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UNEASY ALLIANCE:

Pediatric Shared Decision-Making and Maltreatment

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Introduction

Pediatric medical decision-making (PDM) entails a therapeutic alliance of minor patient, guardian(s), and provider(s) operating within a complex environment. Morally and legally, minors are regarded as a vulnerable population, obligating others to protect their interests and well-being. Their parent(s) or guardian(s) are generally held to be the party best suited to make decisions on their behalf. [1] Such beliefs are reflected in the United States' legal system and societal norms, which afford guardians wide latitude and discretion in making medical decisions regarding their minor children. [2] Not surprisingly, these beliefs are challenged when there exists potential or confirmed maltreatment by those same guardians. While legal precedent regarding medical decision-making in cases of severe abuse is well established, there are many instances in which maltreatment is either not confirmed or does not clearly cross the threshold to justify state intervention. Even when maltreatment is reported and substantiated, guardians often retain medical decision-making rights. This creates a unique ethical conundrum for providers. The possibility of guardians that are both decision makers and potential causes of injury for a minor patient fundamentally challenges

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Bioethics Network of Ohio
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ANNIVERSARY
Serving Ohio Healthcare Ethics

President's Greetings

Happy Fall!

It's dreary this morning as I write this letter, but today's weather belies the generally beautiful fall we've had in Ohio. It is my favorite time of year, even if also the busiest—wrapping up the year's projects and anticipating new ones at work, enjoying time outside, and celebrating family through the holiday season. I wish you well at this time of year.

BENO has been busy as well. Our educational series has continued with a talk by former BENO Board Vice President Alan Murphy, PhD on DNR-related laws and issues in Ohio. The first two sessions have been very well attended and we've heard that folks are finding the content valuable to their work, whether viewing live or later through the recording available to BENO members (individual, institutional, and system). Planning continues for quarterly sessions in 2024. We're endeavoring to provide meaningful, high-level sessions that provide relevant content to folks engaged in clinical ethics work across Ohio.

Speaking about recordings on the website, did you know that sessions from the 2023 BENO Annual Conference are also available for those who attended the conference? It is our hope that attendees who wish to use the content for educational purposes within their home institutions will continue to make use of this resource.

Planning has begun for the 2024 BENO Annual Conference. The conference will again be virtual and held over two days, April 18-19th (likely an afternoon and morning). This year's conference theme centers on end-of-life issues across the lifespan. More details to come, but save the date on your calendar!

Thank you all for your continued support of BENO. I hope you all have a wonderful fall, happy holidays, and fantastic new year.

My Best,

Josh

FOLLOW BENO ON:

***Alliance** continued from page 1...*

the conventional, best interests-based pediatric decision-making model.

Unfortunately, maltreatment is neither an uncommon nor insignificant threat to health and is one most pediatric healthcare professionals will encounter at some point. Most providers are well-informed of their legal and moral obligations to identify and report maltreatment. However, maltreatment can be difficult to define concretely, presenting a challenge for pediatric providers when it does not clearly cross a threshold for reporting or intervention. Additionally, many laws and objectives of child protective organizations aim at a long-term goal of familial unity and guardians who are accused of maltreatment typically retain their legal custody and rights until they are terminated through a formal, often lengthy, legal process. [3, 4] Thus, providers are forced into the precarious position of navigating an uneasy alliance where they must balance the rights and authority of guardians against their fiduciary duty to their minor patient and their own values without the mutual trust often considered essential to shared decision-making.

> **"The possibility of guardians that are both decision makers and potential causes of injury for a minor patient fundamentally challenges the conventional, best interests-based pediatric decision-making model."**

Ethical and Procedural Challenges
The literature concerning ethical considerations of pediatric medical decision-making is extensive, but it is less robust as it relates to maltreatment that is unconfirmed or falls below interventional thresholds. Most medical institutions have guidelines and procedures for recognizing and reporting maltreatment in accordance with legal requirements. Yet, such guidance may be insufficient as providers seek to maintain the therapeutic alliance and may fail to resolve feelings of moral uncertainty or distress. Early identification of maltreatment reduces morbidity and mortality, [5] making the role of the provider essential. Thus, the persistence of ethical and procedural barriers that impact their work must be addressed.

