

Surgical Ethics Tactics and Strategies -- #1-#40

Douglas Brown, PhD

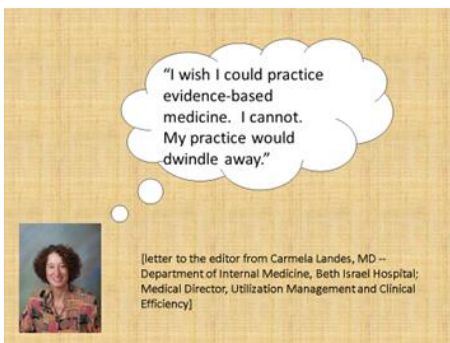
[I am sharing with you ‘tactics and strategies’ I have created/tested (often in collaboration with medical/surgical faculty members) over the past 40+ years embedded in various hospitals, medical school departments, biomedical research teams, and medical practices. I welcome your observations if/when you can send such and will respond promptly to any questions you may have. You are at complete liberty to use these resources in every way that seems to have potential value for your efforts to advance surgical ethics.]

#1

For this 1st ‘tactics and strategies’ communication, I want to share a PowerPoint slide (inserted below) from my collaborations with Lewis Wall, MD/DPhil. For several academic years, Dr. Wall and I framed our monthly ethics conferences with the WashU Ob/Gyn residents as ‘a look just beyond residency’. The conference centered by this PowerPoint slide alerted the residents to powerful forces that pull away from practicing ‘evidence-based medicine’ in patient care. As you will likely expect, the residents in response to the opening questions about their residency training were nearly unanimous that they were being trained to practice evidence-based medicine and that they fully intended/expected to practice evidence-based medicine. They were then jolted by the quotations from senior leaders re the harsh realities in the trenches beyond residency. Here are some of the questions we discussed with the residents –

- Is ‘evidence-based’ always unambiguous?
- Why/how is grounding patient care decisions in ‘evidence’ ethically significant?
- Do pressures to diminish/surrender ‘evidence’ cut across all patient groups?
- What are patients or their surrogates seeking if an ‘evidence-based’ foundation is not essential?
- Can this concern be addressed when interviewing for a position with a practice?

Doug



#2

For the 2nd ‘tactics and strategies’ communication, I am sharing with you one component of a professionalism/ethics curriculum I designed and introduced in the 2013-14 academic year for our surgery clerkship students.

I began managing our 12-week surgery clerkship in November 2011 and immediately started attending all of the dozen or so clinical/operative lectures delivered by various surgery faculty members during each clerkship, both to make sure any logistical/technical snags were quickly resolved and also to consider the educational effectiveness of the faculty lectures. As I listened to the faculty lectures, I quickly decided to keep a log of the professionalism/ethics concerns they revealed in passing – i.e., 15-20 second asides, often expressed with noticeable frustration – during their lectures. After several clerkship cycles, I organized my list of the faculty members’ numerous professionalism/ethics concerns into themes/categories and began sending the resulting template (with direct quotes from the faculty lectures) to the clerkship students mid-way through their surgery clerkship with a request that they prioritize (‘high’, ‘medium’, ‘low’) each of the

listed faculty members' professionalism/ethics concerns. I have inserted below an example of the template plus the clerkship students' prioritization that was sent to the faculty members recruited to facilitate an hour session of small group discussions with one set of clerkship students in Week 9 of their surgery clerkship. The 'high priority' percentages varied from clerkship to clerkship, as you would expect.

This adaptation of qualitative research methods was very well received by our clerkship students as well as by our faculty members. The format proved to be substantive and relevant but not disproportionately time consuming, two linked 'head scratching' challenges for integrating meaningful professionalism/ethics education into a clerkship student curriculum. A very encouraging secondary result was the discovery/identification of a rather sizable pool of faculty members who welcomed the opportunity to speak with the clerkship students about these professionalism/ethics concerns.

I suspect your faculty colleagues have/express similar professionalism/ethics concerns in settings not designed for extended deliberation and careful analysis. I encourage you to consider experimenting with some variation on this curriculum design with your clerkship students and/or residents.

Doug

**Professionalism/Ethics Roundtable Discussion
Surgery Clerkship Students' Input Re Their 'High Priority' Subjects/Concerns**

[N=23/27 Students]

1. Subject/Concern – Failing to be cost-conscious or follow EBM thinking	% Students 'High Priority'
"A MRI for a 80 y/o with arthritis is a waste of healthcare dollars" . . . "Fight the urge to do a CT scan for every pt" . . . "In the ED – 'ABC' is Airway, Breathing, CT Scan".	50%
"Patients rarely see the costs they incur and so want many unnecessary tests done and are not satisfied until they are. Conversely, they often do not do what would help make their health care effective."	50%
Re colloids cost range compared to crystalloids – "The data do not justify expensive colloids which are nonetheless heavily used" . . . "Who care?" . . . "Your generation will be more cost conscious".	40%
"Do we over-prep or under-prep pts for surgery?"	25%
"I have missed many diagnoses because I wasn't thinking".	15%
"You have an ethical obligation to look at/to check every item of every test you order".	10%
2. Subject/Concern – Attitudes about and perceptions of patients	% Students 'High Priority'
"Should students be instructed/permitted to perform rectal exams on sedated patients in the OR?"	50%
"I just cut off this pt's leg and all he can think about is getting out to smoke" and other discouraging comments re patients failing to make changes in risky behaviors.	35%
"Patients harm themselves to manipulate the system—e.g., prisoners who swallow safety pins."	25%
Surgeons making disparaging remarks about patients while the patients are under general anesthesia.	25%
3. Subject/Concern – Impact of time constraints on patient care	% Students 'High Priority'
"Do busy surgeons have time to discuss the diagnosis and keep the patient informed prior to surgery? If not, whose job is it?"	45%
"The trust patients place in surgeons is staggering."	30%
"You can't do a proper history in fifteen minutes".	30%
"You can be caught up in the moment and fail to establish trust".	25%
"You often have to decide/act before test results are back".	20%

(cont. next page)

4. Subject/Concern – Attitudes about and perceptions of other physicians/fields	% Students 'High Priority'
"I wish primary docs would pay more attention in medical school" and "If all you have is a hammer, everything looks like a nail" – re how physicians in one area of medicine perceive (often negatively) physicians in other areas of medicine.	45%
"The surgeon is ultimately responsible for a patient in pulmonary failure, not the anesthesiologist. The surgeon is the pilot; the anesthesiologist, the co-pilot."	30%
5. Subject/Concern – Financial incentives/motives	% Students 'High Priority'
"It's all about money" . . . "The unscrupulous orthopod who drives a Lamborghini who scopes a knee w/o clinical justification".	35%
"Pay for performance is your future" . . . "At BJH we are penalized when the infection rate makes us an outlier—e.g., 5% penalty" . . . "Linking infection rate to compensation gets one's attention".	25%
"West Co gallbladders go to Dr. _____ and the important guys, not to me".	20%
"What drives your decision-making?"	15%
6. Subject/Concern – Research, Surgical innovations	% Students 'High Priority'
"Drug companies are not investing in antibiotics because they can't make money doing so" . . . "We face a serious risk of reverting to pre-antibiotic medicine".	30%
"What are we missing now that is analogous to female MIs that were missed in the 60s-80s?"	25%
"Unfortunately, this device is not yet approved in the US" . . . "This device was approved just a year ago" . . . "The US is behind" . . . "Even though we do these procedures" – re how devices and procedures are approved in the US.	25%
"Back in the day when you could study/test something w/o the IRB" . . . "An experiment design that would not get you in the Post-Dispatch" – re research ethics.	20%

#3

For the 3rd 'tactics and strategies' communication, I am sharing with you a professional integrity challenge/warning one of our CHES fellowship faculty members – Shuddie Ray, MD – issued a few years ago to our department in his graduating chief resident presentation. The subject – surgical innovation. Shuddie used as his reference point a very disturbing revelation my colleague Lewis Wall, MD/DPhil (at the time a senior uro-gynecologic surgeon in the WashU Ob/Gyn Department) and I published in 2010 re a vaginal mesh practice bulletin. I have inserted below the key PowerPoint slide in Shuddie's presentation. Several other related PowerPoint slides are available upon request. You need some background information in order to fully appreciate the serious ethical implications.

By 2007 Dr. Wall and his fellow urogynecologic surgeons in academic medical centers around the country had treated an alarming number of patients for vaginal mesh surgical complications. The reason – various vaginal mesh kits had been marketed aggressively since the late 1990s based only on FDA 510(k) clearance. ACOG released in February 2007 Practice Bulletin #79 that described vaginal mesh procedures as 'experimental'. ACOG then in September 2007 abruptly replaced Practice Bulletin #79 with Practice Bulletin #85. Practice bulletins are never updated/replaced in such a short time unless some dramatic breakthrough has occurred. But no such breakthrough had been announced. So Dr. Wall and I decided to compare #79 and #85 line by line. We discovered that only one sentence had been changed (see the wording in the slide below). The word 'experimental' had been deleted. The new wording shifted responsibility for bad outcomes to the patients.

Dr. Wall and I submitted a manuscript for publication to the *American Journal of Obstetrics and Gynecology* that had two parts – (1) a review of the step-by-step process for the development of surgical innovations that every medical school teaches/expects and (2) a detailed comparison/assessment of Practice Bulletin #79 and Practice Bulletin #85. The journal cautiously offered to publish the first part but refused to consider the second part. We then contacted the *International*

Urogynecology Journal and explained the situation. *IUGJ* decided to publish the second part of the manuscript. So we divided our manuscript and had the two parts published in separate journals. A tense exchange of published letters followed. ACOG's Vice-President of Practice Activities wrote a letter to the *IUGJ* editor, arguing our questions/concerns were unfounded. We responded in a letter to the *IUGJ* editor that the ACOG representative had presented no new or additional information relevant to our questions/concerns. At that point, the Practice Bulletin chair at the time #79 was circulated and then abruptly withdrawn (after which she resigned from the committee) sent – courageously, in our opinion – a clarifying letter to the *IUGJ* editor. Here is her letter to the *IUGJ* editor:

As the author responsible for the controversial wording of the ACOG Practice Bulletin on pelvic organ prolapse, I would like to thank Drs. Wall and Brown for bringing this matter to the attention of clinicians, and Dr. Karram and the International Urogynecology Journal for their willingness to publish this.

The explanation that I was given at the time that ACOG decided to change the wording (over my strenuous objections) was that the meaning of the word “experimental” was ambiguous. This is disingenuous at best. In fact, the ACOG staff member at the meeting of the Committee on Practice Bulletins-Gynecology described the real reason for concern: “...that the current wording would possibly deny payment for some physicians.” Most of the clinicians who objected to the use of the word “experimental” understood only too well exactly what meaning was intended – that these procedures lacked sufficient evidence of risk versus benefit to adequately counsel patients as to expected outcomes. Such clinicians were concerned that insurance companies would not cover procedures labeled experimental, and they were concerned about their medicolegal risk should a complication arise in the course of procedures labeled experimental. Exactly the kinds of concerns that a professional organization that truly promoted best medical practices would see as a red flag – that clinicians’ concerns were not focused on what was best for the patient, but on what protected their income. That ACOG chose to align itself with these few Fellows at the expense of patients’ outcome and safety is of grave concern.

If ACOG had actually decided that the meaning of the word “experimental” was ambiguous, it could have decided to clarify the meaning of the term in the document itself. As an alternative, ACOG could adopt an official definition of the term, as other professional organizations (such as the American Society of Reproductive Medicine) have done. That ACOG made neither of these choices underscores the real motivation behind deleting the “experimental” term from the Practice Bulletin.

I agree with Drs. Wall and Brown that ACOG can, and should, do better. Particularly given the heightened concern about complications with the mesh kits that prompted the FDA's public health advisory, as noted in the article by Drs. Wall and Brown, the appropriate action of the part of ACOG at this time is to restore the wording of the original Practice Bulletin, to emphasize the truly experimental nature of these procedures and to stand behind its promise to women, in its own Bylaws, by “serving as a strong advocate for quality health care for women, and maintaining the highest standards of clinical practice”.

[key PowerPoint slide from Shuddie's graduating chief resident presentation]

What ACOG did. What would ACS do?

A February 2007 ACOG Practice Bulletin (#79) warned doctors and patients to consider the vaginal mesh procedure to be experimental: **“Given the limited data and frequent changes in marketed products (particularly with regard to type of mesh material itself, which is most closely associated with several of the postoperative risks, especially mesh erosion), the procedures should be considered experimental and patients should consent to surgery with that understanding.”**

Seven months later, ACOG replaced Practice Bulletin #79 with Practice Bulletin #85. Only one sentence had been changed. The word ‘experimental’ had been removed and the responsibility for outcomes had been shifted to the patient: **“Given the limited data and frequent changes in marketed products for vaginal surgery for prolapse repair (particularly with regard to type of mesh material itself, which is most closely associated with several of the postoperative risks, especially mesh erosion), patients should consent to surgery with an understanding of the post-operative risks and lack of long-term outcomes data.”**

I welcome your questions and observations.

Doug

#4

For the 4th 'tactics and strategies' communication, I am reaching back to the early 1990s when I was with the LSU New Orleans Obstetrics and Gynecology Department, managing the department's large multi-site residency program as my way to be embedded as the department's ethics educator. As I scanned the mail one day, a conference brochure caught my eye (inserted below). I have tried repeatedly but without success over the years to identify the source of this image since I have used the image so often to visualize/frame the link between 'burnout' and 'ethics' with residents as well as with practicing physicians/surgeons, nurses, social workers, et al. Several PowerPoint slides that offer suggestions for facilitating the discussion are available upon request. Note --

- The burned-out matchhead brings the subject into focus. An effective way to jumpstart the discussion is to cover the burned-out matchhead in order to solicit reaction to two subtle and somewhat surprising parts of the composition – (1) the fully compliant dress code (suggesting a person who does not 'make waves' and is likely considered exemplary by a supervisor) and (2) the hands tucked deeply into the coat sleeves (making a gripping statement about reservations when faced with ethically significant decisions).
- In order to firmly establish the participants' attention, I prompt them to probe the experiences they associate with 'burnout' – (1) What burns out? (2) What triggers burnout? Where does being burned out leave you? What counters/corrects burnout?
- The participants are now ready to examine how being burned out can affect/alter ethical decision-making. With a spectrum in mind from 'minimally acceptable' decisions to 'exceptional/sacrificial' decisions, cases should be presented to highlight the possible impact of being burned out on being careful (i.e., do no harm), on benefiting the patient, on understanding/honoring a patient's values/goals, on being fair, on respecting co-workers.

I welcome your questions and observations.

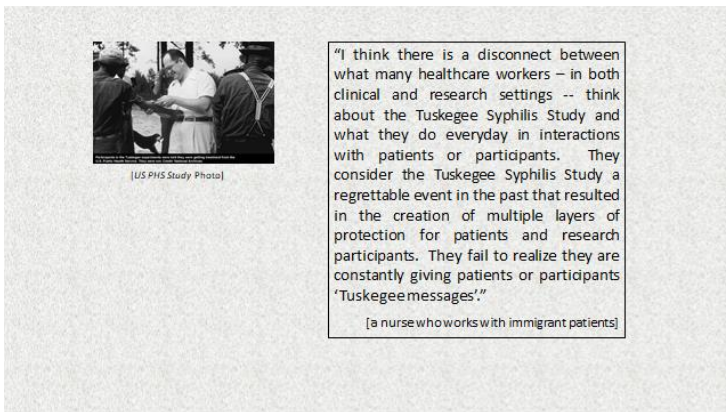
Doug



#5

For the 5th 'tactics and strategies' communication, I have inserted below the last/critical slide in a series of slides I prepared a few years ago as one way to enter the complexities and responsibilities inherent to human-based research. The back story – the two years (2009-11) before I began working within our Surgery Department, I was the field researcher and qualitative research guide for a NIH-funded study led by a geriatrician in our Internal Medicine Department. The study

aimed to understand why African-American elderly St. Louis residents living near our medical school campus and teaching hospital are so underrepresented in and so hesitant to participate in research protocols relevant to the health disparities they face. We conducted interviews and focus groups with African-American elderly residents throughout the nearby 26th Ward of St. Louis, with our medical school's research teams, and with hospital nurses, social workers, and interpreters who care for vulnerable patients. The African-American elderly St. Louis residents who spoke with us referenced often the *Tuskegee Study of Untreated Syphilis*. This last/critical slide from the larger set of slides draws from my interview with a seasoned nurse who coordinated/supervised our teaching hospital's interpreter service. The first ten slides (designed for use with audience-response technology) give the participants an opportunity to assess the accuracy of their understanding of the *Tuskegee Study of Untreated Syphilis* (to which virtually all have been exposed). Then the last/critical slide asks participants a question they do not anticipate – "In your clinics and in the hospital, are you constantly giving patients or research participants 'Tuskegee messages'?"



I welcome your questions and observations. You are free to use the above and attached set of slides as you think might be helpful in your surgical ethics education efforts.

