'm excited for them to progress and think they have a lot of potential to make a large impact in expanding ethics knowledge and enhancing meaningful engagement with the organization.

Another group of initiatives is supporting healthcare professionals experiencing moral distress. With my colleagues Georgina Morley and Laura Longbrake, a few years ago we developed Moral Distress Reflective Debriefs, giving healthcare professionals a safe moral space in which to reflect on ethically challenging cases and how those cases impacted them as individuals and professionals. We are improving the post debrief process and creating a facilitator training course within our organization. I've also been working with Georgina Morley and Lauren Sankary on elucidating how ethics consultation supports healthcare professionals experiencing moral distress.

Helping patients and families is of central importance to my work and what drew me to clinical ethics. The initiatives above though are meaningful to me because they support healthcare professionals throughout their career. I did not fully appreciate how emotionally and mentally challenging healthcare is as a profession until I was in the thick of it myself. These initiatives give me the opportunity to use my expertise and experience to support healthcare professionals, help them navigate challenges and ultimately improve patient care.

### Something about you! What would your perfect day outside work look like?

As a mother of three young children, I am often a bit sleep deprived. A perfect day off would begin with sleeping in! My day would be partly quiet and partly chaotic with beautiful 75 degree weather – sunny, no humidity, as weather often sets the tone for my day. I would start with coffee outside on the deck, then make the kids breakfast before heading out to a family friendly activity like the zoo or pool. Then my husband and I would drop the kids off for a sleepover at Grandma's and enjoy a quiet evening at home. We might take a walk with the dog, get takeout for dinner, and watch a movie (during which I'd promptly fall asleep). If you had asked me 10 years ago, my answer would have been very different!

## UPCOMING EDUCATIONAL OPPORTUNITIES

### 1. Catholic Medical Association: 91st Annual Educational Conference:

*Searching for the Truth: Medicine, Morality, and the Media*

September 8-10, 2022 | Denver, Colorado

Link to register:

<https://www.cathmed.org/events/annual-educational-conference/>

### 2. The Ruth Frost Parker Center for Abundant Aging annual conference: (Pro) Longevity: The Convergence of Ethics, Tech, and Spiritualist.

Keynote: Dr. Tracy Trothen; BENO board member Craig Dove a panelist.

Friday, September 30<sup>th</sup> | 9:30 a.m. – 3:00 p.m.

Live in Columbus with a virtual option.

Link to register:

<https://www.unitedchurchhomes.org/2022-annual-symposium/>

### 3. ASBH conference: A Critical Moment in Bioethics: a Virtual Event

*A report calls on the field of bioethics to take the lead in efforts to remedy racial injustice and health inequities in the United States. Join the editors of the report, "A Critical Moment in Bioethics: Reckoning with Anti-Black Racism Through Intergenerational Dialogue."*

October 28 | 12:45 pm – 1:45 pm EDT | Hastings Center, Portland Oregon  
Link to register:

<https://www.thehastingscenter.org/hastings-center-event/a-critical-moment-in-bioethics/>

### 4. Clinical Ethics Immersion Program: Cleveland Clinic March 17-19, 2023

Cleveland Clinic's Clinical Ethics Immersion Program (CLEIP): a three-day preparatory intensive course and a two - or three - week clinical ethics immersion customized to meet participants' individual needs and interest.

Link to register:

<https://my.clevelandclinic.org/departments/patient-experience/depts/bioethics/bioethics/cleip>

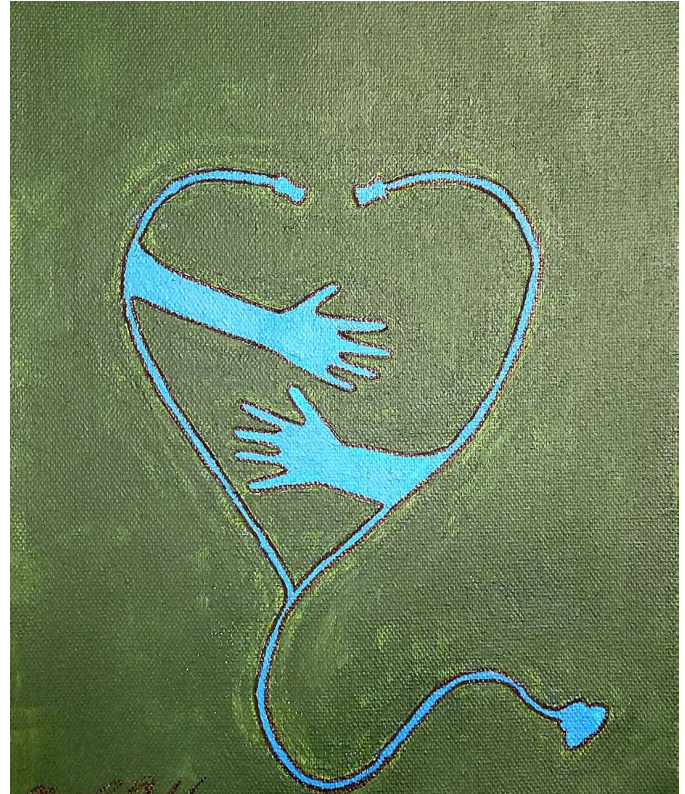
## ART SPOTLIGHT

### 100mg Hug BID PRN

waves of greek letters erode morale  
and transform hospital hallways into trenches,  
exhaustion seeps into the bones of healthcare workers  
whose limbs feel heavy  
under the suffocating gravity of responsibility and frustration.  
what happens to grief deferred?  
is there a motrin for emotions?

two colleagues recognize the dark clouds  
in each other's eyes.  
without words, they invest a precious moment  
in the stock of human contact  
by embracing each other.  
a double espresso shot of endorphins  
flow through their weary bodies and minds.  
chronically tense muscles slightly soften  
the percussive tempo of their hearts decreases  
and small sighs of relief escape their lungs.

the intimacy of closeness  
gently reminds them that they are not alone  
and for a few heart beats;  
lub-dub  
lub-dub  
the relentless tide of burnout subsides.



*Michael Arnold is a DO and a current PGY-2 (second year resident) at Akron General Center for Family Medicine.*