Uncertainty and Systemic Bias
Mandated reporting laws require providers to report cases if they have reasonable cause to believe that maltreatment has occurred, but do not require a preponderance of evidence. [6] While this standard is beneficial, it may lead providers to underreport suspected maltreatment because of uncertainty or to disproportionately report certain populations. Providers are more likely to report injuries on children from lower socio-economic families, families belonging to minority groups, families with whom they do not have a previous relationship, or families where the mother appears to be the cause of injury. [7] This is compounded by the fact that persons with limited access to health care are more likely to utilize emergency departments for primary care, resulting in a higher frequency of interactions with less continuity of care. [7] Certain features are often strong indicators of maltreatment, including pattern injuries, delay in seeking care, and lack of adequate explanations. [8] However, there are several other explanations for such signs, including lack of access, finances, or mistrust. Likewise, suspicions based on parental concern, or lack thereof, for the welfare of their child is susceptible to bias rooted in communication differences. [9, 10]

Institutional Barriers
Providers are also placed under several institutional limitations that may negatively impact their judgement, like time constraints. Medical records may provide the context and documentation necessary to establish a pattern of concern, but providers may be reluctant to record suspicions because of the possibility their notes might be copied and pasted without verification or context. [11] This makes both instances of maltreatment and bias harder to identify. The concern is even more relevant given recent legislation like the 21 st Century CURES Act, which provides patients quicker and expanded access to their records.

Providers may also underreport cases because of uncertainty, the possible harmful effects on a family, lack of knowledge about reporting procedures, and fear or anxiety about going through court proceedings or the effect on their career. [12] In particular, providers may hesitate to report knowing they may cause irreparable damage to the therapeutic alliance by prematurely reporting a family who later turns out not to have committed intentional maltreatment, especially if they have an established relationship with the minor and their family. Reassurance of legal protections for providers who report in good faith or other technical information may not be enough to mitigate these fears, especially if providers do not have adequate support from colleagues or the institution.

Collection and Use of Information
Maltreatment also presents unique ethical challenges related to the collection, use, disclosure, and protection of information. Early identification of child maltreatment victims or at-risk minors and subsequent enrollment in intervention programs benefits them by ensuring short-term safety and reducing long-term morbidity and distress. However, if the maltreatment is not overt or severe, diagnosing it may require collecting large amounts of personal information from the patient, guardians, and other relevant individuals. [13] Upon reasonable suspicion of maltreatment, personal medical information is reported to CPS and may become part of court proceedings. If the evidence substantiates maltreatment and leads to intervention, it generally outweighs the detrimental effects of using and disclosing personal medical information. However, in cases where allegations are not substantiated, or where concern is identified but children remain in the custody of their guardians, the question must be asked whether the minor's privacy has been violated without proportional benefit. This may be less of a concern to younger children than to adolescents who may object to the release of information but cannot prevent it.

Guardian/Parental Fitness
Both legal precedent and moral discourse confirm that parental rights are never absolute and are always interpreted in light of their custodial responsibilities and the rights of their minor charges. [1] Guardians are not required to be objective or altruistic decision makers, but they are generally assumed to be able to balance their interests and their children's. In cases of suspected maltreatment, the guardians' fitness to act as surrogates becomes controversial. Not only is the fundamental idea of the guardian as a protector of child interests undermined, but accusations of maltreatment challenge shared decision-making. In more egregious circumstances, parental decisions are made in the shadow of the knowledge that charges against them may be dependent on the medical outcome of their child. [14] Even in less severe cases, the potential of legal action may inflame conversations between guardians and the care team, potentially resulting in concerns about guardians inappropriately weighting their interests at the expense of the minor, resisting provider recommendations, or being unable to make substantial changes due to environmental or other constraints. Even if maltreatment has been accurately noted and reported, and providers are involved with other surrogates in addition to or instead of the guardians, the length of most legal processes may challenge expeditious decision-making. [15] Such ar-

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rangements may cause moral distress in providers who feel they are required to comply with the decisions of guardians who do not have their child's best interests in mind in the interim.

A Four-Point Response

Suspicion or confirmation of maltreatment below the threshold of critical injury may not substantially change obligations regarding care, yet it nevertheless disrupts the standard order of operations. However, too much of a focus on thresholds for harm or determination of intent may be counterproductive. Providers do not necessarily need increased standardization or more education on identifying maltreatment. They need ethical guidance and support to navigate the therapeutic alliance in the context of maltreatment. Four suggestions may be helpful.