Doug

#6

For the 6th 'tactics and strategies' communication, I am sharing the PowerPoint slide I routinely used to open the professionalism/ethics small group case discussions we organized/conducted with our surgery clerkship students. The slide inserted below (a nearly exact quotation from some WashU 3rd-year students with whom I was having a conversation a few years ago) indicates the ethics education problem we were attempting to address --



Re background -- I joined the WashU Surgery Department in 2011. My primary responsibility was to manage our department's 12-week surgery clerkship (under the supervision of Vice-Chair for Surgical Education Dr. Klingensmith and Surgery Clerkship Director Dr. Kirby). Thus embedded, I have additionally served as an ethics educator and qualitative

researcher for our department. Near the beginning of my work within the department, I prepared and began to circulate seven brief professionalism/ethics promptings for/to our surgery clerkship students, distributing one prompting every couple of weeks during the clerkship. We soon began experimenting with several ways to provide the surgery clerkship students a meaningful professionalism/ethics didactic session timed so as not to be near the beginning or the end of the clerkship and structured so as not to be too time-demanding. We eventually settled on the following format –

1. All surgery clerkship students are required to submit one disturbing case (template for case presentation provided) from their surgery clerkship, ideally by Week 8 of the clerkship. (This surgery clerkship requirement was approved beginning with the 2014-15 AY.)
2. I select 5-6 cases from the submitted cases and edit/organize them (with input from Jennifer Yu, now a PGY4 in our residency program) into a set of cases for small group discussion. (Cases submitted too late to be considered are rolled forward into the next surgery clerkship.)
3. We routinely have enough faculty members and residents to have 2-3 facilitators per small group. (More than twenty faculty members and several residents have participated regularly as small group discussion facilitators.)
4. I begin the session with a brief ‘ethics 101’ reminder/refresher presentation after which the facilitators and clerkship students are separated into small groups for an hour discussion of the selected cases.

We have been very pleased with the encouraging feedback from the surgery clerkship students and also from our faculty and residents. Over several academic years, we collected more than 500 cases from surgery clerkship students.

I welcome your questions and observations. You are free to use the above information and attached set of cases as you think might be helpful in your surgical ethics education efforts.

Doug

#7

For the 7th ‘tactics and strategies’ communication, I have inserted below a brief fictional narrative of a young practicing surgeon (with two accompanying language matrices). The brief fictional narrative is a compressed presentation of the conclusions from my attempt – as a keen listener/observer – to understand the ethical resolve and the ethical vulnerabilities of the physicians and surgeons with whom I have been privileged to live/work for the past 40+ years. I used the first draft of the narrative and language matrices as the heart of a grand rounds presentation I was invited to deliver in 2000 for the Johns Hopkins Department of Obstetrics and Gynecology honoring their colleague and my close friend Tom Elkins, MD, the department’s recently deceased chief of gynecologic surgery. I have frequently revised the narrative and language matrices incorporating the critical feedback from numerous medical students, residents, teaching faculty, and practicing physicians/surgeons. I welcome your questions and observations. You are free to use the narrative and accompanying language matrices as you think might be helpful in your surgical ethics education efforts. Doug

What does it mean for a practicing surgeon to be ‘ethical’?

Douglas Brown, PhD

Consider the intentions and the struggles of a young surgeon in her first years of practice after residency. Let’s call her Stephanie. Stephanie is the youngest and newest member of a team of surgeons whose practice is administered by a for-profit management company. She joined this practice with the assurance she would be fully supported in her deeply-rooted resolve to care for her patients in the most beneficial and cost-effective way, with special attention to socio-economically disadvantaged patients. She quickly discovers that numerous competing interests and expectations – some professional, others personal – pressure her to shift her focus away from her patients and their interests.

Stephanie begins most days poised to be empathetic. She is prepared to give disproportionate attention to her more vulnerable patients. She is ready to open herself to her patients’ suffering to the point of risking burnout. She intends to be meaningfully present with her patients. She grips firmly her integrity. She gauges her capacity to tolerate the moral

dissonance she experiences from value clashes with some of her patients. She seeks to grow professionally for patient benefit as much as for personal security. She feels a nagging tension between her lifestyle interests and her accountability to her patients.

Stephanie would violate her integrity if she refused to look beyond each patient's presenting problem. She has already seen far too much. However, she accepts that she is not yet one of those rare surgeons who seem capable of saying "yes" to every deeply pained patient and enter yet another broken story. Fatigue, accountability to her other patients, administrative obligations, research protocols, teaching assignments, family responsibilities, reimbursement pressures, personal interests apart from medicine, and a host of other considerations force her to limit many patients' access to her time, her energy, her heart. Instead, Stephanie triages her patients carefully to sift out the encounters in which she will enter more deeply into the patient's story, in which she will make and impose on others the sacrifices to be fully present with the patient.

Especially on her most exhausting days, Stephanie might glance enviously toward the many flourishing surgeons for whom the medical environment is most fertile. For these surgeons, a patient encounter is a sale; the patient, a consumer. Some are entrepreneurs. Lifestyle incentives motivate them. Others are researchers. Innovation and publication motivate them. Stephanie knows these surgeons subtly sift out difficult patients from their panel of patients. They stay sufficiently detached from patient suffering to avoid any risk of being burned out. They have learned to make patients think they are present and care. They turn professional advancements into marketing tools. They lead unreflective lives. They have an easy conscience about at-risk patient groups. But Stephanie is not seriously tempted to join their number.

However, Stephanie is troubled by how often she ends the day wearily thinking of the next patient as one more demand; thinking of herself as a mechanic. She ends many days numb toward patients and tired of confronting the healthcare delivery system. She feels acutely the loss of important family experiences as she does her job. She often sees little evidence that she is making a difference in the lives of vulnerable patients. She finds herself becoming apathetic to patient suffering as the day's paperwork drains her. She feels ambivalent toward patients for whom she has a dimming vision. She senses that her struggle to stay current with advancements in her specialty is posing subtle risks to patients. She is haunted by the look in her child's eyes, a look that asks, "Mom, do you care more for your patients than you do for me?" She can sound defensive. She can look disheartened.

Surgical ethics addresses the vulnerability of surgeons such as Stephanie and the many other surgeons who finish residency without such a deeply-rooted, well-grounded resolve to care for all patients – including the most difficult patients -- in a respectful, beneficial, fair, and cost-effective way. Once in practice, they too often yield – some with initial remorse – to incentives to practice surgery in a comfortable and an entrepreneurial way that actually – if subtly – discourages them from being genuinely present with patients. They too often compromise their integrity. They too often lose any initial qualms with hedging their fiduciary responsibilities to patients. They too often are easy targets.

Most medical students who choose to pursue a surgical career are confident they will be ethically exemplary surgeons, humane with a resilient social conscience. However, they quickly feel they are being herded through year after grinding year of preparation. They are being trained, but not necessarily educated. They are under intense supervision as they expand/strengthen their knowledge base, as they become efficient in examining patients, as they learn to do procedures. From one stage to the next, they accommodate standards for identifying 'good performance' that may have little to do with valuing patients as individuals. They finish residency still feeling the effects of chronic fatigue, but anxious finally to be focusing on their own patients. Instead, for several more years -- among new colleagues and under smothering fiscal scrutiny – they struggle to find their own practice style, to get out from under enormous debt, to publish, to catch up on a long-delayed personal life. Do they receive sufficient incentives to give of themselves . . . to care deeply . . . to be truly present with their patients . . . to concentrate on the disadvantaged . . . to be reflective?

Ethics education for these surgeons is analogous to an irrigation system delivering nourishment to plants that would otherwise wither.

(See below a language matrix that differentiates four common professional identities found on a spectrum with “I could not care less” at one end and “I could not care more” at the other end followed by a language matrix that probes the struggle to retain integrity.)

Matrix 1

Professional Profiles That Delineate Integrity

“I could not care less”			“I could not care more”
an assault pt a victim a scam	a sale pt a consumer a business	an encounter contract with pt a profession	a meeting covenant with pt a vocation
criminal; manipulates pt; desecrates social fabric	entrepreneur; accommodates pt; capitalizes on social fabric	servant; empathetic toward pt; leavens social fabric	partner; respects pt; challenges social fabric
lifestyle is everything	lifestyle is highest priority	lifestyle is in tension with accountability to/for pts	lifestyle is integrated with accountability to/for pts
pt mix is defined by fraudulent intent	pt mix is weighted toward personal interests	pt mix is weighted toward the more vulnerable pts	pt mix is centered on the most vulnerable pts
exploits pt suffering; immune to being burned out	detached from pt suffering; avoids being burned out	burdened by pt suffering; risks being burned out	drawn into pt suffering; copes with being burned out
harmfully present pt a means only	apparently present pt primarily a means	meaningfully present pt an end and a means	fully present pt essentially an end
professional advancement sought as a cover	professional advancement sought as a marketing asset	professional advancement sought for quality of care and security	professional advancement sought as a benefit to pts
no conscience; no moral dissonance; no integrity	easy conscience; little moral dissonance; compromises professional integrity	pangs of conscience; underlying moral dissonance; wrestles with integrity	restless conscience; deep moral dissonance; risks self-righteous self-image and/or reputation

Matrix 2

The Struggle

“I could not care less?”	“Do I care . . . really?”	“I could not care more”
	a task pt one more demand a job	an encounter contract with pt a profession
	mechanic; numb toward pt; tired of confrontations	servant; empathetic toward pt; leavens social fabric
	experience with family sacrificed to care for pts	lifestyle is in tension with accountability to/for pts
	patching rather than healing the more vulnerable pts	pt mix is weighted toward the more vulnerable pts
	apathetic to pt suffering; overworked; drained by paperwork	burdened by pt suffering; risks being burned out
	weakly present pt a means to an end	meaningfully present pt an end and a means
	professional advancement slowed by being behind; subtle risks to pts	professional advancement sought for quality of care and security
	guilty conscience; moral complacency; defensive; sounding cynical	pangs of conscience; underlying moral dissonance; wrestles with integrity

#8

For the 8th ‘tactics and strategies’ communication, I have inserted below some lyrical reflections I wrote in November 2001 for our youngest daughter Morgan. The location – The James Joyce Irish Pub on State Street in Santa Barbara. The occasion – Morgan’s thirteenth birthday which in November 2001 was just a few weeks ahead. The day before, I had delivered a Grand Rounds presentation entitled *‘I and Thou’: An Endangered Idea(I) in the Practice of Medicine* for the Cedars-Sinai Medical Center Department of Obstetrics and Gynecology. Two months before, the life realities into which Morgan was growing/maturing had pivoted abruptly and harshly with the ‘9 11’ tragedies. My wife and I returned to Santa Barbara in November 2018 with Morgan (then nearing thirty and soon to be married). When we looked into The James Joyce, I could see myself sitting at one of the tables across from the bar years ago drafting and redrafting on a couple of 4x6 cards what I wanted to say to Morgan about how ‘to live life well’, realizing my soon-to-be teenage daughter would be increasingly on her own – beyond my sight/reach – face to face with life’s certainties and uncertainties. Ethics has to do with what we prioritize, with what we assign unparalleled value. Doug

To live life well -

*Your cup, drink completely
Your values, test existentially
Your love, release freely
Your joy, reveal tastefully
Your vision, pursue boldly*

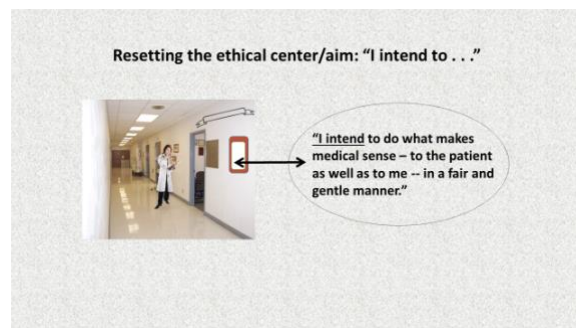
*Your lifestyle, simplify radically
Your family, shelter vigilantly
Your friend, stand with unconditionally
Your neighbor, meet respectfully
Your vocation, embrace cheerfully*

*Your darkness, enter courageously
Your fears, confront vigorously
Your disappointments, weather patiently
Your wounds, tend silently
Your failures, see honestly*

*Your integrity, grip firmly
Your gifts, develop humbly
Your victories, celebrate gratefully
Your insights, remember clearly
Your path, mark carefully*

#9

For the 9th ‘tactics and strategies’ communication, I have inserted below one of the half-dozen slides I shared with and reviewed this week with an experienced nurse who co-leads an ethics consult team for a hospital in St. Louis. We were deciding on some talking points to go along with her use of the slides in an upcoming nursing staff ethics in-servicing she will be facilitating.



The challenge introduced by this slide is to compress the essence of the ethical dimension of patient care into an accessible answer to the question – “What do I intend for this encounter?”

I have (co)authored enough articles over the past 4+ decades to understand and appreciate the investment necessary to craft insightful extended commentary and interpretation re the ethical complexities associated with the practice of medicine and surgery. These resources are invaluable. However, they are often not easily or quickly retrieved and utilized within the time constraints and the stresses common to the daily care of multiple patients. So as a complement to these more lengthy resources, I began working in the other direction – toward brevity, toward a single centering sentence, toward capitalizing on the few ‘take a deep breath’ seconds before the physician or surgeon approaches the next patient. I realized early on that using those few seconds to recall the four anchoring concepts/principles – non-maleficence,

beneficence, self-determination, justice – lacked the pause effect needed for physicians or surgeons to reset their attention to include the ethical dimension of patient care. I began to test the question – “What do I intend?” One reason – ‘intend’ and ‘intention’ are etymologically linked to ‘tendon’ (i.e., to extend, to stretch)! Years of observing, listening, questioning, drafting, revising while working alongside physicians and surgeons have led to the compressed answer proposed in the slide – “I intend to do what makes medical sense -- to the patient as well as to me -- in a fair and gentle manner that respects the values and goals of the patient”. I am still searching for more efficient ways to reach the essence of the ethical dimension of patient care. I will welcome learning about your answers to the question.

One of my favorite novels is Irving Stone’s biographical novel about Michelangelo – *The Agony and the Ecstasy*. Perhaps what we are attempting with surgical ethics is analogous in certain ways to the sculptor with chisel and hammer in hand passionately chipping toward the image s/he sees inside the marble block. Consider this description of Michelangelo’s work on the Pieta – “He broke into his marble block at the left side of the Madonna’s head, worked to the left of the block, the north light behind him. By getting (his assistant) Argiento to help him turn the block on its beams he was able to have the shadows fall exactly where the cavities were to be carved, a play of light and shadow to show him where he must cast out stone; for the marble he took away was also sculpture, creating its own effects”.

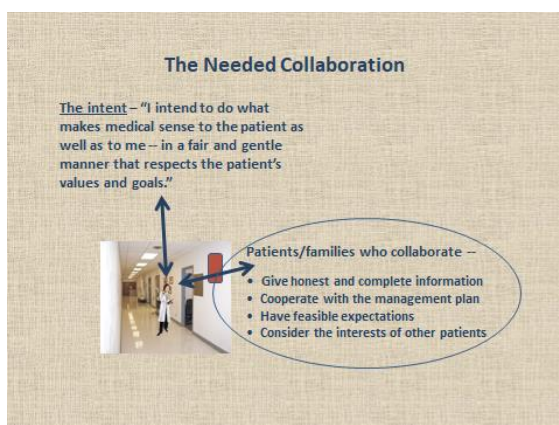
Doug

#10

For the 10th ‘tactics and strategies’ communication, I have inserted below a companion slide to the teaching slide I shared with you (in the 9th communication) from the set of a half-dozen slides I created for use in coaching hospital ethics committee members who conduct ethics consults. The challenge addressed in the previous slide is to compress the essence of the ethical dimension of patient care into a crisp/accessible answer to the question – “What do I intend for this encounter?” -- by which physicians or surgeons can pause to reset their attention to the ethical dimension of patient care. The wording I recommend is -- “I intend to do what makes medical sense -- to the patient as well as to me -- in a fair and gentle manner that respects the values and goals of the patient”.

The companion slide below reminds us that an ethically grounded/sound case is a partnership with the patient (or the patient's surrogate). In order for the centering intention of the physician or the surgeon to be realized (or at least approximated), the patient (or the patient's surrogate) must partner with the physician or the surgeon in specific ways -- i.e., (1) give honest and complete information, (2) cooperate with the management plan, (3) have feasible expectations, and (4) consider the interests of other patients.

I trust you can see in the previous slide and in this slide implicit references to the four landmarks of the ethical dimension of patient care -- i.e., non-maleficence, beneficence, self-determination, justice.



I am still searching for more efficient ways to represent the essence of the ethical dimension of patient care in concise yet deeply rooted wording. I will welcome learning about your attempts.

Doug

#11

For the 11th 'tactics and strategies' communication, I have inserted below two sections – i.e., 'Definitions' and 'Conceptual Considerations' – from a larger set of guidelines for navigating ethically conflicted cases re the withholding or withdrawing of life-sustaining technologies. This set of guidelines was created by the ethics committee for a North St. Louis community hospital I was privileged to lead for several years. We developed this set of guidelines in response to a needs assessment we conducted, in which we asked the hospital's various services/staffs to identify the cases they faced that posed the most difficult and/or the most recurring ethical challenges. After working through numerous drafts over many months (including seeking feedback from the hospital's surgeons, hospitalists, and intensive care attendings), we sought and received from the hospital's board and executive leadership the formal approval for the set of guidelines. We used the set of guidelines both for ethics consults and for hospital staff education. Among the definitions and the conceptual considerations, the most unexpected and yet reassuring particulars have been (1) the differentiation between 'physiological futility' and 'value-based futility' ('Definitions' #9-10) and (2) the reminder/explanation that refusing an intervention is a patient's absolute right, but that requesting/insisting on an intervention is not a patient's absolute right ('Conceptual Considerations' #5).

I have found these definitions and conceptual considerations to be useful in ethics education conferences for residents and for medical students. I will welcome your feedback.

Doug

DEFINITIONS:

1. Life-sustaining treatment: any treatment that keeps the patient alive but does not cure the patient. A treatment is considered life-sustaining when the patient will die imminently due to the underlying illness or injury if life-sustaining treatments are withheld or withdrawn.
2. Advance Directive: a living will, a durable power of attorney for health care, and other written or oral sources that express a patient's health care preferences, goals, and values.
3. Decisional capacity: the ability (1) to receive information regarding the risks, benefits, and alternatives of a specific treatment, (2) to understand and process this information, (3) to deliberate, and (4) to make, communicate, and explain choices. Decisional capacity is determined by a physician, whereas competency is a legal determination rendered by a judge. An individual's decisional capacity can fluctuate and can depend on the complexity of the decision being made.
4. Emancipated minor: an individual under the age of 18 who is married, who is the parent or guardian of a minor child, or who has been declared emancipated by a court.
5. Surrogate: a person with decisional capacity who makes decisions on behalf of a patient who does not have decisional capacity.
6. Substituted judgment: a decision based on what a surrogate has reason to think under the present circumstances would have been the patient's choice, based on knowledge of the patient's preferences, goals, and values.
7. Best interest: decisions that are made based on a surrogate's and a physician's judgment about what is best for the patient under the present circumstances or what a hypothetical 'reasonable patient' would want under the present circumstances.

8. Futile treatment: medical treatment provided to a patient with a life-threatening illness that will do no more than prolong the dying process. Conflicts about the delivery of care thought to be futile should be resolved by a due process approach.
9. Physiological Futility: The utter impossibility that the patient's condition can be improved by continuing and/or increasing restorative interventions (i.e., 'only prolonging the dying process').
10. Value-based Futility (or Quality-of-life Futility): The recognition that continuing and/or increasing restorative interventions conflicts with the patient's preferences, values, and goals of care.
11. Non-beneficial treatment: treatment that, in the best professional judgment of the treating physician(s), will not have a reasonable chance of benefitting the patient. Physicians are not ethically obligated to deliver care that is non-beneficial.
12. Cardiopulmonary Arrest: A cardiopulmonary arrest (also known as a cardiac arrest or circulatory arrest) is the abrupt cessation of normal circulation of the blood due to failure of the heart to contract effectively during systole. Patients in cardiopulmonary arrest do not have enough circulation to maintain blood flow to the brain. Irreversible brain damage and death will usually occur within a few minutes of the onset of cardiopulmonary arrest.
13. Cardiopulmonary Resuscitation: A set of techniques designed to restore circulation and respiration in the event of acute cardiac or cardiopulmonary arrest. Advanced CPR techniques include closed-chest compression, intubation with assisted ventilation, electroconversion of arrhythmias, and use of cardiogenic and vasopressive drugs. CPR is an indicated procedure to reverse the effects of cardiopulmonary arrest. CPR is not indicated when a clinical judgment is made that the procedure is unlikely to do so.
14. Do Not Resuscitate: In the event of cardiopulmonary arrest, no cardiopulmonary resuscitative measures or endotracheal intubation and mechanical ventilation are initiated.
15. Comfort Measures Only: The patient receives only therapeutic treatments that are specifically intended to optimize the patient's comfort. In the event of cardiopulmonary arrest, no cardiopulmonary resuscitative measures or endotracheal intubation and mechanical ventilation are initiated.

CONCEPTUAL CONSIDERATIONS:

1. The ethical obligations of beneficence, non-maleficence, autonomy, and justice are all compatible with an informed decision to continue or to discontinue any life-sustaining intervention.
2. It is the responsibility of the treating physician/s to ensure the patient (or surrogate) has the appropriate information and support required to assist the physician/s in making decisions and recommendations (including but not limited to life-sustaining treatments). It is the responsibility of the patient (or surrogate) to thoughtfully consider and convey to the treating physician/s the preferences, values, and goals that are hoped to be achieved from the patient's medical care. These preferences, values, and goals may need to be periodically re-evaluated as the patient's medical condition and prognosis change.
3. Foregoing life-sustaining treatments includes both the withdrawing and withholding of any life-sustaining treatment (including, but not limited to, mechanical ventilation, bi-level positive airway pressure, vasopressors, oxygen, dialysis, antibiotics, blood transfusions, artificial hydration and nutrition). Withholding or withdrawing artificial nutrition/hydration from a patient without decision-making capacity by a surrogate requires clear and convincing evidence of the patient's wishes.
4. There is no ethical or legal distinction between withdrawing and withholding of life-sustaining treatments. The same rationale and justification should be applied to withholding and to withdrawing of life-sustaining treatments. Decisions to forego life-sustaining treatments should be based on medical indications in relation to feasible goals

of care and should be consistent with the patient's advance medical directives and/or other documented expressions of the patient's preferences, values, and goals (or lacking such guidance, consistent with the best interests of the patient).

5. Patients with decisional capacity have the right to participate in decisions about the life-sustaining medical treatments they receive, especially by clearly conveying to the medical team their goals of care and their values. They have the right to be informed of their diagnosis and their prognosis, to be involved in their care planning and treatment, and to request or refuse treatment. They have the right to refuse or to discontinue any medical treatment even if doing so will hasten their death. However, as per CMS Standard 482.13(b)(2), pp. 66-67, "this right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate".
6. If a patient lacks decisional capacity, an appropriate surrogate (usually but not necessarily a close family member) should assist in the decision making (1) ideally/preferably by representing the patient's known preferences, values, and goals or (2) if such are not know, then by promoting the patient's best interests.
7. Discussions with the patient (or surrogate) should be conducted in private, with ample time for questions. Discussions should follow the attached 'Goals of Care Communication' template and should include:
 - a. Diagnosis, prognosis, and potential outcomes for the patient.
 - b. Outcomes that are acceptable and/or unacceptable to the patient and the likelihood of those outcomes.
 - c. Treatment options available and clinical implications of each option.
8. The treating physician/s and healthcare team are under no ethical or legal obligation to offer, implement, or continue medically inappropriate (i.e., futile or non-beneficial) treatments, including life-sustaining treatments and CPR. Note: every intervention is a 'trial of treatment'. Patients should not be encumbered with treatments that cannot be reasonably expected to achieve meaningful goals of care (such as return to pre-injury/illness status, discharge from the hospital to home, discharge to non-acute care). Should a patient's life-sustaining management become futile in this sense, the treating or consulting physician -- following an institutionally approved protocol for futile (non-beneficial) care resolution -- may enter appropriate orders restricting or withdrawing life-sustaining treatments. At all times, pain relief and comfort measures should be provided.
9. When the decision is made to forego life-sustaining treatments, it is ethical and it may become necessary to provide treatments to control symptoms including narcotics with the sole purpose of alleviating symptoms and suffering, even at the risk of accelerating or contributing to death.
10. When the decision is made to forego life-sustaining treatments, the emotional, physical, and spiritual care of the patient should continue. Withholding or withdrawing life-sustaining treatments in no way implies withholding or withdrawing care for the patient. Maintaining the patient's dignity is paramount.

#12

For the 12th 'tactics and strategies' communication, I am sharing (see below) an adaptation of a values assessment tool the first draft of which I created in the late-1990s while working as part of the leadership team for a community health center serving a truly rural and impoverished patient population in East TN/KY. Rather than simply state/post a claimed set of values, we created a values assessment tool to use in surveys, interviews, and focus groups with all staff members (i.e., physicians, nurses, and administrative staff) as well as with a cross-section of the communities/families we served. By soliciting their feedback re four criteria (i.e., a 'core' value is clearly explained, significantly influences decisions and actions, is expected throughout the organization, and is encouraged/incentivized), we dared to ask if our community health center's stated/claimed values were in fact true and experienced, realizing that we were inviting the staff and the communities/families to expect us to address barriers to prioritizing/strengthening any value/s in question.

I was prompted to recall this exercise in taking values seriously when I recently came across a copy of our department's annual report in which eight 'core values' are highlighted. I have inserted below an adaptation of our community health center's values assessment tool and plan to suggest we use some such tool for measuring the breadth and depth of the eight values presented as 'core' within our department.

Values and ethics are strongly linked. Each individual forms a personal sense as to what is of ultimate value and what is of lesser value. These ultimate (i.e., core) values serve as a filter through which information is interpreted before being applied to life's decisions. Certain relationships, experiences, circumstances, and objects are thus regarded to be of such importance to us that we are prepared to suffer great loss rather than to violate them.

Judgments about what ought or ought not to be done can usually be acted upon safely without much conflict. However, some situations – certainly in the education and the practice of medicine -- require a collective judgment from a number of individuals with competing values or divergent viewpoints. In such situations, a reflective approach to decision-making -- i.e., ethics -- is necessary. Ethics then has to do with the determination of what ought to be done in a given situation, all core values considered.

I suggest that one way we can encourage surgical ethics education in our respective departments is to introduce creative ways to identify and assess the values that shape the experience of staff and patients. Please feel free to make any use of this values assessment tool that you think might be helpful. I welcome your feedback.

Doug

Values – Assessment Tool

The following 'core' values are highlighted in our department's 2017 annual report. A clarifying definition from the report is added for each value. Please rate (1-5 scale, '1' meaning 'definitely yes' and '5' meaning 'definitely no') each value using the four criteria re how central/essential (i.e., 'core') you have found each value to be in the decision-making and conduct of our department. Your assessment is to be descriptive – i.e., is there evidence that these values are in fact true of and pivotal within our department?

	This value is clearly explained	This value clearly influences decisions and actions	This value is expected throughout the dept	This value is encouraged (i.e., there are incentives to honor and maintain the value)	Comment/s
Psychological Safety. We all should feel safe when sharing ideas, concerns, and mistakes.					
Fostering Leadership. We build successful leaders and provide leadership opportunities.					
Broad Promotion Criteria. We reward contributions in education, patient care, research.					
Recruiting Diversity In All Forms. We encourage all to achieve their best.					
Addressing Disparities. We do so through research and community engagement. We welcome researchers who are members of underrepresented minorities.					

Work-Life Balance: We foster work satisfaction by allowing all staff to contribute on flexible terms.					
Mentorship: We expect strong mentors and provide resources to develop these skills.					
Serving A Diverse Population: We work hard to address the complex barriers to minority clinical trial participation.					

#13

Greetings from St. Louis and WashU. I depart Tuesday for Palestine (the West Bank and Gaza) to join my close friend and physician colleague David McRay, MD, for the last ten days of this year’s global health elective in Palestine – the tenth year (beginning in 2009) we have conducted this month-long educational project which now more than sixty learners – mostly 4th-year medical students with a few upper-level residents from medical schools across the US -- have completed. In addition to shepherding the educational experience for the participants, Dr. McRay serves as a clinical instructor for Palestinian primary care physicians, obstetricians, and palliative care teams and I serve as an ethics education/training instructor for medical and surgical staffs at Palestinian teaching hospitals.

So for the 13th ‘tactics and strategies’ communication, I am sharing what I consider to be my primary contribution to the healthcare professionals in Palestine re medical and surgical ethics – i.e., the opportunity for them to translate into Arabic a set of six basic tools for navigating ethical conflicts in patient care. For the first several years, we very cautiously and attentively sought to understand the challenges they face and the resources available to them. Their patience eventually resulted in sufficient insight to offer for their consideration the set of tools I had developed for use with our WashU 3rd-year surgery clerkship students and with the ethics consult services I chair for two community hospitals here in St. Louis. Three years later, we took the pivotal step – i.e., facilitating an ongoing series of workshops bringing together attendings and residents from several teaching hospitals in Palestine for them to translate the set of tools into Arabic. By doing so, they have taken ownership of the tools . . . they have made the set of tools their own.


I know many of you are involved in global health surgical education. I offer this example as a way to encourage your efforts to be very rigorous in respecting the local caregivers’ skills/potential, in contextualizing what you deliver to them, and in trusting their leadership. I welcome your feedback and am happy to respond to any questions you may have about our Palestine global health elective.

Doug

Ethics has to do with the determination of what should be done in a situation, all things considered.

Why do well-intentioned individuals come to different judgments re what should be done in a situation?

- One reason – differences in what they consider
- A second reason – differences in what weight/priority they give to what they consider



Action expresses priorities. Gandhi

الأخلاقيات: معرفة كيفية التعامل في موقف معين مع الأخذ بعين الاعتبار جميع الظروف المحيطة

لماذا يتبع الأشخاص (المعنيين بنفس المصلحة للمريض) قرارات مختلفة و ماذا يجب العمل في مثل هذه المواقف

- السبب الأول: الاختلاف في وجهات النظر (و ماذا يعتقدون)
- السبب الثاني: اختلاف الأولويات
- الأفعال تعبر عن الأولويات الأهميية-أولا



Action expresses priorities. Gandhi

What do we have to do to improve patient care?

... we have to do it in a way that is not...
 (non-acceptable)

... we have to do it in a way that is not...
 (non-acceptable)



... we have to do it in a way that is not...
 (non-acceptable)

... we have to do it in a way that is not...
 (non-acceptable)

How do we build trust in the treatment of the patient and ourselves?

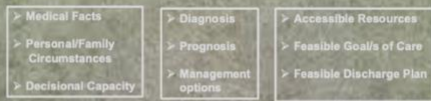
... we have to do it in a way that is not...
 (non-acceptable)

... we have to do it in a way that is not...
 (non-acceptable)



... we have to do it in a way that is not...
 (non-acceptable)

... we have to do it in a way that is not...
 (non-acceptable)



[Ethically Grounded Patient Care]



[Ethically Grounded Patient Care]

PART A: Document Goals of Care

Based upon comprehensive discussion between the patient (or surrogate) and the treating physician/s, the following explanation best describes the patient's current goals of care:

EXAMPLES include but are not limited to: "return to prior living situation at previous functional status" or "return to prior living situation after physical therapy" or "remain in my home" or "be free of pain or breathlessness" or "maintain my privacy and dignity" or "be able to interact with my loved ones" or "attend my granddaughter's graduation" or ...

NOTE: "Do everything" is NOT a goal of care. Ask the patient (or surrogate) what "everything" is intended to achieve. NOTE: To set realistic goals, the patient (or surrogate) needs a clear description of what to expect.

Discuss and document if the patient wants to focus on comfort and dignity (i.e., "palliative care" or "allow natural death") if any one or combination of the following is the most likely outcome:

- ___ being permanently unconscious (i.e., completely unaware of surroundings with no chance of regaining consciousness)
- ___ being permanently unable to remember, understand, make decisions, recognize loved ones, have conversations
- ___ being permanently bedridden and completely dependent on the assistance of others to accomplish daily activities (e.g., eating, bathing, dressing, moving)
- ___ being permanently dependent on mechanical ventilation
- ___ being permanently dependent on hemodialysis
- ___ being permanently dependent on artificial nutrition (tube feedings) and/or intravenous hydration for survival
- ___ death likely to occur within days to weeks with life-sustaining treatments only prolonging the dying process
- ___ other (specify) _____

PART B: Document Focus of Care

Based upon the above understanding of the patient's goals of care:

The focus of care will be to restore the patient to a level of function compatible with the goals outlined above. Specific testing and treatments will be ordered by the patient's physician/s as a trial of treatment with the intent to achieve these goals.

The focus of care will concentrate on the patient's comfort and dignity. Treatments that serve only to prolong the process of dying or place undue burden on the patient will not be initiated or continued.

PART C: Recommended Resuscitation Status

1. Weighing the patient's prognosis and comorbidities, resuscitation's risks and benefits, and the goals of care outlined above --

- A. The treating physician does / does not (circle one) recommend CPR in the event of cardiac arrest.
- B. The treating physician does / does not (circle one) recommend intubation in the event of impending respiratory arrest.
- C. The treating physician at this time cannot make a defensible recommendation (circle) regarding CPR and intubation.

2. These recommendations have been discussed with the patient (or surrogate) with reassurance that if resuscitation is not performed, care will be provided in a manner that ensures the patient's comfort and dignity. Yes / No (circle one)

3. For the patient (or surrogate) who decides to be resuscitated despite the treating physician's recommendation against such, the treating physician has described the risks/benefits/comorbidities of resuscitation if successful. Yes / No (circle one)

أهداف الرعاية نموذج التواصل

الجزء (أ) - وثيقة أهداف الرعاية

التسليم إلى مناقشة شاملة بين المريض (أو الوكيل) والطبيب المعالج ، فإن أهداف المريض

التي تترجم هي:

من الأمثلة على ذلك: "العودة إلى الحالة الصحية الجيدة في المنزل أو العودة إلى العمل" أو "العودة إلى العمل الجيد بعد العلاج الطبيعي" أو "البقاء في منزلي" أو "أن يكون خالي من الألم" أو "الحفاظ على خصوصية والكرامة" أو "أن أكون قادرًا على التفاعل مع أحبائي" أو "حضور حفل تخرج حفلي" أو ...