A Holistic Understanding of Best Interests

The best interests standard serves as the accepted model for pediatric medical decision-making and is, for many, a theoretically appealing approach. Some have noted, however, that the best interests standard should be viewed more broadly as providing a foundation for active and collaborative efforts to improve minor well-being wherever it falls on the spectrum. All individuals experience well-being in the context of their relationships, roles, and situations. [16] Minors are generally highly dependent on the support network provided by their family. Thus, the most appropriate decision-making model includes a holistic conception of best interests that understands the minor as both part of, and independent from, their current position in the therapeutic alliance.

Compassionate, Comprehensive Information

Discussions to determine a minor's best interests must be based on accurate, comprehensive information that facilitates fully informed decision-making. However, healthcare professionals may be tempted to withhold information or run tests without informing guardians of their true purpose in order to confirm maltreatment. Such deception, even if well-intentioned, undermines parental authority and the patient's developing autonomy. In addition, withholding information and deception are generally difficult to maintain successfully in an acute environment given the number of healthcare professionals involved.

When potential maltreatment has not reached the threshold of justified state intervention and there is no court order, provider obligations of adequate disclosure and consent do not change, regardless of perceived parental fitness or culpability, and especially if tests are not medically indicated beyond confirming the potential of maltreatment. [11] Providers should also inform guardians that they are required by law to report suspicions of maltreatment and tell them on what basis they are making a report if they choose to do so. [11] Guardians should be given the opportunity to have results and interpretations explained to them, provide explanations or clarification, ask questions, and raise concerns. Guardians should also have access to any reports filed and should have recourse for appealing or requesting further review by an ethics committee or independent examiner.

Transparency is equally important for the minor patient. Not only does this recognize the rights of the minor, but it also lays the foundation for a long-term therapeutic relationship beyond childhood. [11] Minors should be given an accurate, age-appropriate diagnosis and assessment of their health. If the team believes an assessment's accuracy would be undermined by full disclosure, they should still explain the general purpose of the exam(s) and any risks/benefits. In addition, accommodations should be made for minors who express concerns or refuse testing, [4] including temporary stays or reasonable alternatives, even if the result may be less valuable than the originally proposed test.

> **Providers do not necessarily need increased standardization or more education on identifying maltreatment. They need ethical guidance and support to navigate the therapeutic alliance in the context of maltreatment.**

Family-Centered Care

Though the provider's fiduciary duty is to the minor and the minor's health is most at risk, a family-centered approach accounts for the benefits gained from remaining part of a family. Most current child maltreatment response models support family maintenance and reunification, and providers are only a few of the entities who may interact with the minor overall. As with many health interventions, the beneficial impact is arguably increased when individual elements work in a manner that is consistent and compatible with other existing infrastructures and procedures. Providers should therefore avoid unilateral decisions, support guardians as the legal decision makers by providing education and access to resources and strive to elicit and accommodate genuinely held beliefs. Providers should also strongly consider delegating tasks related to maltreatment to specialists, not only because of their expertise but also because such specialists may also be able to help facilitate and/or navigate initial conversations with guardians about requirements related to reporting to CPS and the likelihood of their situation resulting in that outcome. [17] Of course, these strategies must always be subordinate to the commitment to the minor's well-being. The maintenance of a therapeutic alliance for the well-being of the minor loses its fundamental purpose if the minor's interests are sacrificed for the sake of the relationship. [18]

Institutional Pathways

Providers and institutions are required to comply with legal reporting requirements but should also commit to maximizing benefits for those who enter the child protection system and addressing situations which are concerning but do not meet reporting thresholds. Reporting is obviously appropriate for cases of clear maltreatment. However, there is a wide continuum of quality in parental care and decision-making, and providers do not have the discretion to only care for patients with "good" parents. The best answer is not necessarily increasing reporting frequency. An increase in referrals may overload the system and result in delays for minors for whom a lack of intervention may result in significant harm. Moreover, it is not clear that additional involvement by CPS would result in better care for the minors, especially when balanced against the potential for systemic bias or the difficulty many fami-

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lies face after being reported. A better solution is to implement or expand institutional pathways that provide time, space, and support for providers to discuss concerns, as well as resources to help them as they engage with families. Such pathways may facilitate more effective early intervention, maintain therapeutic alliances, protect families against overreporting due to bias, and reduce distress in providers. A robust and well-integrated ethics service can also provide key institutional support to facilitate effective PDM by ensuring appropriate stakeholder involvement, including the most relevant information, offering expertise on the moral supportability of options, and facilitating discussions.