ملاحظة: "فعل كل شيء" ليس هدفًا من أهداف الرعاية (أو الوكيل) أو المريض. اسأل المريض عما يتوقعه من "كل شيء".

ملاحظة: لتعيين أهداف واضحة ، يحتاج المريض (أو الوكيل) إلى وصف واضح لما يمكن أن يتوقعه.

ناقش ووثق إذا كان المريض بحاجة إلى رعاية تركز على ما يعلو راحة وكرامة (مثل الرعاية التلطيفية) أو السماح لموت طبيعي بالحدوث) في حال وجود واحدة أو مجموعة من الأمور

التالية التي تروج مسبقًا للمريض:

___ إذا كان المريض في حالة غير مستقرة تمامًا (غير مستقر تمامًا) لن يتحرك ولا يوجد أمل بالشفاء و (هنا)

___ إذا كان المريض بشكل دائم غير قادر على التفكير أو فهم أو اتباع قرارات أو معرفة مخاطر أو الفوائد

___ إذا كان المريض يتردد في اتخاذ قرار بشأن ما يريد أن يفعله على مساعده الآخرين في اتخاذ قراراته اليومية (مثل الأكل و الاستحمام و ارتداء الملابس و الحركة)

___ إذا كان المريض بشكل دائم معتمدًا على جهاز التنفس الصناعي

___ إذا كان المريض بشكل دائم معتمدًا على غسيل الكلى

___ إذا كان المريض بشكل دائم معتمدًا على العناية بالجلد. على هذا الحد (أو العكس)

Create PDF
 Adobe PDF Pack
 Convert files to PDF and then with other file type conversions.
 Select File to Convert to
 Select File
 Send Files
 Store Files

Navigating/Steering "I want everything done"

Clarifying "I want everything _____ done" --

- in the patient's best interests?
- medically reasonable? justifiable? defensible?
- consistent with the patient's values?
- consistent with the caregivers' values?
- consistent with the patient's goals/expectations?
- consistent with the caregivers' goals/expectations?
- within the limits of the caregivers' knowledge/skills?
- the hospital is accredited to do?
- the law permits?
- <other> _____?

"أريد عمل كل شيء للمريض"

وضح ماذا يعني عمل كل شيء

- أريد عمل كل شيء في مصلحة المريض
- طيبا مقبولاً-أو مبرر و كافي
- حسب قيم المريض
- حسب قيم الشخص القائم على رعاية المريض
- حسب توقعات و-آمال المريض
- حسب توقعات و-آمال الطبيب
- حسب المعلومات و-المهارات الطبية المتاحة
- حسب المتعارف بعمله في المستشفى
- حسب القانون

"But what is a 'fair' use of severely limited resources?"



"But what is a 'fair' use of severely limited resources?"

ما هو التوزيع العادل في ظل شح الامكانيات المتاحة؟



#14

For the 14th 'tactics and strategies' communication, I am calling your attention to a 2018 *Surgery* article (plus responses and commentaries) you may already have seen.

A Yee, E Zubovic, J Yu, S Ray, S Hildebrandt, W Seidelman, J Polak, M Grodin, J Coert, D Brown, I Kodner, S Mackinnon. Ethical considerations in the use of Pernkopf's *Atlas of Anatomy*: a surgical case study. *Surgery* 165(5) (May 2019):860-67. Commentaries by A Caplan (*Surgery* 2019, 165; 871), M Muller et al (*Surgery* 2019, 165; 871-72), and S Mackinnon (*British Medical Journal* 2020, 368; 96-99).

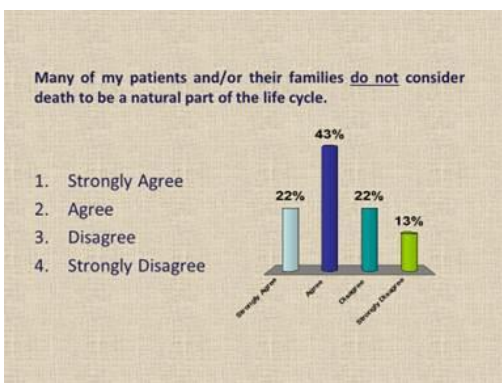
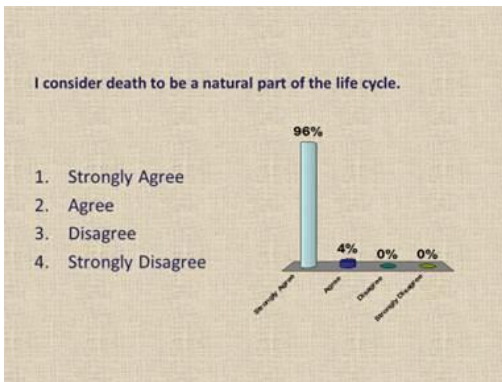
Several of us here at WashU were involved in the authorship of this article. The article offers an ethical justification and a protocol for using the controversial Nazi-era anatomy atlas, as exemplified by patient cases and by educational/training activities in the practice of WashU micro-nerve surgical specialist Susan Mackinnon.

The article's centering the ethical challenge and the decision-making in an actual case reflects the format of our department's 4th-year medical student 'Ethical Challenges' elective I have co-facilitated for many years. The elective was introduced by Dr. Kodner and is now led by Dr. Kopar. This format gives the article its potential for use as a resource for surgical ethics education with medical students and residents. The list of publications resulting from the elective is available upon request. We welcome your feedback. Doug

PS: We would be pleased to share with you a detailed explanation of our 'Ethical Challenges' 4th-year medical student elective and to learn about similar educational efforts in which you are involved.

#15

For the 15th ‘tactics and strategies’ communication, I have inserted below two PowerPoint slides I used recently as part of an ethics education session with the ethics committee for a community hospital that I chair. The two slides suggest a rather sharp contrast between surgeons and their patients re whether death is perceived as a natural part of the life cycle. The responses tabulated in the two slides were gathered from WashU surgery residents a few years ago as a discussion starter for an ethics education conference. I suspect the contrast revealed in their responses is present to some degree among your surgery residents. After presenting the tabulations, we weaved two discussion threads into the presentation of a series of illustrative cases – i.e., (1) What does it mean not to view death as a natural part of the life cycle? and (2) How does this perception of death shape the end-of-life decision-making of patients and their families who hold this perception? We welcome your feedback. Doug



#16

For the 16th ‘tactics and strategies’ communication, I am sharing with you (inserted below) four metaphors -- i.e., ‘conscientious objector’, ‘lifeguard’, ‘backed against the wall’, ‘peripheral vision’ -- by which to differentiate responses to abortion cases I offered WashU’s incoming Ob/Gyn interns during the values clarification session I co-facilitated for them earlier this week. Each slide includes an explanatory commentary.

These four metaphors first came into focus for me as a grounded theory qualitative research interpretation/construct when I was several years into a fourteen year (1992-2006) longitudinal study of how a cohort of Dutch physicians were approaching cases in which they considered assisting patients in the dying process. The research upon which this longitudinal study was based began in 1991 as an extension of an ethics project we conducted in The University of Michigan Department of Obstetrics and Gynecology. We studied end-of-life decision-making from the perspectives and experiences of 108 gynecologic cancer patients who were receiving care from the department’s gynecologic oncology division. The subject of assisted dying became a central issue in Michigan with Dr. Kevorkian shortly after the data gathering for this study had been completed. Needing to expand the project to incorporate the subject of assisted dying, in Spring 1992 I made the first of fourteen annual research trips to Holland. The University of Leiden Department for General Practice served as host for the initial visit, made accessible its faculty as well as its residents, and remained helpful

in the coordination of the subsequent visits. During each two-week research trip to Holland, I spent time with a steadily expanding network of Dutch professionals -- including 24 physicians. This research network included:

- five general practitioners of varying persuasions regarding euthanasia;
- a former chair and emeritus professor with The University of Leiden Department for General Practice who contributed significantly to the formation of a consensus by the early 1980s regarding euthanasia for competent patients experiencing unbearable suffering;
- a senior neonatologist with the Amsterdam Medical Center who chaired the Dutch Pediatrics Association ethics committee for addressing neonatal decision-making in light of euthanasia guidelines;
- a senior professor of medical ethics at The University of Leiden who was a past-president of the Voluntary Euthanasia Society;
- three junior members of the research team at Erasmus University doing follow-up studies to the Rummelink Commission's 1991 national study of end-of-life decision-making in Holland;
- a psychiatrist whose assisted-dying case was the first case considered by Holland's Supreme Court in which the patient's suffering was not related to a somatic condition.

I first presented these four metaphors in what we call 'grand rounds' at The University of Leiden. With the values clarification sessions for WashU's incoming Ob/Gyn interns, it became apparent that the four metaphors had didactic use for ethical challenges at the beginning of life as well as at the ending of life. I welcome your feedback and would be pleased to discuss further the euthanasia study upon request.

Doug

Four Responses

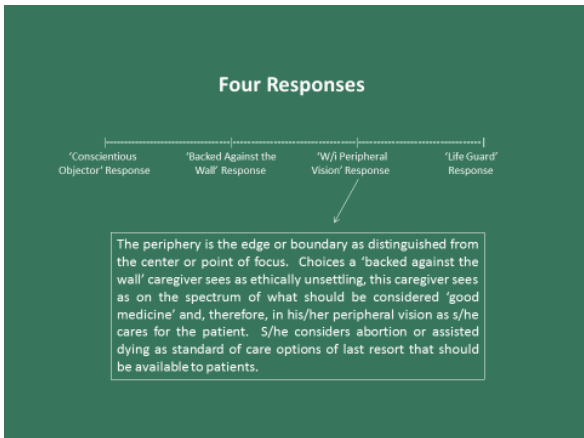
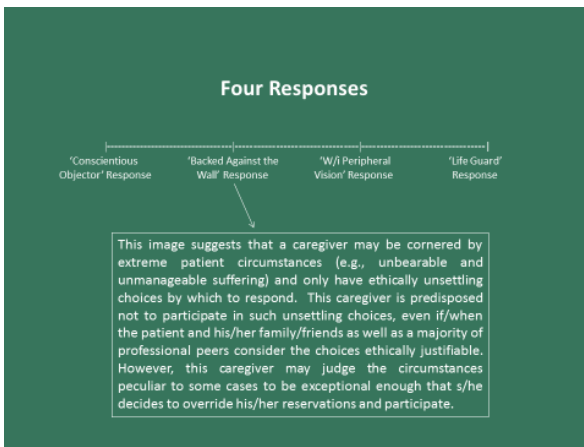
'Conscientious Objector' Response 'Backed Against the Wall' Response 'W/I Peripheral Vision' Response 'Life Guard' Response

The life guard is responsible for insuring that swimmers (1) are sufficiently skilled for the activity they are undertaking and (2) do not put themselves or others at risk. A caregiver with this disposition is predisposed to meet a patient's request once s/he is convinced the patient has the decisional capacity to make the request and will only hesitate to participate in a patient's care when in doubt about such. S/he considers the determination that the suffering is unbearable to be the patient's responsibility.

Four Responses

'Conscientious Objector' Response 'Backed Against the Wall' Response 'W/I Peripheral Vision' Response 'Life Guard' Response

A citizen who appeals for 'conscientious objector' status rather than to bear arms must make the case that to take up arms would essentially be to occasion his/her own existential death. Being classified a 'conscientious objector' is not popular in a time of national crisis. The government cannot protect the individual from criticism, ridicule, even harm. A caregiver who responds in a way analogous to a 'conscientious objector' is one who is convinced that participating in a patient's care under certain circumstances (such as abortion or assisted dying) would profoundly threaten and/or compromise his/her professional and/or personal integrity.



#17

For the 17th 'tactics and strategies' communication, I am sharing with you (inserted below) a set of possible discussion starters for reaching consensus with patients and their families re feasible expectations (goals) of care. These observations and recommendations are drawn from extended time spent with surgical teams and intensive care teams in various ICUs – Neonatal, Medicine, Neurology, Surgery, Cardio-Thoracic – over the past 30+ years. I welcome your feedback and would be pleased to learn about other discussion starters you have found to be effective for gently but intentionally opening/sustaining these very important discussions. Doug

[Establishing Feasible Expectations: Possible Discussion Starters] Two residents who were near the end of their ICU rotations were asked separately – “At any given time, how many of the management plans in the ICU make no medical sense to you?” The question had to do with whether a link was present between the management plans and feasible outcome/discharge expectations. Both residents independently responded – “50%”.

An ethically skilled surgeon is prepared to move discussions with patients or surrogates toward consensus re the patient's outcome/discharge expectations. A patient's expectations may be restoration to preadmission functional status, relief from pain and suffering, survival regardless of quality of life, or survival long enough for desired closure. Quality of life outcomes that may be unacceptable to a patient include being permanently unconscious, being permanently unable to remember or make decisions or recognize loved ones, being permanently bedridden and dependent on others for activities of daily living, being permanently dependent on hemodialysis, or being permanently dependent on artificial nutrition and/or hydration.

The focus of care for most patients is to restore the patient to a level of function compatible with the patient's expectations, with all appropriate therapies being initiated and continued. If the surgeon concludes that such restoration cannot be achieved, further discussion with the patient and family members is needed in order to reconsider the

expectations for the hospitalization. Based on this discussion, current management may not be escalated, additional interventions may not be introduced, and current life-sustaining treatments may be discontinued so as not to place undue burden on the patient. In some cases, the focus of care should shift to concentration on the patient's comfort during the dying process.

Sustaining the discussion of feasible goals of care with patients and their families is an art. Here are some effective discussion starters an ethically astute surgeon may use --

- **“What makes a day ‘good’ for you?”** (with attention given to how ‘good’ is described)
- **“What are your difficult days like?”** (with attention given to how ‘difficult’ is described)
- **“Do your good days help you make it through your difficult days?”** (with attention to indications of how firm a ‘yes’ is and whether the good:difficult ratio is diminishing)
- **“Do you more often find yourself waking up in the morning hoping for a good day or hoping not to have a bad day?”** (with attention to how encouraged or discouraged the patient is)
- **“What do you want me to know as I and the surgical team consider how best to take care of you?”** (with attention oriented toward acceptable or unacceptable outcomes rather than toward management plan details)
- **“What outcomes do you want to keep fighting for?”** (with attention to how feasible the outcomes are)
- **“Are you concerned that your illness will interfere with your participation in any activities or events in the near future that are especially important to you?”** (with attention to what demands these activities or events would make on the patient, to how feasible it is for the patient to participate in these activities or events, to what condition the patient hopes to have at the time of these activities or events)
- **“Do you have any questions or worries that are hard to talk about with your family or friends?”** (with reassurances that such can be discussed with you in complete confidence)
- **“Patients sometimes tell me they find themselves thinking ‘that would be worse than dying’. Have you had this thought?”** (with attention to indications re what such conditions would be)

#18

For the 18th ‘tactics and strategies’ communication, I am sharing the first few slides from a set of slides I developed when I was added to the Barnes-Jewish Hospital working group that had been tasked with updating/revising the hospital’s mass casualty preparation plan. My assignment was to facilitate discussion of the ethical challenges associated responding to a mass casualty event. I subsequently used the set of slides in several ethics education conferences. The first slide sets out three educational objectives. The second slide draws attention to the language frequently heard during a mass casualty event as a way to demonstrate the paradigm shift is indeed difficult. The next four slides present surgery and emergency medicine resident responses to four questions. I have found that presenting the responses to each question quickly opens illuminating and at times intense exchanges re the reasoning that leads to differing responses. I welcome your feedback and would be pleased to learn about other discussion starters you have found to be effective for probing the ethical challenges associated with mass casualty events. Doug

Objectives

1. Gain a fresh understanding of the shifts in meaning a disaster imposes on the basic ethical responsibilities – e.g., do no harm, deliver benefit, respect/optimize patient self-determination, be fair -- that guide the practice of patient-centered medicine.
2. Recognize more clearly the various views of justice present when decisions are made about the distribution of limited resources.
3. Have a set of steps in mind for developing an ethically grounded decision-making framework for distributing limited resources in a disaster.

“... It will be a **difficult paradigm shift** to emphasize population-based care over the individualized care that physicians presently give to each patient, but this shift will be necessary in order to weather the storm and minimize morbidity and mortality...”