Conclusion

Maltreatment threatens the conventional decision-making model for minors because it challenges guardians' traditional role as surrogates acting in their minor child's best interests. While there are moral and legal precedents in cases of egregious abuse, there is a vast realm between good parenting, inadequate parenting, maltreatment, and severe abuse. Ultimately, preserving the therapeutic alliance should be the primary operational and ethical goal even in cases of suspected or known maltreatment insofar as it is used to fulfill the commitment to the minor patient's well-being and protection of their potential for expression of their core rights.

ART SPOTLIGHT

Jean-François Millet, "Autumn Landscape with a Flock of Turkeys," 1872-1873. Metropolitan Museum of Art.
https://www.metmuseum.org/art/collection/search/437094

With the recent end of daylight savings time, 5 p.m. commuters accustomed to having plenty of daylight left for their drives suddenly find themselves emerging from work into dusk. Familiar routes seem strange in the failing light as fall passes into winter. Jean-François Millet's "Autumn Landscape" reflects this weird autumn light and compounds it with tricks of perspective, positioning several turkeys beside a distant structure on a hazy horizon so that the turkeys seem improbably large. The figure has its back to the viewer, a dark outline against a darkening sky, just as are the leafless tree and the hay stack. Millet renders a stark, almost sinister image in autumn's creeping darkness. What's good for ethics would be terrible for Millet's art: with clearer perspective and brighter light, this is just a bunch of turkeys on a hill. But as we wind our way through autumn, I hope we can appreciate the season's visual reminders of how much difference healthcare ethics can make when it can shed even a little more light or shift perspective, however subtly.

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What's in a Name?
Revisiting the "Network" Aspect of the Bioethics Network of Ohio

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At a recent BENO Board of Trustees meeting, there was discussion about the reasons each member sought election to the board and whether we had known much about each other and our work prior to serving together. It became very apparent that, with a few exceptions of having read each other's publications or otherwise being generally aware of areas of scholarship, board members had not known much about the realities of each other's day-to-day experiences working in different healthcare systems, settings, and geographic locations around the state. Unanimously, everyone indicated that they had personally benefitted from being associated with BENO and had a desire to continue the organization's history of supporting clinical ethics in Ohio. The dialogue traversed topics including our most impactful experiences engaging in various forms of professional networking, how we individually have benefited from our shared work as BENO trustees, and, most importantly, how BENO might increase its impact by connecting its members to each other.

The idea of "networking" is certainly not new, of course, and it is likely that each healthcare professional associated with BENO has engaged in some form of networking—whether intentionally or as part of the natural interactions we have all had with colleagues in the workplace. These interactions would occur with or without BENO; what is less clear is how to create new opportunities (and further support existing ones) that are responsive to local needs of members, **within the unique context of a state-wide network.** The kind of work associated with clinical ethics is rigorous and can sometimes be isolating within a single hospital or health system. Some resources are available at the national level through professional organizations such as ASBH, but these may not provide the type of additional information, access to best practices, and solidarity that are most needed or relevant to do the work at hand locally.

I have had the good fortune, personally, both to contribute to and benefit from various forms of networking throughout my career. Whether a new connection through a mutual colleague that leads to years of collaborative scholarship and writing, gaining access to projects outside my immediate work environment, receiving advice from a community of more experienced clinical ethicists, or just checking in with others about shared patients in a geographical region, the increased connectivity created by recognizing or being shown overlapping concerns, areas of interest, and challenges has been indispensable to my growth as a professional and to my ability to do my job better.

Networking, in one form or another, has always been part of BENO's mission to serve as an educational resource and forum for bringing people together who are working in clinical ethics across Ohio. BENO's long-standing commitment to providing clinical ethics-related education has included opportunities to learn skills associated with engaging in clinical ethics consultation and, of course, themed plenaries and break-out sessions at the BENO Annual Conference. When held in person, the Annual Conference was also the primary outlet for individuals to meet and share aspects of their day-to-day experiences during refreshment breaks and over lunch, as well as providing an opportunity for a BENO business meeting—effectively a "state-of-the-organization" discussion between the board and BENO members.