↓

“do as little as possible for as many as possible as quickly as possible”

“utilitarian ... the greatest good for the greatest number”

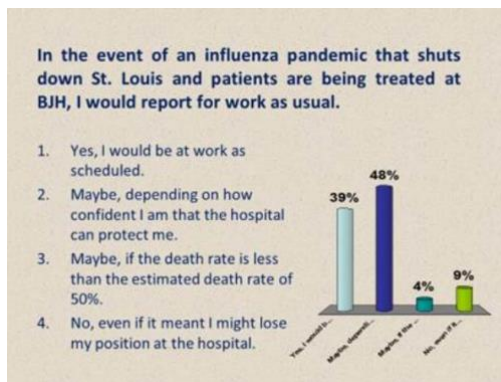
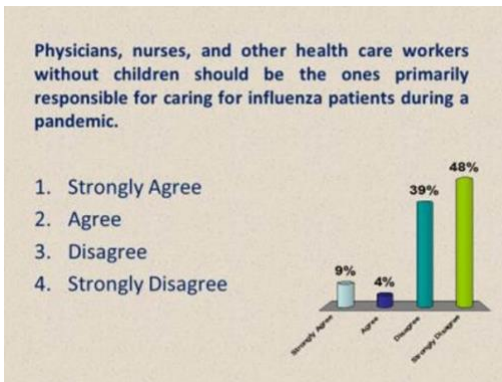
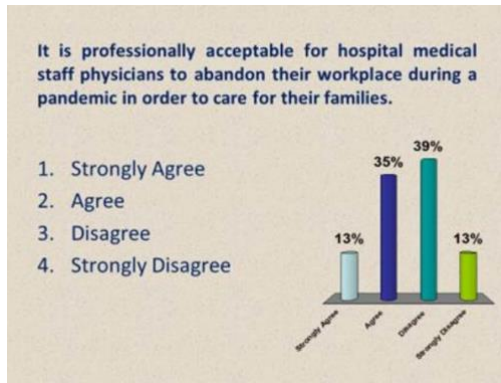
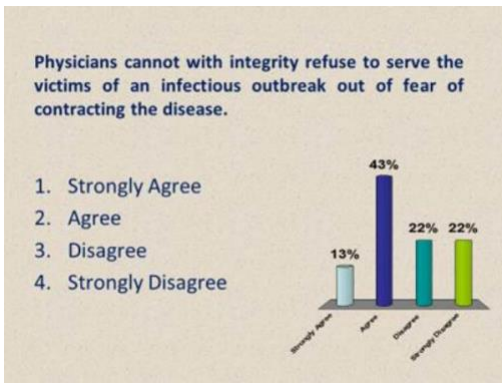
“ration ... equity ... the triage officer’s decision is final”

“in harm’s way ... excruciating burden ... concern for family’s safety”

“the focus must be on the community more than the individual patient”

“the results may not be fair at the individual level”

“withdraw the potentially life-sustaining treatment from one patient to give it to another patient”



#19

For the 19th 'tactics and strategies' communication, I am sharing with you the first of two selections from the most recently revised/updated draft of a Grand Rounds presentation I initially prepared/delivered in 2000 titled "Addressing patients' spiritual wellbeing". The impetus then was the opportunity to participate in the creation at Vanderbilt of a training video for in-servicing hospital staff in response to the new Joint Commission accrediting standard re addressing patients' spiritual needs. Note – the definition/differentiation of the spiritual dimension of patient care I am offering for your consideration in this and the following communication focuses on the integrity of every patient and family whether or not they are religious. I remain convinced that this definition of and approach to spirituality is relevant to ethics. I welcome your feedback and would be pleased to learn about ways you have found to incorporate attention to patients' spiritual (in)stability when challenged by illness or injury. Doug

[These reflections represent the most recently revised draft of a Grand Rounds presentation on the subject of assessing patients' spiritual wellbeing I was invited to deliver in August 2000 for the Obstetrics and Gynecology residents in the Phoenix area. I prefaced the presentation by (1) describing my role with an intervention project at the University of Miami for 125 cocaine-abusing women who had prematurely delivered cocaine-exposed babies, (2) explaining my responsibilities as a member of the executive leadership team for a non-profit community health center serving medically un(der)served patients and families in three truly rural counties of eastern Tennessee and Kentucky, (3) summarizing my contributions as an adjunct faculty member with Michigan State University's Center for Ethics and Humanities in the Life Sciences in the development of a curriculum for addressing spirituality in medical education, and (4) recalling my first wife's fourteen-year struggle against her deterioration and eventual death due multiple sclerosis. The impetus for clarifying my thought re 'spirituality and medicine' came from preparing to participate in the creation of an training video that was being developed at Vanderbilt in 2000 as a tool for in-servicing hospital staff re assessing patients' spiritual needs (which Joint Commission had recently added as an accrediting standard).]

Assessing a Patient's Spiritual Wellbeing: A Few Suggestions (1)

Douglas Brown, PhD

1. When to consider a patient's spiritual wellbeing:

1.1 For several years, the senior physician – David McRay, MD -- at the Appalachia community health center where I worked (1997-2006 as a member of the executive leadership team) and I met weekly to review his most perplexing and burdening patient encounters. Consider this summary narrative of one such case:

It was a busy Wednesday afternoon. The patient – new to our health center -- was in her late-20s, had four children, and was now 32-weeks pregnant. The fetus' fundal height was smaller than expected. She had received no prenatal care. A colleague asked David to do an ultrasound. The patient was sitting on the edge of the exam table when David and a nurse entered the room. David helped the patient into a supine position. She was covered with a sheet up to her blouse. The nurse turned down the light. As David began the exam, the patient said barely above a whisper, "I have a lot of scars." David's first thought – "surgery . . . perhaps a previous c-section". Once he saw the scars, he thought – "accident . . . perhaps a burn". He asked the patient, "Did you have a car accident or . . . ?" She interrupted and, as she stared at the wall, said quietly, "My mother set me on fire when I was three." David had no response. It turned out the baby was fine. As we later reflected on the case, David explained to me, "Her life is so far removed from my range of experiences. I did not know how to respond. She will never be free of this childhood experience, these scars. If my mother had . . ." His voiced trailed off.

When the patient whispered "I have a lot of scars", she was making an existential as well as a literal comment about her wellbeing. Simply put, she was saying, "My story is broken. Can you help me fix it." (Howard Brody, MD/PhD, is my source for this way to frame a patient's meaning.)

1.2 Imagine you and the care team are looking down a hallway with patients in most of the exam rooms. Whether or not the patients in these rooms share similar definitions of or approaches to spirituality is immaterial to each patient. The patients are not together in the hospital as a community. What does matter to each patient ultimately is his/her own particular spirituality. However, you and the care team – moving from room to room – need a definition of and an approach to spirituality that prepare you to meaningfully integrate the 'spiritual' and the 'physical' in caring for each patient. Finding/clarifying such a definition of and approach to spirituality is no simple task.

1.3 Most hospitals and outpatient clinics exist to respond to patients' physical needs and, therefore, are centered by scientific/clinical language. Scientific/clinical language is the 'first language' of these health care settings. With symptoms, with injuries, with diseases, . . . – patients enter anticipating that their physical conditions can be corrected or brought under control. The expansion/deepening of the scientific knowledge base and the introduction of increasingly sophisticated technologies continue to concentrate attention on patients' physical interests in health care settings.

1.4 Patients hope that entering a hospital or a clinic will be no more than a quick pit stop or, at most, a repair shop delay in their day-to-day routines and life journeys. The circumstances that lead patients to seek medical attention are often benign and/or soon resolved. In these situations, assessing a patient from a spiritual perspective may remain (by patient choice and/or by caregivers' choice) on the periphery. By 'periphery' I mean that caregivers remain attentive to subtle or incidental indications that, in addition to the patient's immediate problem, there may be a deeper 'wound'. Such indications put the caregivers in the tough position of deciding whether they have the time, emotional capacity, expertise, and resources to determine if indeed there is a deeper 'wound'. And the circumstances that lead patients to seek medical attention may in fact have to do with a deeper 'wound'. In these situations, caregivers need a language and perspective re spiritually in order to attend to the patient's needs.

2. Objectives for considering a patient's spiritual wellbeing:

2.1 Given the immediate attention in most health care settings to patients' physical needs, the objectives for integrating attention to spiritual wellbeing into patient care need to be precise and appropriately circumscribed. Hospitals and outpatient clinics do not have purposes parallel to spiritual retreat centers, synagogues, churches, mosques, What would be objectives for attending to a patient's spiritual wellbeing that are consistent with the purposes of health care settings? Possible answers might be (1) to insure effective communication, (2) to show respect for and

understanding of patient preferences regarding their medical care, (3) to maximize the health benefits associated with optimizing a patient's capacity to implement the treatment plan, (4) to search for factors contributing to a patient's failing health, (5)

2.2 Attending to patients' spiritual wellbeing, then, has to do with minimizing the spiritual disturbance they are experiencing due to being in a hospital and/or due to injury/illness in order to maximize the benefits from their spiritual resources (1) for making decisions about their care and (2) for realizing their full measure of healing. To make the objectives for assessing a patient's spiritual wellbeing concrete, think in terms of assessing patients' centeredness – their balance and focus. It is crucial that a patient has (or recovers) sufficient balance and focus to communicate well (which requires listening carefully, thinking courageously, and speaking clearly) and to participate appropriately in decisions about his/her care.

2.3 Assisting patients in the recovery of balance and focus is, in my judgment, the primary goal/consequence that makes giving attention to spiritual wellbeing pertinent to caring for patients. (Fear of) serious illness or injury can challenge/threaten patients' balance and focus, thus raising crucial questions about the credibility of the spiritual foundation upon which they have built their lives. A hospital is a particularly difficult setting in which to face this possibility. Sheer pain may eclipse a patient's use of his/her spiritual resources. By being in a clinic exam room or in a hospital, s/he is distant from (or even cut off from) the activities and experiences essential to his/her spirituality. Then again, a patient's spirituality may be contributing to his/her loss of balance and focus.

2.4 Loss of balance and focus may be a deeply significant process by which a patient's spirituality is tested and eventually strengthened. How many individuals, before being confronted with (the possibility of) significant injury or disease, have ever taken seriously the existential premise that facing one's finitude is prerequisite to authentic living? Whatever the number who have, the fraction is far too low for caregivers to assume that patients will retain their balance and focus when faced with (the real possibility of) life-threatening injury or disease. Caregivers, thus, may face a dilemma -- (1) on the one hand, they need their patients to be balanced and focused in order for treatment decisions/plans to flow, (2) while on the other hand, they may have to give some of their patients time/opportunity to experience the spiritually refining/restructuring that may be necessary for them again to be centered.

[continued in Part 2]

#20

For the 20th 'tactics and strategies' communication, I am sharing with you the second of two selections from the most recently revised/updated draft of a Grand Rounds presentation for Ob/Gyn residents in the Phoenix area I initially delivered in 2000 titled "Addressing patients' spiritual wellbeing". As I explained in the cover note for #19, the impetus then for addressing this subject was the opportunity to participate in the creation at Vanderbilt of a training video for in-servicing hospital staff in response to the new Joint Commission accrediting standard re addressing patients' spiritual needs.

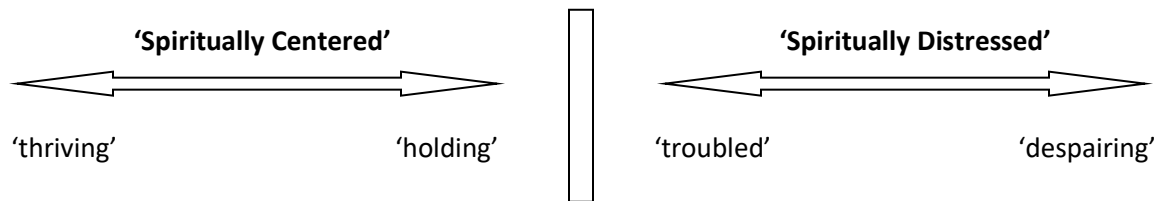
Note – the definition/differentiation of the spiritual dimension of patient care I am offering for your consideration in this and the previous communication focuses on the integrity of every patient and family whether or not they are religious. I remain convinced that the definition and approach in this essay illuminate a clinically significant link between spirituality and ethics. I welcome your feedback and would be pleased to learn about ways you have found to incorporate attention to patients' spiritual (in)stability when challenged by illness or injury.

Doug

Assessing a Patient's Spiritual Wellbeing: A Few Suggestions (2)
Douglas Brown, PhD

3. Understanding a patient's spiritual distress:

- 3.1 The root meaning for 'distress' has to do with pressure or strain. To be distressed, therefore, is to be tense, troubled, oppressed, threatened. **'Spiritual distress' has to do with the loss of peace, joy, hope, and resolve individuals experience (to varying degrees) when faced with unsettling life circumstances that threaten to overwhelm their core paradigm by/within which they live day-to-day.**
- 3.2 Caregivers are trained to think in terms of the least invasive means (i.e., 'do no harm') to resolve a patient's problem. The response to an asthmatic patient who is wheezing is less intensive than the response to an asthmatic patient who is listless. The intervention should match the level of concern/danger. Caregivers should have an analogous framework by which to assess a patient's spiritual wellbeing. Think in terms of two sides of a spectrum – i.e., 'spiritually centered' and 'spiritually distressed' – separated by a threshold. Variations of being 'spiritually centered' range from 'thriving' to 'holding'. Variations of being 'spiritually distressed' range from 'troubled' to 'despairing'.



- 3.3 Caregivers cross a threshold when the description on the spectrum that most fully accounts for their observations about a patient shifts from 'spiritually centered' to 'spiritually distressed'.
- 3.4 Patients who are spiritually centered are capable of participating meaningfully in the decisions about their care and can be counted on to be diligent in fulfilling their responsibilities. They come across as attentive, hopeful, and self-confident. They ask insightful questions, make accurate comments about their condition, and have a sense of humor. Other of these patients may be struggling to maintain their balance and focus. They show signs of being fearful, upset, disoriented, and impatient. As these dispositions strengthen, they are moving toward and may eventually cross the threshold into being spiritually distressed.
- 3.4 Patients who are spiritually distressed complicate the decision-making process and the management of their care. Some of these patients are troubled for inward as well as circumstantial reasons. They are losing confidence, motivation, hope. They may appear despondent or panicky. They may deny the reality of their situation. Other of these patients are despairing. They are immobilized, depressed, apathetic, fatalistic. Their spiritual distress may surpass in urgency their injury or disease. Professionals with special training for such situations (e.g., social workers, psychologists, chaplains, ethicists, . . .) may need to be more central to the medical team's care for these patients.

4. Defining/distinguishing 'spirituality' and 'religion':

- 4.1 I suggest that caregivers begin with this premise – i.e., that all individuals are more than the insights made possible through various empirical analyses. In the health care sphere, this premise implies that patients are more than potential or actual illnesses and accidents; professionals, more than highly skilled scientists/technicians. To consider this 'more', a vocabulary and a manner of discourse -- in addition to scientific/clinical language -- are required. I have found that most (perhaps all) individuals have, with varying levels of sophistication, such vocabulary and manner of discourse. Such vocabulary and manner of discourse disclose, in the most elemental and inclusive way, each individual's spirituality. An individual's spirituality reaches, shapes, and sustains his/her integrity (i.e., wholeness, oneness, character).
- 4.2 The definition of 'spirituality' that has worked well over the years for me in opening discussions of this subject with health care professionals is: **'Spirituality' has to do with the sort of person a patient is, with the basis upon which patients' lives have integrity and balance. Patients reveal their spiritual identity when they share their core ideas and life values and when they explain how they sustain these ideas and values. Fear, loneliness, and guilt as well as happiness, contentment, and wonder are windows into a patient's spirituality.**

4.3 Some caregivers may question the absence of the word 'God' or a reference to a divine transcendence in this definition of spirituality. This definition represents an attempt to define spirituality so as to minimize the risk of eliminating individuals as 'spiritual' by definition. I strongly recommend against making either a reference to a divine transcendence or a claim of experience of/with a divine transcendence prerequisite to being considered 'spiritual'. Instead, the transcendence that, in my judgment, is prerequisite to a fully inclusive approach to spirituality is the human sense/awareness of self (i.e., the 'more' about human beings for which empirical analysis/explanation alone does not account). I am proposing (1) that this 'more' is present in/with all patients and (2) that this 'more' is very relevant to empirically-driven health care professionals who are expected to assess their patients' spiritual wellbeing. With this 'more' in common, patients experience and express their spirituality in ways special/peculiar to each one (including but not limited to those who interpret their spirituality in terms of experience of/with a divine transcendence).

4.4 The definition of 'religion' that has worked well over the years for me in opening discussions such as this one is: **'Religion' has to do with the way many patients experience and express their spirituality. They center their lives on worshipful devotion to 'God' as a mystery that transcends human beings and the world. They are encouraged in their religious communities to live this way through the study of sacred writings, the affirmation of core ideas and life values, the sharing of inspirational stories, and the celebration of special rituals.**

4.5 Some caregivers may express concern that this definition of religion is decidedly institutional in wording. There are certainly less institutional ways to define/nuance 'religion'. However, in order to meet the Joint Commission regulations for assessing patients' spiritual wellbeing and in light of the likely assumptions many caregivers hold re 'religion', it seems to me that an institutional definition of religion accomplishes the primary objective of distinguishing religion as a subset of the larger phenomenon of spirituality.