Through long-standing collaboration with Ohio legislature, BENO is a required contributor to revisions of Ohio legal code regarding Do-Not-Resuscitate orders. The BioQuarterly has served both educational and networking purposes by sharing content of interest to BENO members throughout the year. Finally, BENO has had a web presence for many years, providing access to past issues of BioQuarterly, links to various ethics-related resources, and, more recently, recordings of conference and education sessions.

These examples are core to what BENO aims to achieve but may have remained static for many years or been lost altogether. Looking ahead, Board members have begun to think about how current resources can be enhanced and where there is opportunity to innovate exciting new ways to bring members together. BENO will continue to provide high-quality education through the Annual Conference and the newly reinvigorated education series. Board members are currently working with our website service providers to create an updated and more accessible web presence that contains a much broader collection of relevant information. It is our hope that over the next few years benoethics.org will become a go-to resource for content that enhances the work of those engaged in clinical ethics throughout the state. We are also committed to connecting members to each other. Many of you may be familiar with current (inter)national clinical ethics listservs (e.g., the ASBH Clinical Ethics Consultation Affinity Group), which are very active for both academic discussion and peer input on specific consult-related questions or organizational ethics issues. A similar listserv for BENO members will be launched in early 2024. Recognizing the value of in-person connection, early planning has begun within the Board to create opportunities for BENO members in relatively close regional proximity to meet others engaged in the work of clinical ethics. We anticipate new professional collaborations and increased insight as an organization into what matters most as folks share work experiences and engage in discussions following education sessions.

Still, there are stones yet unturned. Over the next couple of months, the Board of Trustees will be sending a survey to BENO members to understand better what the organization can do to increase the impact of the amazing diversity of experiences and wealth of knowledge represented by everyone associated with BENO. True to its name, the Bioethics **Network** of Ohio will continue to thrive because of its various nodes of connectedness—individual members, healthcare institutions and systems, and related organizations. Together, we will form new partnerships, innovate creative ways to bring members together, and find under-utilized avenues to better share best practices to improve the quality of services provided by those engaged in clinical ethics work within the state.

EDITORIAL

Bioethics Organizations Can Be Leaders in Facilitating Networking for Clinical Bioethics Fellows

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Acknowledgment: Thank you to the current and past fellows who were willing to share their experiences for this article. Any comments are intentionally presented in the anonymized aggregate and/or integrated into the overall argument. The author takes responsibility for the interpretation of the comments and any stances taken in this article.

As the field of bioethics continues to mature and expand, so does the trend towards professionalization. As Wayne Shelton and Bruce White note, the complex nature of clinical ethics consults requires advanced skills and content expertise. [1] Unqualified individuals may (and likely will) cause direct harm to patients and families, [2, p. 3] violating well-established principles of medical and professional ethics as well as undermining trust in the healthcare system. Thus, education and training are essential for clinical bioethicists and individuals who intend to serve in ethics roles within their institution or system.

The field's acknowledgement of this is evident in the increase in bioethics degrees and fellowships, the publication of the ASBH's *Core Competencies for Healthcare Ethics Consultation*, and the establishment of the Healthcare Ethics Consultant-Certified (HEC-C) credential. Fellowships provide an opportunity for advanced training, protected space for research and scholarship, and targeted mentorship, all of which facilitate professional maturation and attainment of competency. Currently, clinical bioethics fellowships vary widely in their pedagogical approaches, structures, cohort size, institutional support, and opportunities, among other things. Naturally, it raises the question if the wide variability among the bioethics fellowships undermines their value or increases it. [3] At the moment, bioethics fellowships are not accredited, though work is underway to identify and assess the features of programs to inform if pursuing accreditation would be feasible or desirable. Despite the ongoing conversations about the most effective ways to ensure that aspiring ethicists have the competencies outlined by ASBH, fellowship program directors, educators, and coordinators clearly demonstrate a commitment to ensuring that their programs adequately prepare trainees to enter the field and meet the expectations of their future employers and the patients/families they serve.

Networking as an Opportunity for Improvement

One skill that is adjacent to ethics-specific competencies and yet essential to the effective practice of an ethicist or ethics leader is networking. This is well-stated by Paula Chidwick and colleagues: "Clinical ethicists cannot work in isolation and need the support of a network of colleagues both within and outside the field of ethics, especially when confronted with complex or unusual cases in new and emerging areas." [4] A recent comment by Bioethics Network of Ohio (BENO) President Josh Crites excellently encapsulated networking as not only the deliberate conversations sought at conferences, but more broadly as "meaningful engagement with people who are doing the work you are doing." Empirical and literature support is underdeveloped, but identification as part of and participation in a professional community that facilitates a sense of belonging might not only improve individuals' practice, but also help their resiliency in an emotionally and morally taxing environment and encourage retention in the field.

Networking is not only essential for those already in the field, but also for those who are training to enter it. Fellowships are an opportunity not only for advanced training, but also for professional maturation. Networking is a key component of this professional growth, and one that training programs in general have not always facilitated as intentionally or systematically as other aspects of their programs. [5] That said, networking can also lead to inequitable outcomes through unequal access to collaborations, unequal visibility between and within institutions, or unequal sharing of knowledge or opportunities, all of which have direct career implications for trainees. [5] This potential inequity was alluded to in conversations with fellows, some of whom were able to enjoy connections because of institutional support to larger events or the network of their mentors and others who were left largely on their own as they tried to navigate the broader field and establish connections.

A risk of the variability in fellowship programs is that they might unknowingly contribute to this inequity, but also that they might be cognizant of it and be uncertain how best to avoid it without undermining their obligation to provide the best assistance they can for their own trainees. Mitigation of these concerns and realization of the benefits of networking for fellows can be accomplished at the level of individual programs or institutions, but it is also an appropriate task for professional networks like BENO or the recently formed Bioethics Fellowship Collaborative.

When speaking of strategic networking, there are two broad pathways. The first is horizontal networking between peers (i.e., fellow to fellow). The second is vertical networking between trainees or junior professionals with high-level individuals. There are opportunities in the field for both to be improved.

Horizontal Networking

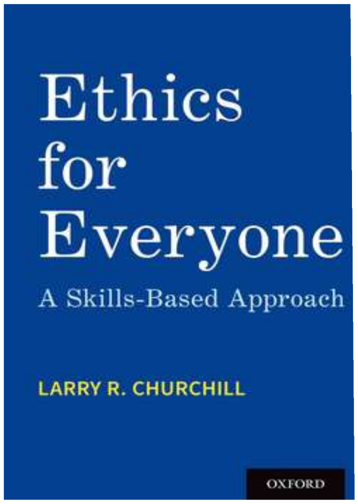
While some fellowship programs are large enough to support a cohort of fellows, many programs support only one or two. Whether this is the result of a deliberate pedagogical choice or due to logistical constraints, each model presents strengths and weaknesses for networking. A single fellow may have the opportunity for a higher level of exposure and mentorship. The additional exposure is valuable given the term-limited nature of fellowships, and tailoring the program to support their individual interests, career goals, and needs may allow them to develop further than they would under a more standardized program. However, somewhat paradoxically, single fellows may simultaneously find the experience to be isolating. As part of their fellowship, they are often well-integrated into their respective health systems but their status as term-limited, trainee-employees means they are unlikely to remain within system after completion.On the other hand, fellowship programs with cohorts see benefits from creating a community of trainees. Cohort-based learning is argued to increase social interaction, motivation, a sense of community, critical thinking skills, and program completion rates. [6] While concerns for program completion are less worrisome for fellowship program directors because the population seeking fellowships have likely already demonstrated a high motivation to finish, camaraderie between fellows may help offset a few challenges of postgraduate training, including stress caused by financial insecurity and short tenures. More importantly,

continued on page 9...

BOOK REVIEW

Ethics for Everyone: A Skills-Based Approach

Author: Larry Churchill
Year of Publication: 2020
Publisher: Oxford University Press
Genre: Non-fiction
No. of Pages: 208
Reviewed by: Anna Meurer



As the title implies, Larry Churchill intends his book to be used by anyone "seeking to live a life that makes moral sense" (p. 1). That statement, at once thoroughly practical and human, encapsulates the tone of the entire work. As Churchill defines it, the moral experience is a rich and complex one, founded in curiosity about ourselves and our values. It exists as part of a dynamic lifespan, engaging the full spectrum of human experiences and skills; this makes it fundamentally humanizing and available to everyone. As such, the traditional approach to ethics emphasizing rational problem-solving based in theory is often insufficient when faced with the varieties and complexity of life. Instead, he offers what he terms a "multitextured" approach that embraces the full range of human capacities as a means to ethical reflection that realizes what it means to be fully human. Ethics aims to discover our own values, discover the values of others, achieve accord between our internal moral lives and external actions, and then solve problems.