4.6 I suspect that a significant number of physicians and their support staff as well as most of their patients are more familiar with the following association of spirituality and religion:

'Being religious' subdivides into – (1) 'being spiritual' (a favorable assessment according to the particular religion's criteria) and (2) 'not being spiritual' (an unfavorable assessment according to the particular religion's criteria)

rather than:

'Being spiritual' subdivides into – (1) 'being religious' (in experience and expression) and (2) 'being non-religious' (in experience and expression)

4.7 The definition of and approach to spirituality used in a hospital, in a clinic, and by a medical team need to be inclusive of all the patients for whom care is being delivered. Not all patients are religious. Not all patients are affiliated with a particular religion. Not all patients are members of any one sub-division of one particular religion. And crucial non-religious aspects of every patient's spirituality are missed when 'being spiritual' is viewed as interchangeable with or a subset of 'being religious'. Concerning these missed windows into a patient's spirituality, here are some examples:

- a morning/evening walk
- participation in community/civic organizations
- a refreshing hobby (e.g., photography or gardening or hiking or . . .)
- participation in volunteer community service activities
- reminders of life-changing experiences
- travel opportunities
- inspiring music
- the company of a pet
- a thought-provoking book
- a favorite art gallery or museum
- social pleasures (e.g., a glass of wine or a pleasant dinner or a theater outing or a sports event)

a special friend

5. 'Respect' as the anchor for assessing patients' spiritual wellbeing:

- 5.1 'Respect' is foundational to effective assessment of patients' spiritual wellbeing. The root meaning of respect – i.e., 'to look back or to look again' -- is very vivid. There is very little benefit from attempting to assess a patient's spiritual centeredness or spiritual distress if the professionals responsible for the patient's care do not genuinely respect the patient.
- 5.2 It should not be taken for granted that caregivers are predisposed to truly respecting their patients when assessing their patients' spiritual centeredness or distress. Many caregivers have been born into and/or raised in fairly conservative families and communities. I was. In the religious and social setting into which I was born and in which I was raised, I remember being taught to doubt the motives and to avoid taking seriously the ideas of all others who differed with 'us'. In time I came to see this instruction as instruction in disrespecting others. Variations on instruction in disrespecting others are implicit, if not explicit, to some degree in virtually all organized constituencies or spheres in our society (including the medical sphere).
- 5.3 'Respect' does not mean 'cater to'. It does mean 'take very seriously'. This clarification calls attention to the rather complicated process by which the attending physician and medical team work with the patient and family/friends in decision-making.
- 5.4 The following set of questions illustrates the skill physicians and other caregivers need in order to be fully informed about and respectful of patients who are experiencing spiritual distress:
- **"What makes for a good day for you?"** – with attention given to how 'good' is described
 - **"What are your difficult days like?"** – with attention given to how 'difficult' is described
 - **"Do your good days help you make it through your difficult days?"** – with attention given to indications of how firm a 'yes' is and whether the good:difficult ratio is diminishing
 - **"Do you more often find yourself waking up in the morning hoping for a good day or hoping not to have a bad day?"** -- with attention given to how encouraged or discouraged the patient is
 - **"What do you want me to know as I and the team consider how best to take care of you?"** – with attention oriented toward acceptable or unacceptable outcomes rather than toward management plan details
 - **"What outcomes do you want to keep fighting for?"** – with attention drawn to feasible outcomes
 - **"Are you concerned that your illness will interfere with your participation in any activities or events in the near future that are especially important to you?"** – with attention given to what demands these activities or events would make on the patient, to how feasible it is for the patient to participate, to what condition the patient hopes to be in at the time of these activities or events
 - **"Do you have any questions or worries that are hard to talk about with your family or friends?"** – with reassurances that such can be discussed with you in complete confidence
 - **"Patients sometimes tell me they find themselves thinking 'that would be worse than dying'. Have you had this thought?"** – with attention given to what such conditions would be

POSTSCRIPT

Adding to patient care the responsibility of assessing patients' spiritual wellbeing increases the likelihood that caregivers will often be in a position to share their core ideas and basic values with patients. Healthcare professionals who interpret the responsibility to assess their patients' spiritual wellbeing as liberty to look for opportunities to impress their own core ideas and basic values on patients risk failing to respect or to be truly present with their patients. Pressing their core ideas and basic values may lead them to prejudge the spiritual wellbeing of patients whose core ideas and basic values differ from their own. Their attention span may narrow. Their diagnosis and/or management may be adversely influenced. Also, considerable diversity regarding 'spirituality' and 'religion' is usually found among the numerous professionals involved in a patient's care. Liberty to impress one's own core ideas and basic values on patients would not be restricted to the attending physician. Instead, all the professionals involved in a patient's care -- including consultants, residents,

medical students, nurses, social workers, chaplains, social services personnel, et al -- could assume the same liberty, thus potentially putting patients in confusing as well as insecure situations. In order to guard against disrespecting patients and weakening their trust, caregivers should limit the way they share their core ideas and basic values with patients to discussions (1) they will summarize in the patient's medical record and (2) the medical team will consider on rounds to be part of the patient's care.

#21

For the 21st 'tactics and strategies' communication, I am sharing with you a section from an article I am pleased to have had included in the Fall/November 2019 issue of *Literature and Medicine*. Each article in this *Literature and Medicine* issue demonstrates a way to use Albert Camus' novel *The Plague* as a primary resource for medical humanities courses. The issue's guest editor specifically asked me to explain how the relationship/collaboration between the novel's two main characters – Dr. Bernard Rieux and Jean Tarrou -- has framed my personal narrative and has been my centering professional paradigm since I transitioned in the mid-1980s from being a history professor to being an ethics educator and qualitative researcher embedded in medical school departments, teaching hospitals, and non-profit community health centers. This article is the first time I have placed in print a detailed account of being with my first wife (d. 1987) through her unremitting fourteen year illness as a victim of multiple sclerosis.

I have taken the liberty to insert below one section from the *Literature and Medicine* article to draw your attention to one way the article might be a surgical ethics education resource for you to use. The section inserted below opens with a reminder that the core meaning of 'disillusioned' is to be rescued from or relieved of an illusion – i.e., 'dis' + 'illusioned'. For many years, I have routinely opened educational sessions by placing this definition on the screen/board and then asking the participants to identify the word being defined. The typical responses are 'enlightened' or 'educated' or 'illuminated' or . . . but rarely 'disillusioned'. The point – ethics has to do with how we regroup on the other side of a disillusioning experience. The section inserted below then offers a series of poignant examples from conversations with medical students, residents, and practicing physicians/surgeons.

Doug

[a section from my 2019 *Literature and Medicine* article]

Dr. Rieux and Tarrou prompt me to see into the complexities of being disillusioned that seem unavoidable for healthcare professionals who care deeply for and about those most immediately and most often at risk. To be disillusioned is to be rescued from illusion, to be moved closer to reality. To be disillusioned is also to suffer a devastating blow to motivation, purpose, courage, resiliency, inspiration. Well-intentioned learners continue to be drawn to medicine by the vision of caring deeply for patients, by the vision of making a difference in patients' lives. At various points across the continuum of medical education and medical practice, they realize the vision that drew them to medicine is, far more often than not, an illusion. For many humanistic language soon seems hollow, soon becomes embarrassingly naive.

Listen to these representative medical students, residents, and practicing physicians as they speak candidly about having their illusions torn away and about their struggles each time to regroup. Note especially the images they use to make their disorienting experiences vivid.

A frustrated medical student soon finishing his first year disclosed as we sat together at a mixer near the end of the academic year: "We had the 'keep your balance, don't lose your relationships' orientation talk from the dean on Day One. And an ethicist we never saw again reminded us the same day to 'nurture your interior life.' Day Two blew by all that. After the first round of tests, reality set in. Getting decent grades means 80-100 hours of study every week. What's left for relationships? or for my 'interior life'? The grades for my first set of tests reassured me. I can do this. But at what price? Where is the dean? Where is the ethicist? Obviously not near enough to us to speak with understanding and integrity. I feel betrayed." He expected the dean and the ethicist to recycle their platitudes in a few days to the next class of new students and wondered if or how to warn them. What are the odds this medical student would complete his

training resolved to be humane and concerned about injustices? I asked myself how a Tarrou would be present with this student as he silently carried this sense of betrayal through his medical school years.

A confused third-year medical student, considered by the pre-clinical faculty to be one of the top students in her class, admitted soon after her first clinical rotation as we chatted briefly before rounds: “I am excited about finally being in the clinical setting. I want to help patients. I want to contribute to the team. I understand I need to make my upper level look good. And yes, I want to impress the residents and attendings. But now I feel very uncertain. Residents and attendings broke bluntly into my case presentations. It’s demeaning to be told – ‘We don’t have time for a 3rd-year medical student history and physical’— and then to be ignored. The one thing I thought I knew how to do was a history and physical. I am afraid of failing, of appearing weak.” After my first few months with 3rd-year medical students in a teaching hospital, I understood. The aim eye of medical students who have crossed the threshold into the complexities of actual patient care has to be on developing a functional knowledge base and on acquiring basic technical skills. The fraction of attention they can spare for focusing on a patient’s care being humane, respectful, and fair is small and at odd hours. How would a Tarrou make the most of the slight and erratic openings to add something substantive to their professional growth within such tight limitations?

A shaken medical student near the beginning of his fourth year, in response to my questions about the way he was selecting elective rotations and assessing possible residency programs, paused and then rather embarrassingly acknowledged: “It’s all about balancing residency program status with personal convenience. I am in the rural-track program of my medical school because I began with the intent to practice in an underserved area. But my fellow rural-track students and I hardly ever talk about that goal when we discuss rotations and the residency programs we are considering.” This student’s medical school had designed its curriculum to maximize each year the number of students who were intent on caring for truly rural and underserved populations. This student and his fellow rural-track students were to be examples and leaders. Instead, they had lost their distinction. What is revealed about the medical education milieu when an institution so intentional still fails to nurture one potential Dr. Rieux after another?

A tearful fourth-year medical student, during her interview for the residency program I was managing, revealed: “I majored in English Literature. But when I sat down to write my personal statement for the residency application, I discovered I had lost the skills to think in narrative style or to write an essay.” Yes, having majored in English literature meant she had very high standards. However, by the transition to residency most medical students have been steered away from the basics for telling or writing a story – e.g., character formation, plots and sub-plots, vivid descriptions, intrigue/surprise, passion – toward sterilized case presentations that are efficient, bare, and predictable. How many can still hear a plague victim’s appeals as Dr. Rieux did?

A second-year resident, during a lunch conversation, admitted: “By the third year of medical school, I realized that being a physician is not what I had envisioned. Being with patients and making a difference in their lives 90% of the time would be great. Even 70%. But 40% or less? I feel stuck. What else can I do? It is hard to quit after having invested so many years. I am not in medicine for the money. There are much faster and easier ways to that goal. My college friends are making shit buckets full of money while I am sacrificing my 20s and amassing an enormous debt. I am frightened by the ways I have changed. Fatigue has darkened my mood and shaken my plans. My family and friends do not understand how tired I am. Will these changes reverse after residency?” She added that she no longer viewed those who withdrew from medical school as weak but as courageous. She advised me not to encourage my sophomore undergraduate daughter to choose pre-med. Then after lunch, she drew the curtain of silence and returned to work. She progressed through the remaining two residency years. Can a Tarrou help someone in such intense professional pain?

A young physician, three years out from residency, explained: “The audience in residency is your attending physician. You tend to adopt his/her approach. If you take your own approach, you risk getting into trouble. So you put personal responsibility on a back burner. Your career rides on the attending’s interpretation and your upper level’s interpretation of your performance. Residents – especially interns – implement the decisions of those above them. They must move quickly. They know their medical analyses will be quizzed. They have little time to think about anything else. Every year that such reflection is suppressed, the harder it is to recover. Many residents take the position – ‘When I get out, I won’t do it that way.’ The danger in taking a ‘later’ attitude is that you tend to become what you do. Many days slip quickly into a downward spiral. You fall behind due to patient volume and the inability to anticipate or control the complexity

presented by patients. Getting the work done takes over. Addressing the chief complaint without falling further behind severely restricts attention to deeper issues in the patient's story. This cycle eats away at the joy of what you are doing." I met this young physician near the end of his first year after residency. In the first few weeks with his new practice, he began to feel pressed to catch up to his partners in generating revenue. His spouse was just as insistent that he contribute to long-delayed family interests. He and I met at 6:00am every other Wednesday for six years searching as I imagine a Dr. Rieux and a Tarrou would for firm footing re five core questions essential to his integrity – Who am I? What do I do? For whom do I do what I do? To what end do I do what I do? Within what values do I do what I do?

A physician in his late 30s, a couple of years past his decision to leave the practice of medicine, looked back as we shared coffee and another conversation: "I made course selections for requirements other than pre-med courses based on whether a course or instructor would make it easier to get into medical school. The humanities were downplayed . . . downgraded at my undergraduate school. Pre-med students were perceived and thought of themselves as the toughest among all the students in science programs. The sneering about the humanities was severe. I did not realize then that to let the mental habits characteristic of the humanities atrophy is to let a crucial part of the self die. Yet students, residents, academic physicians, and practicing physicians who place value on these traits run the serious risk of being perceived as not being fully committed to medicine. Medical school and then residency are meat grinders that spit you out on the other side. You are pushed through. There is little or no opportunity to pause and assess. There is hardly any occasion to ask, 'Why am I doing this? Is this what I want to do? Is this what I ought to do?' It is ironic that during the years when you need to be most reflective, you do not have the tools, the time, or the energy." He loved science. His academic record was outstanding. His clinical knowledge was deep. His technical skills were excellent. His work ethic was exceptional. His father was an internist. These gifts were sufficient to get him through training and into practice, but minus the skill to consistently integrate his intent to be truly present and stable with his patients and his colleagues. Realizing he was teaching me more than I was aiding him as he confronted the disturbing evidence that he would never be centered as long as he remained in medicine, I began searching in *The Plague* for indications Tarrou was transformed by Dr. Rieux's presence in his life.

A physician with fourteen years' experience as the lead physician for a community health center in a poverty-burdened and underserved region of East Tennessee Appalachia reflected on being a physician as we sat on a quiet ridge overlooking the valley: "Medical school and residency are not educating experiences. You are not taught how to think. You do not engage ideas. You memorize information and learn to make differential diagnoses. There is little historical perspective. Medicine is not integrated into larger and related spheres of thought. Becoming a physician is analogous to a trade school experience. Little attention is given to what it means to be a professional." This physician stands out within the intimate circle of physicians in whom I have seen a Dr. Rieux. He has permitted me to be near – as a Tarrou – for the past twenty-five years as his career transitioned into a faculty position with his residency program and as we have found a way to be clinical and ethics education resources for physicians, medical students, nurses, and public health NGOs in Palestine (the West Bank and Gaza). He knows that an eye-opening experience is often not a life-changing experience. Our special friendship is anchored by a shared judgment that seeing life from the perspective of the most at risk patients and their families is an incomparable and unparalleled value by which we must live.

A physician in her late-40s reflected: "I remember quite clearly my first day in medical school. The dean did not mince his words. 'Medicine must be your husband, your wife, your children, your family, your life. If you can't make this commitment, get out now.' I fought to keep hold of the grand ideas that brought me into medicine. I fought against the dean's angle on medicine. And twenty-five years later, I am disillusioned about my profession, burned out, cynical. The medical school, residency, and practice settings have worn me down." This single exchange reminded me of a recent conversation with the spouse of the first physician in whom I saw a Dr. Rieux. He created opportunities for me to be with him ("in the arena with us as a Tarrou" he delighted to say) as he navigated his academic career in uro-gynecologic surgery from a junior faculty member to a division chief to a department chair, from introducing model clinics for the gynecologic care of disabled women to using a simple surgical procedure to rescue women in Ghana whose lives had been ruined by lingering fistulas after prolonged labor and delivery. Just months into his appointment as chief of gynecologic surgery at a renowned medical school, he suddenly died. He was 49 years old. A few weeks after his death, his spouse and I sat quietly in his still untouched office before beginning to pack. After several minutes, she turned to me and asked, "What was it all about?" I remember pausing and then reassuring her, "It was about building communities in which every member begins life with hope, lives life with joy, and ends life with dignity."

I have filled scores of journals with such vignettes. Dr. Rieux and Tarrou in *The Plague* sharpen my efforts to hear with insight the numerous stories of regrouping after being disillusioned I am privileged to be near enough to hear. Common to each story is the fact that the three required languages in medical education and medical practice – i.e., clinical, legal, and economic – all default to impersonal encounters that diminish patients as individuals.

The environments for medical education and medical practice are most fertile for impersonal encounters. Listen to echoes from rounds, patient records, call room conversations, doctor's lounge conversations, grand rounds, morbidity-mortality conferences, evaluation sessions, faculty meetings, medical staff meetings, depositions, productivity reviews, and so on.

An ethic firmly rooted in a humanizing approach to patient encounters entails a fourth language – the language of respect, compassion, and fairness – a fourth language that is fundamentally distinguishable from clinical language, from legal language, from economic language. Fluency in the language of respect, compassion, and fairness is not required to successfully complete medical school, to pass post-graduate boards, to be rewarded by practice management, to secure hospital privileges, to pass recertification examinations, to be promoted, to be elected to national positions of leadership, to be on a hospital ethics committee. Fluency in the language of respect, compassion, and fairness is, however, essential for sustaining the experience of being a humane physician who cares deeply about patients – especially the most difficult patients – and who brings a resolute social conscience to the practice of medicine.

Dr. Rieux welcomed Tarrou. They worked side by side. They relaxed together. They became friends. Dr. Rieux used and refreshed his language of respect, compassion, and fairness with Tarrou. Tarrou's role – to listen . . . to suggest . . . to recall . . . to question . . . to encourage.

#22

For the 22nd 'tactics and strategies' communication, I want to introduce you to a physician – Sheldon Korones, MD (1924-2013) -- whose presence radically (i.e., to the root) altered my personal life and my professional experience. Dr. Korones was one of the first generation of academic physicians who in the 1960s pioneered the formation of the neonatology specialty. In 1968 he left a lucrative private pediatric practice to establish an intensive care unit for critically ill newborns at Memphis' Charity Hospital. I hope the narrative below will prompt you to be mindful of physicians/surgeons who have been similarly pivotal for you.