The best way to do this, Churchill says, is to practice and hone certain skills, learn central moral concepts that can be used as tools, and avoid ethical pitfalls. Readers are unlikely to be surprised by the skills he lists as essential to ethics, among them 1) decentering the self and reorienting within a moral community; 2) relinquishing the comfort of moral certainty; 3) expanding empathy; and 4) embracing and learning from emotions. Neither are they likely to disagree with the obstacles and pitfalls to ethical thinking he outlines, which include relativism, absolute certainty, binary thinking, perfectionism, and unrealistic expectations for theory. The central concepts Churchill outlines—truth, forgiveness, liberty, hope, responsibility—will likewise be familiar to readers but the manner in which he presents and connects them draws a roadmap to moral competency that will seem reasonable and obtainable to anyone.

I see a dual strength in the book. On one hand, it is accessible to a multitude of ethics-committed individuals in that it can be easily taught, understood, referenced, and discussed. The case studies and guided questions will further aid in these efforts. On the other, I find that it is equally valuable to those with deep expertise in ethics, who are no less in need of the ethics skills and no less vulnerable to some of the pitfalls mentioned. All who read it will find his framework helpful in their ethical reflection, analysis, and discourse. Ultimately, this is a thoroughly realistic but optimistic book that should have a place on everyone's shelf.

MEMBER SPOTLIGHT

Fr. Carl Lee Mullins M.Div, BCC

Board Certified Staff Chaplain at St. Vincent Bon Secours Mercy Health in Toledo, Ohio

In addition, I am an Anglican priest with the Jurisdiction of the Armed Forces and Chaplaincy and the Society of St. Michael.

I have recently become a part of BENO and am currently working on my Master's degree in Bioethics from Loyola University Chicago. I found my passion in bioethics and healthcare approximately five years ago when I began my chaplain residency at St. Vincent Hospital in Toledo, Ohio, where I currently serve.

As a chaplain at a level 1 trauma hospital, I have encountered many ethically complex cases, often revolving around end-of-life issues, especially during the height of COVID-19. As I continue to encounter ethical complexities around healthcare, I have become more aware and appreciative of clinical ethics and its vital role in the care of patients, families, and staff. After many conversations with peers whom I deeply admire in the hospital, I decided to formally pursue an education in bioethics with the aim of participating further in clinical ethics.

In terms of experience, what has impacted me most in healthcare and ethics was participating in 21-day consults during the COVID-19 pandemic. Many of the ethics consults revolved around end-of-life issues, and I was given the opportunity to learn clinical ethics hands-on from other ethicists and multidisciplinary staff during this time. It gave insight into the complexities between families, patients, and medical staff while allowing me to be fully present and hear differing perspectives on ethical issues.

This experience furthered my interest in research regarding the usage of ethics subcommittees to assist in medical decision-making for non-decisional patients. It is an honor and privilege to be a part of the board for BENO and participate in professions such as chaplaincy and ethics while aiming to contribute to the betterment of healthcare in Ohio in some small way.

Potentially interesting facts about me: I have lived nearly a quarter of my life in Thailand and look to the country as my second home. The country and culture have shaped my life in many ways, and I deeply miss my family there. In addition, I have been trained in exorcism with the Roman Catholic Church in Rome and enjoy collecting books on Theology.

HUMOR

"And for that pain deep down in your soul,
I'm going to prescribe the saxophone."

***Networking** continued from page 7...*

it also contributes to the sharing of knowledge and perspectives that underlies the reflective and analytical processes essential to clinical ethics practice. [3,7] That said, programs with cohorts may find tailoring the experience to individual interests more challenging logistically.

All fellows benefit from interacting with others outside of their programs who will likely be their professional colleagues in the future. However, given the limited timespan of fellowships it may be difficult for individual fellows to establish (horizontal) networks with other fellows. A group like the Bioethics Fellowship Collaborative may be well suited to taking on the task of providing the infrastructure to facilitate these connections and conversations. Fellowship directors and coordinators have the ability to establish regular meetings, strategically align didactic components to provide common material for discussion, form partnerships, and provide technical or financial support for their fellows to network. In doing so, they can create the space for their fellows to engage with each other and form community. These spaces, therefore, can be programmatically supported but fellow driven, encouraging professional growth without logistical burden. Program directors are also well-positioned to focus on strategic inclusivity as part of their ongoing evaluation of their programs.

Vertical Networking

Though some fellows enter their programs while already working in ethics, many enter with the intent to find employment afterwards. Because of this, awareness of opportunities and ongoing initiatives, knowledge of the structure and functioning of ethics services in various institutions, and building rapport with other ethics professionals is particularly necessary. Organizations like BENO or groups like the Clinical Ethics Consultation Affinity Group (CECAG) may be helpful in facilitating vertical networking by providing access to individuals or organizations that may otherwise be insulated. A noted strength of bioethics networking organizations is their ability to reduce isolation, increase education, provide resources and, subsequently, facilitate strong professional relationships. [8] As an example, CECAG has an initiative whereby junior ethicists are paired with a senior ethicist mentor. Fellows may already have this mentoring relationship within their program, but a networking organization may provide access to other high-level ethics professionals. For example, BENO may choose to offer a conference session, expand opportunities provided for students to include fellows, sponsor a standalone networking event, or host an educational session geared towards fellows and other junior ethics professionals. Like fellowship leaders, BENO also has the ability to promote strategic inclusivity in networking and connect groups with each other when they might otherwise not. This goe far in addressing the concerns for inequity mentioned before.

To conclude, bioethics fellowships as a whole do an excellent job in imparting clinical ethics consultation skills, research capabilities, and interpersonal skills within an institution or system. Many also focus on developing ethics leaders and supporting connections with the wider community. However, there are still opportunities to deepen professional relationships between fellows and others in the field and these are desirable both as a means to ensuring good ethical practice and encouraging retention. Bioethics networking and professional organizations are well suited and equipped to capitalize on the foundation already established and to serve as leaders in networking initiatives. Finally, efforts to increase networking should partner with fellowship programs and include fellows whenever possible.

Bioethics Fellowships in Ohio

Cleveland Clinic: Advanced Bioethics, Transplant Ethics, Nursing Ethics, Neuroethics *https://my.clevelandclinic.org/departments/bioethics/fellowships*
The Ohio State University: Clinical Bioethics *https://medicine.osu.edu/departments/bioethics/education/clinical-bioethics-fellowship*
University Hospitals: Clinical Ethics

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UPCOMING EDUCATIONAL OPPORTUNITIES

Bioethics Grand Rounds – "Exploitation in Medicine"

- Naomi Scheinerman, PhD
- January 10, 2024 from 12:00-1:00pm ET via Zoom
- CME Available
- Center for Bioethics and Medical Humanities, The Ohio State University
- More information at: *https://medicine.osu.edu/departments/bioethics/events*

BENO Quarterly Ethics Education Series – "The Role of Ethics in Community Health Environments"

- Julie Aultman, PhD, MA and Craig Dove, PhD, MDiv
- January 30, 2024 from 4:00-5:00pm ET via Zoom
- More information at: *https://www.benoethics.org/*

Association for Practical and Professional Ethics 33rd Annual Conference

- February 22-25, 2024 in Cincinnati, OH
- More information at: *https://www.appe-ethics.org/conference-overview/*

4th International Conference on End-of-Life Law, Ethics, Policy, and Practice (ICEL4)

- March 6-9, 2024 in Salt Lake City, UT
- More information at: *www.icel4.org*

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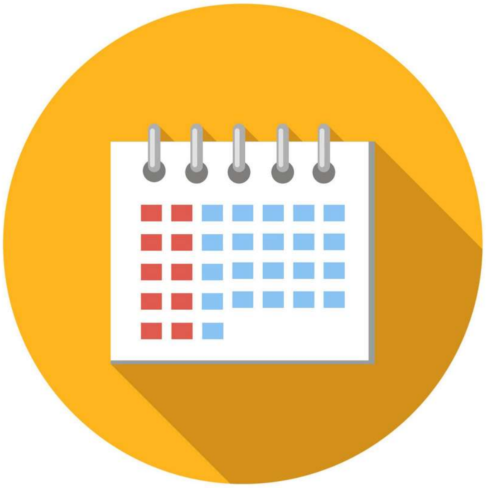
- January 30, 2024
- 4:00-5:00pm ET via Zoom
- Julie Aultman, PhD, MA and Craig Dove, PhD, MDiv
- Registration Link to Come



BENO's 33rd Annual Conference

- Held virtually
- Thursday, April 18th 12pm – 4pm
- Friday, April 19th 9am – 1:15pm
  (times are approximate)
- Registration Information to come early in 2024