I first met 'Dr. K' through an introduction arranged by the first physician to invite me to collaborate in the early 1980s -- Thomas Elkins, MD, a young Ob/Gyn physician who had recently completed his Navy obligation after residency. As he transitioned into an academic career with the University of Tennessee Memphis Medical School's Obstetrics and Gynecology Department, Tom looked to Dr. Korones as a mentor. Tom soon discovered that Dr. Korones had barred the medical school's medical ethicists from his still novel neonatal intensive care unit after they repeatedly stayed on rounds only long enough to find some controversial case about which to write, never to return to test their ethical analysis with Dr. Korones or his neonatal staff. Tom hoped my being a historian might earn a second look from Shelly.

I came to that first meeting hoping to be oriented to the ethical strains peculiar to the care of critically ill newborns. We quickly found our way to a much deeper and more profound place as we shared our stories. After a few meetings, Shelly invited me to spend a sabbatical -- the first six months of 1986 -- at his side. I discovered him to be a physician very seasoned in the struggle to be humane toward disadvantaged and vulnerable patients. As a wall-hanging reminded him and every person who entered his office -- **"Some children may dance to the joyous music of the lyre, while elsewhere other children only cling to existence. They are all ours."**

After completing his pediatrics residency in 1954 at Boston General Hospital, Shelly and his wife Judy moved to Memphis where he joined a medical school friend in a private pediatric practice. Every day he faced a severe social contrast. He spent his mornings at Charity Hospital; his afternoons, at his private ("carriage") practice. His morning patients – babies born into poverty – were dying in infancy at twice the rate of his afternoon patients – babies born into

privilege. Memphians, as was true across the South, remained entrenched in discrimination and in injustices when he made the decision in 1967 to leave private practice in order to devote himself to his Charity Hospital patients. E.g., --

An eight-year-old Caucasian boy who, after noticing an African American girl in an exam room, questioned Shelly -- his doctor -- innocently, "I didn't know you treated animals here."

Medical students and residents who, while rounding with him at Charity Hospital, repeatedly expressed disrespect for their indigent patients by asking a defensive Shelly, "How should we treat a private patient with this condition?"

Caucasian parents who told Shelly, "We would rather our baby die than be taken to that 'nigger' hospital."

A fellow physician from whom he expected support who whispered to Shelly, "It's too dark for me on this side of the restaurant."

Philanthropists who counseled Shelly, "You'll never raise money from this city for those babies."

This jagged contrast ate at Shelly's conscience. As did a noble theme first planted in him by his grandfather -- Nachman Gogel -- in whose shadow he was raised on New York City's Lower East Side.

Shelly's instinct to respond to crushing oppression formed from this oft-repeated childhood scene. It is 1930. Six-year-old Shelly is nestled in front of a Fada Radio, listening attentively to the day's episodes of Jack Armstrong. The stubble-bearded Nachman locks the dark green doors of his nearby blacksmith shop. Walking around the corner, he climbs a flight of steps to the landing of a modest five-room 'railroad flat'. Shelly eagerly meets his grandfather in front of the dining room buffet. With unequal strides, they make their way to the living room where Nachman settles into his chair. The stocky lad begins his nightly ritual. Pulling off the heavy work boots and socks, Shelly runs his fingers over each foot's single chunk of nailless flesh that had once been separate toes. Shelly prods Nachman to repeat yet again the painful memories always just a thought away. Conversing in Yiddish, they reenact an old Russian proverb that says, "A child's education begins with his grandfather's education."

"Papa, tell me again what happened to your toes."

"My son, Cossacks chased me. I hid in the forest for a long time. My toes froze off in my shoes."

With these few words, Nachman's attention would drift to 1880s Czarist Russia, to the peasant village of Mogilyov. Jewish parents in the hundreds of villages like Mogilyov stopped at nothing to keep their boys from being snatched by the marauding Cossacks who enforced the Czar's harsh conscription laws. Conscription for Jewish boys meant more than military service. It meant to be brutally stripped of their identity. In far away military schools, they were severely beaten, forced to violate dietary traditions, and even denied food. One freezing winter night, young Nachman Gogel suffered severe frostbite in the woods while hiding from the Cossacks.

The year 1968 is remembered more often for the death of noble themes than the birth of noble themes: January -- The Tet Offensive shatters reassuring interpretations of the Vietnam conflict. February -- The Turner Commission releases its warning that two separate and unequal societies -- one black and one white -- remain entrenched in the United States. March -- President Johnson announces he will not seek reelection. April -- Martin Luther King is fatally wounded on the balcony of the Lorraine Hotel in Memphis. Riots leave over 100 cities in flames. June -- Robert Kennedy is fatally wounded on the night he wins the California primary. August -- The processes of democracy virtually collapse at the Chicago Democratic convention.

Overshadowed by such disheartening headlines, Shelly announced 1 July 1968 to the medical school and to the city his intention to create at Memphis' Charity Hospital an intensive care unit for critically ill newborns. The scenario still looks quixotic. A physician with an uneasy conscience who dared to dream. A city polarized and embarrassed. A medical school and city hospital with neither plan nor funds for newborn intensive care. Skeptical local philanthropists before whom Shelly peddled his vision in vain. And yet three years later -- with the support of the local media, a persistent local

journalist, some diligent nurses, an encouraging Pediatrics Department chairman, a new Charity Hospital board, a strategically placed Children's Bureau official in Washington, a courageous rabbi, a few faithful friends, and an unwavering family -- The Newborn Center had been established.

The story continued to unfold as Shelly neared eighty years old still as the point-person for The Newborn Center. Critically ill babies received state-of-the-art care there, regardless of socio-economic or ethnic distinctions. They were referred to by names or personal pronouns rather than by bed numbers, disorders, or illnesses. Even the sickest of the babies were given every plausible chance to defy the odds.

Back in 1985, Shelly waited patiently as I adapted my historian's mental/analytical habits to the medical education/practice sphere that would in time become the well-defined framework within which a special friendship and a firm professional partnership formed between us. Beginning with that first conversation, Shelly and I spent hundreds of hours together – in the intensive care unit, in his office, or at his kitchen table -- reconstructing his professional biography . . . and sorting through my experience with my first wife as multiple sclerosis relentlessly undermined her humanity. He never flinched as I chronicled my reactions to her relentless deterioration. I had no more devoted friend during the increasingly dark months before she died (d. 1987). In the midst of the individuals who comprised my most intimate 'community' stood this pioneering pediatrician for whom I had utmost respect and appreciation.

In my office hangs a photograph of a hand cradling the tiny head of a prematurely born baby. The inscription on the back -- "To Doug, consummate comrade-in-arms and dear friend. Shelly." And so we were for more than thirty years.

Doug

#23

For the 23rd 'tactics and strategies' communication, I am sharing with you the second of the seven 'Ethics 101' promptings we distributed to our surgery clerkship students – one prompting every couple of weeks during their 12-week clerkship – as the foundation for the professionalism/ethics curriculum we developed for our surgery clerkship several years ago. We encourage the students to find a few minutes to consider the suggestions in each prompting as they rethink the tools they bring to the ethical challenges they are facing in clinics, in ERs, in ORs, in ICUs, and on the floors. I welcome your feedback. Doug

Prompting #2 – How should 'ethics' be understood in the context of clinical realities?

Douglas Brown, PhD

'Encounter' is one of those everyday words in medicine. To encounter is to come upon another person face to face, often unexpectedly. To encounter is to meet another person suddenly, necessitating a decision to assert or to defer. Each day is a series of encounters – turning hallway corners, crossing lanes, reaching for an object, getting in line, looking up from a table, chasing a prize, competing for a position, Encounters make concrete and visible the set of values and the sense of purpose out of which we decide what we will do, how we will live. Medical school is no exception. Residency is no exception. Academic medicine is no exception. Private practice is no exception.



'Ethics' examines how well we respect those we encounter. To respect is to see again or afresh, to look back wanting to see more clearly. The same root verb (L., *re + specere*) has given us such related words as speculate, inspect, spectacles, and speculum. To respect someone is to be artistic, subjective, freeing, reciprocal, gentle, engaged, holistic, attentive, patient, modest, trusting, graceful, reconciling, humanizing. But surgeons must be scientific, objective, detached. Therein lies the ethical complexity of patient encounters. A surgeon's clinical mindset can deteriorate into being rough, indifferent, curt, suspicious, selfish, alienating, dehumanizing – in short, into being disrespectful.

To be seen/treated by a surgeon as "the chest wound in Room One" or "the liver cancer in Room Two" or "the acute abdomen in Room Three" is not necessarily damaging. Excellent surgical care is evidence-based. The surgeon frames the patient with statistical associations that concentrate on damaged or diseased body parts. Differential diagnoses reflect plausible cause and effect explanations. The surgeon necessarily focuses on the patient's immediate problem more than on the patient's larger story. The surgeon must be sufficiently detached to achieve *aequanimitas* or balance.

However, at some point, clinically competent patient encounters cease to be respectful patient encounters. At that threshold, only by a surgeon's being sufficiently disciplined to regard patients as individuals worthy of respect, compassion, and fairness can a surgeon avoid the indifference that degrades patient encounters into self-serving alienation . . . the indifference that leaves patients bruised, manipulated, exploited, dehumanized.

The environments for surgical education, surgical training, and surgical practice tend to depersonalize patient encounters. Listen to the chatter alongside rounds, note the tone in medical record entries, analyze call room conversations and physician lounge conversations, recall morbidity-mortality conferences, remember discussions about depositions or about productivity numbers, . . .

For patient encounters to be truly respectful, a fourth professional language is required – i.e., the language of respect, compassion, and fairness. This fourth professional language is fundamentally distinguishable from clinical/scientific language, from risk management/legal language, and from billing/economic language. Fluency in the professional language of respect, compassion, and fairness is not required to successfully complete medical school, to pass post-graduate boards, to be rewarded by practice management, to secure hospital privileges, to pass recertification examinations, to be promoted, to be elected to national positions of leadership, even to be on a hospital ethics committee. Fluency in the professional language of respect, compassion, and fairness is, however, essential for sustaining the resolve to be a humane surgeon who cares deeply about patients – especially the most difficult patients -- and who brings a resolute social conscience to the practice of surgery. These promptings are designed to measure/strengthen your fluency in the professional language of respect, compassion, and fairness.

Each individual forms a personal sense as to what is of core/ultimate value and what is of lesser value. The core/ultimate values serve as a filter through which information is interpreted before being applied to life's decisions. Certain relationships, experiences, circumstances, and objects are thus regarded to be of such importance to an individual that s/he is prepared to suffer great loss rather than to violate them.

Judgments about what ought or ought not to be done can usually be acted upon safely without much conflict. However, some situations require a collective judgment from a number of individuals with competing goals or divergent viewpoints. In such situations, a reflective approach to decision-making -- i.e., ethics -- is necessary. Ethics then has to do with the determination of what ought to be done in a given situation, all things considered.

Some differences in judgment can be traced to variations in reasoning patterns. For instance, one person may be very logical, deductive, abstract. Another person may be more intuitive, pragmatic, affective. In order for a thorough analysis of the conflict can be undertaken, the participants in the decision-making process must respect each other enough to listen carefully in order to recognize and understand the divergent paths to the conflicting choices under consideration.

Note -- this approach to ethics focuses on the way we make decisions, first in reference to core values and then in reference to the interests of others affected by our decisions.

Well-intentioned individuals may come to different judgments about what should be done in a given situation because they are considering quite different aspects of the situation and/or because they may be assigning different weight, priority, value to considerations they share. When I round with medical/surgical teams in various patient care settings, I take copious notes as I move with the team from patient to patient. Some member of the team -- a resident, or a nurse, or a medical student, or . . . -- almost always pulls me aside at some point to ask, "What are you writing down? What are you hearing us say?" I often answer --

I am listening to how you and your colleagues are talking about the experience of caring for the patient. Not so much what you eventually write in the chart, but the discussion about the case that includes your adjectives, your adverbs, your emotions, your metaphors, your narratives, your whispered exchanges, your humor, your editorial comments. That discourse -- not the note in the chart -- reveals far more completely what you and your colleagues consider important enough to influence what you think should be done in caring for the patient.

Remember -- it is imperative that individuals conflicted about what ought to be done hold tightly to the 'well-intentioned' assumption about each other as long as possible and only surrender the 'well-intentioned' assumption after careful/thorough examination produces overwhelming evidence to the contrary.

#24

For the 24th 'tactics and strategies' communication, I have inserted below a self-assessment tool I created several years ago for a hospital ethics committee I was mentoring at the time. I first reviewed several self-assessment tools I found through a literature search and then I constructed this self-assessment tool based on a blending of selections from these sources with my initial draft. I have found that variations on this self-assessment tool can be helpful with surgical ethics education curricula for faculty, residents and medical students as well as with nurses and social workers. I welcome your feedback. Doug

Ethics Knowledge, Fluency, and Skills: Self-Assessment Tool

The purpose of this tool is to help you assess your progress over the past two years in developing the knowledge, fluency, and skills associated with analyzing the ethical dimensions of care.

Directions: Please circle the answer that best describes your progress.

<p>Communication skills in ethics discussions. For instance --</p> <ol style="list-style-type: none"> 1) Communicate interest, respect, support, and empathy 2) Educate others regarding the ethical dimensions of the case 3) Elicit the views of others in a nonthreatening way 4) Enable others to communicate effectively and be heard 5) Accurately and respectfully represent the views of individuals with conflicting views 6) Recognize and address barriers to communication 		
<p>Based on the preceding items, how would you rate your overall ability to effectively communicate with others in ethics discussions? (Circle a number on the spectrum)</p>	<p>Not Improved -5 . . . -3 . . . -1</p>	<p>Improved 1 . . . 3 . . . 5</p>

<p>Skills for analyzing conflict/s about the ethical dimensions of care. For instance --</p> <ol style="list-style-type: none"> 1) Gather relevant data (e.g., medical facts, patients' preferences and interests, and other participants' preferences and interests) 2) Assess social and interpersonal dynamics (e.g., power relations, racial, ethnic, cultural, and religious differences) 3) Distinguish ethical dimensions of the case from the legal dimensions of the case 4) Identify quality of life assumptions that involved parties bring to the situation 5) Identify and clarify the relevant values of involved participants
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Based on the preceding items, how would you rate your overall ability to analyze conflicts about the ethical dimensions of care? (Circle a number on the spectrum)	Not Improved -5 ... -3 ... -1	Improved 1 ... 3 ... 5
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Skills for providing guidance when there are conflicts about the ethical dimensions of care. For instance --		
<ol style="list-style-type: none"> 1) Formulate an ethics question based on the circumstances of a case 2) Identify the ethically appropriate decision makers (e.g., patient, surrogate, health care team members) 3) Access and apply relevant sources of information re hospital policy and professional codes of ethics 4) Clarify relevant ethics concepts present in the case (e.g., confidentiality, informed consent, best interest, justice) 5) Identify and assess a range of options in the case 6) Recognize possible areas of conflict stemming from your personal values 		
Based on the preceding items, how would you rate your overall ability to provide guidance when there are conflicts about the ethical dimensions of care? (Circle a number on the spectrum)	Not Improved -5 ... -3 ... -1	Improved 1 ... 3 ... 5

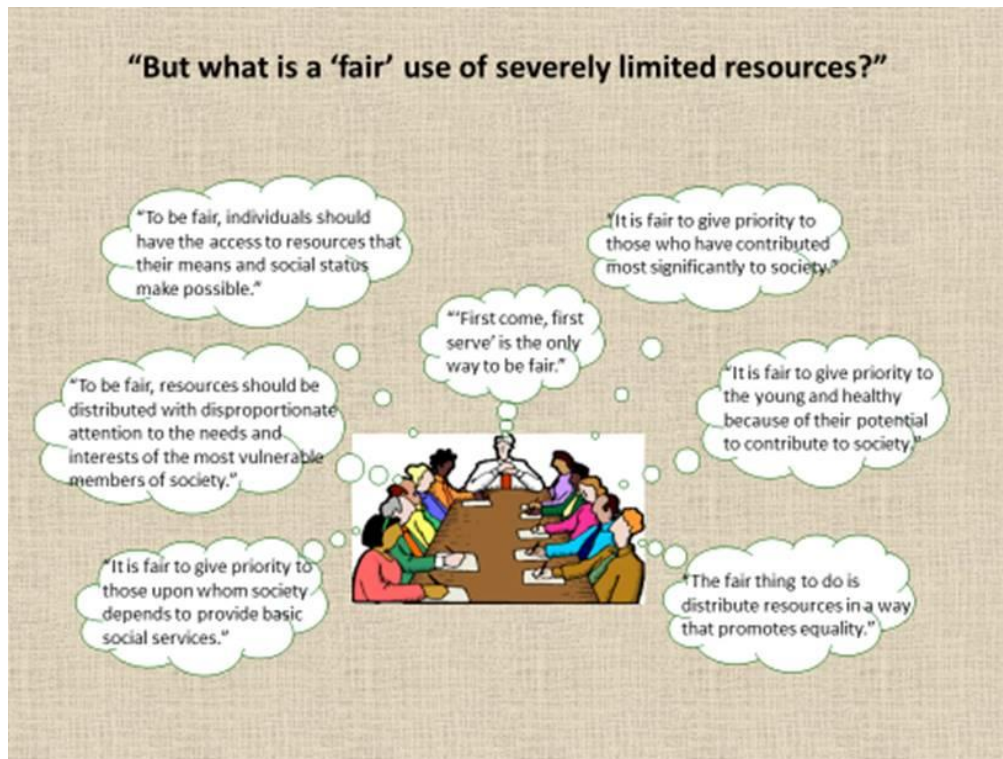
Core ethics knowledge. For instance --		
<ol style="list-style-type: none"> 1) Familiarity with different approaches to ethical analysis (e.g., consequentialist, principle-based, virtue-based, casuistic, organizational) 2) Shared decision making (e.g., decision-making capacity, informed consent process, surrogate decision making, advance directives) 3) End-of-life care (e.g., life-sustaining treatments, medical futility) 4) Professionalism (e.g., conflict of interest, truth telling, cultural sensitivity, confidentiality) 5) Use of limited resources 		
Based on the preceding items, how would you rate your overall core ethics knowledge? (Circle a number on the spectrum)	Not Improved -5 ... -3 ... -1	Improved 1 ... 3 ... 5

In summary, are you more confident now (in comparison to two years ago) to participate in discussions about cases in which the ethical dimensions of care have become problematic? (Circle a number on the spectrum)	Yes -5 ... -3 ... -1	No 1 ... 3 ... 5
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#25

Given the emerging public health crisis as evidence becomes undeniable that the coronavirus is ‘the problem of us all’, I thought it would be timely/appropriate to send you as the 25th ‘tactics and strategies’ communication a first set of reflections on wrestling with the tough decisions faced when resources are severely limited.

It is simple enough to say -- “I am for fair distribution of and access to limited resources”. I have yet to come across someone who says -- “I am for unfair distribution of and access to limited resources”. However, we all know firsthand that it is very complicated to reach agreement/consensus and very challenging to act together in/as community when resources are severely limited. One reason -- the penetrating sacrifices and the sobering risks that are inseparable from following through on the resolve to prioritize justice and to act in a consistently fair manner. A second reason – the reality (as visualized in the PowerPoint slide inserted below and attached) that several ways to imag(in)e what being ‘fair/just’ looks like conflict/collide in tense deliberations when need/demand overwhelms available resources. No single definition or outcome for what it means to be ‘fair/just’ is equally compelling and effective for all situations.

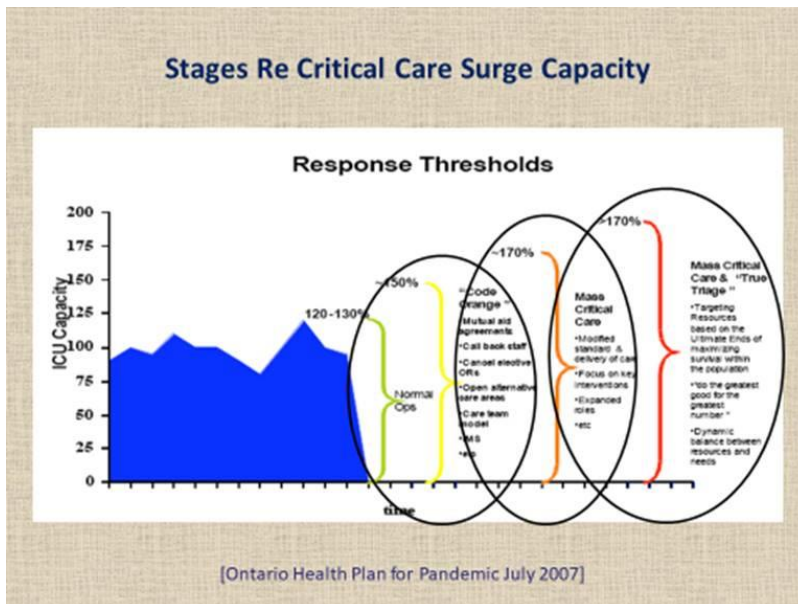


I am sure you all will be steady participants in the deliberations in your hospitals, medical schools, and communities about ethically grounded distribution of and access to severely limited resources. I hope the above reflections refresh your expertise for this responsibility. The focus of this communication is on your skills for detecting/identifying the often competing theoretical paradigms embedded within the concerns and proposals expressed by participants in these deliberations.

Doug

#26

I am sending the 26th 'tactics and strategies' communication a bit early because so much has changed so radically and rapidly for each of us in the last few weeks. As the construct below delineates, the coronavirus pandemic is creating an escalating surge in need/demand that is threatening to overwhelm our capacity to respond and is confronting us with ethically disturbing choices/actions.



I am noticing references to Albert Camus' novel *The Plague*, a well-established standard reading in medical humanities courses that offers a frank and penetrating fictional narrative about remaining humane and advocating for fairness when quarantined and surrounded by victims. With you in mind, I have taken the liberty to insert below a description/analysis of the main character Dr. Rieux and his special friend Jean Tarrou. (This description/analysis is selected from the essay re Camus' novel I was privileged to publish in a 2019 *Literature and Medicine* special issue.)

Be safe. And please do not hesitate to call (314-304-8638) or write (debrown@wustl.edu) if having an exchange – private and confidential – might reinforce your integrity and refresh your courage.

[selection from *Literature and Medicine* essay re Albert Camus' novel *The Plague*]

Let me explain why I quickly came to appreciate the broad-shouldered Dr. Bernard Rieux, an unassuming 35-year-old physician in Oran given to absentmindedness whose loyalty to his poorer and most at-risk patients demonstrates his intent to be humane and to exercise a social conscience. Soon after the morning he steps on something soft – a dead rat – Dr. Rieux, “torn between conflicting fears and confidence”, is the first among his colleagues to utter the word ‘plague’. It takes the Oran city officials several meetings to be convinced to act. But Dr. Rieux knows that the patients have to be evacuated. Families resist, realizing they will likely not see the victim again – “Have some pity, Doctor!” Dr. Rieux has “nothing to look forward to but a long sequence of such scenes renewed again and again”. His perspective on pity is cause for pause. As Camus has him argue – “One grows out of pity when it’s useless”. Dr. Rieux admits – “For the moment, I know this – there are sick people and they need curing. What’s wanted now is to make them well. I defend them as best I can. Against whom? I haven’t a notion. When I entered this profession, I did it because it was particularly difficult for a workman’s son like myself. And then I had to see people die. I saw that I could never get hardened to it.” He sometimes hears well-meaning radio broadcasters call out fervently to the quarantined city, “Oran, Oran, we’re with you!” His assessment -- “They are too remote”. A frightened woman tells Dr. Rieux – “You haven’t a heart!” His exhausted reaction – “A man can’t cure and know at the same time. So let’s cure as quickly as we can. That’s the more urgent job”.

And then there is Jean Tarrou, the good-humored but estranged son of a successful prosecuting attorney. He is a young traveler of private means and new to Oran who “seemed an addict of all normal pleasures without being their slave”. A faithful diarist, he “had a habit of observing events and people through the wrong end of a telescope. He sets himself to recording the history of what the normal historian passes over . . . seemingly trivial details which yet have their importance”. He accompanies Dr. Rieux on home visits and gives him a safe conversation partner. Sitting across from Dr. Rieux at his office desk, Tarrou notes, “In a fortnight, or a month at most, you’ll serve no purpose here. Things will have got out of hand”. He continues as Dr. Rieux nods, “The sanitary department is inefficient – understaffed, for one thing – and you’re worked off your feet. . . . Why not call for voluntary help? . . . I’ve drawn up a plan for voluntary groups of helpers. Get me empowered to try out my plan. . . . I have friends in many walks of life; they’ll form a nucleus to start

from. And, of course, I'll take part in it myself". Dr. Rieux replies, "I need hardly tell you that I accept your suggestion most gladly. But I take it you know that work of this kind may prove fatal to the worker". Later in this evening conversation, they sit together on a terrace where Dr. Rieux has earlier remarked -- "you'd think that plague had never found its way up here". Tarrou reflects -- "I only know that one must do what one can to cease being plague stricken, and that's the only way in which we can hope for some peace or, failing that, a decent death". What then does it mean to live life well? Tarrou's answer -- to minimize "lapses of attention" that result in harming others, in turning others into victims. Tarrou's resolve -- "All I maintain is that there are pestilences and there are victims, and it's up to us, so far as possible, not to join forces with the pestilences". It is indeed "a wearying business" to resist slipping into or even purposefully making shortsighted, self-centered, damaging choices -- "a vigilance that must never falter".

Two days after an official communiqué feeds optimism in Oran that the plague is finally ending, Tarrou closes his last diary entry with shaky handwriting -- "Feeling very tired tonight". Ganglia swell under his burning skin. There is a rumbling in his chest. Dr. Rieux can "only watch his friend's struggle". Tarrou has "lost the match", as Dr. Rieux puts it. But Tarrou endures the experience without flinching and lucid. Who notices? Who understands what his life and his death were about? Perhaps only his friend Dr. Rieux who himself has received word that morning of his own wife's death, a tuberculosis victim who died alone in a sanitarium miles from the quarantined city.

As the survivors in Oran celebrate the plague's receding after killing thousands, Dr. Rieux chooses instead to draft a chronicle so that he will not be among those who remain silent. He chooses to bear witness for the plague-stricken victims -- "The mothers, husbands, wives, and lovers who had lost all joy now that the loved one lay under a layer of quicklime in a death-pit or was a mere handful of indistinctive ashes in a gray mound -- who gave a thought to these lonely mourners?"

#27

For the 27th 'tactics and strategies' communication, I am sharing with you an attempt during the COVID-19 pandemic to raise awareness of and to press for insight into the disproportionate risk, suffering, and death faced by vulnerable ethnic populations among our patients. Here in St. Louis, patients residing in predominantly African American sections of the city are tracking toward the worst scenario public health models while the city overall is tracking toward the best scenario public health models as the peak for a COVID-19 surge reaches St. Louis. Not surprisingly, the overall impression absorbs (conceals?) the experience of vulnerable sub-sets of the city's population. One of our BJC network of hospitals is located in the hardest hit section of the city. For the past decade, I have led the hospital's ethics consult team and am now assisting the hospital's recently constituted COVID-19 triage team. Last week I sent to these front-line medical staff and nursing staff leaders (as well as to the hospital's full ethics committee) links to four recent newspaper articles in the *St. Louis American*. For more than a century, the *St. Louis American* has reported local, state, and national news through an African American lens. Issues are published weekly, available throughout the city, and free. I have inserted below the links to these four *St. Louis American* articles as examples of a way to alert, to remind, and to encourage caregivers to be mindful of those easily overlooked and poorly understood as they make/implement excruciating decisions about (re)distributing severely limited resources. I hope you have a few minutes to take a look. What patient groups in your communities are experiencing disproportionate risk, suffering, and death during the COVID-19 pandemic? I suspect your communities have resources such as the *St. Louis American* that draw attention to these patient groups (essentially call for 'respect', meaning to be seen). How can you use these resources to advocate for those patients too/so easily missed on the margins/periphery of who is included in 'the public', 'the community', in 'we/us'? Doug

http://www.stlamerican.com/news/local_news/black-st-louis-left-behind-in-covid-19-testing-supplies/article_c70a05f4-7451-11ea-8571-832f999891aa.html

http://www.stlamerican.com/news/columnists/guest_columnists/why-north-st-louis-city-needs-a-covid-19-testing-site-now/article_59851be4-7029-11ea-8a47-33453dfbc765.html

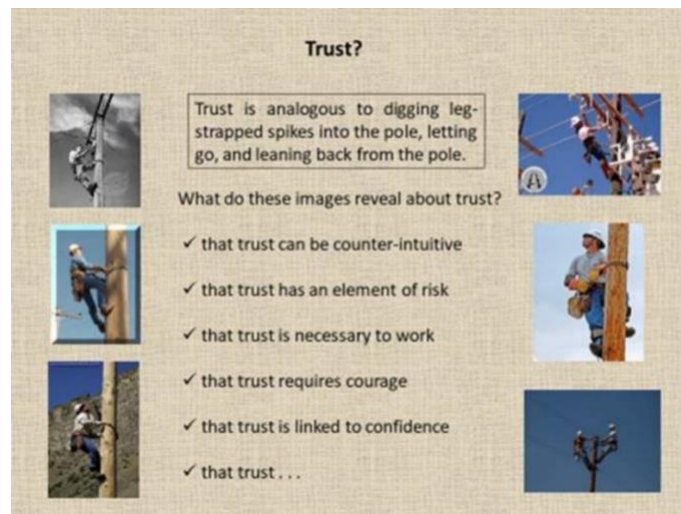
http://www.stlamerican.com/news/local_news/covid-19-and-structural-racism/article_65fb3012-79c4-11ea-8cf9-e336755de3ea.html

#28

For the 28th ‘tactics and strategies’ communication, I am sharing with you a suggestion for establishing the place and significance of ‘trust’ in explaining/framing the ethical dimension of surgical care.

The COVID-19 pandemic has made ‘trust’ front-page news – (the lack of) trust in political leaders, in public health officials, in hospitals, in caregivers, in PPE, in laboratories, in triage officers, in workers deemed essential, in human-subject researchers, in science, in neighbors, et al. We educators have an opportunity to refresh the pause effect of this common but nonetheless profound word – ‘trust’. When I attempt to do so, I tell a story.

Several years ago, I created the PowerPoint slide below to visualize a lasting lesson from my childhood (b. 1951) re what it means to ‘trust’. A few of you are old enough to remember seeing utility line workers ‘walk’ up a utility pole using the strapped-on spiked leggings, reach the lines to repair, turn loose of and lean back from the pole, and begin to work. Quite a site for an impressionable young boy! My father worked on the management side of the local phone company. He often took me to work sites. I vividly recall standing by his side when he would say, “Now watch what he does” once the utility line worker finally reached the lines. I would look up. To my child amazement (time and again), the utility line worker would turn loose of and lean back from the pole. He did so because he trusted the security belt that was looped around his waist and around the pole. Each time, my father would draw my attention to the security belt and say, “Son, that’s trust”.



Do you feel the idea? To this day, I never read, hear, or say the word ‘trust’ without recalling this frequent experience from my childhood years. If you have not already done so, I strongly encourage you to find a striking image for ‘trust’ in your experience with force similar to the utility line worker in my experience. Tell your story. And ask those participating in the educational conference to do the same. I am confident each story will deepen/reinforce the strength of the word ‘trust’ when considering the ethical dimension of surgical care.

Doug

#29

‘Good evening’ hardly seems appropriate since today across the US we did not awake to a ‘good’ day. The protests in linked to George Floyd’s murder are significant and sustained. I expect many of you are looking as I am for ways to be

aligned with the unfolding protest – so raw, pained, exasperated, exhausted -- against this brutal and senseless death and against the day after day/year after year dehumanizing encounters that have led to this tipping point.

From the May 5 leaks about the February 23 lynching of Ahmaud Arbery through last Monday's dismaying murder of George Floyd – this month I have frequently (re)turned to recollections of a three-hour continuing education workshop three years ago for 20-25 experienced/'in the field' social workers WashU's social work program asked me to facilitate. The assigned subject – 'pursuing justice'. We began the workshop with a reality check posed by the Organization for Economic Cooperation and Development criteria for assessing the OECD member nations --

Social Justice in the OECD – How do members compare?

Criteria – poverty, poverty prevention, child poverty, senior citizen poverty, income inequality, pre-primary education, health rating

<u>Top Third</u>	<u>Middle Third</u>	<u>Bottom Third</u>
Iceland	Czech Republic	Australia
Norway	New Zealand	Japan
Denmark	Austria	Portugal
Sweden	Germany	Slovakia
Finland	Britain	South Korea
Netherlands	Belgium	Spain
Switzerland	Hungary	United States
Luxembourg	Ireland	Greece
Canada	Italy	Chile
France	Poland	Mexico
		Turkey

(Organization for Economic Cooperation and Development – 2011 data)

The workshop participants were quick to share stories illustrating the OECD message that pursuing justice in the US is precarious and discouraging. We used a set of probing questions re 'pursuing' and re 'justice' for the workshop's three parts – (1) each participant for thirty minutes alone with the questions, (2) an hour disclosing/listening in small groups, and (3) an hour for full group strategic planning. We paused to feel the full force of the term/image 'pursue' before we claimed to be among those who in fact were pursuing justice. We then dared to ask ourselves – e.g., What does it mean to 'pursue' justice? What indicators clarify where we are on a spectrum with 'I could not care less about justice' at one end and with 'I could not care more about justice' at the other end? What alternatives lie between 'ignoring injustice' and 'pursuing justice'? How defensive are we about our own affluence/privilege? Can we keep our jobs even if our effort falls short of pursuing justice? What barriers do we face when we pursue justice? How do we work with colleagues who are not pursuing justice? What competes with justice for our attention? Do we think about quitting? How do we recover from fatigue and disappointment? How do we define success? What urgency about justice would our personal statement suggest if we were applying for a new position? According to the workshop feedback, most of us departed agreeing that to be of any use we must stay near, be attentive, and expect opportunities to find us. I wonder what we would say to each other if we huddled again tomorrow.

Doug

#30

For the 30th 'tactics and strategies' communication, I am sharing with you (inserted below) a way to frame surgical ethics with 'trust' as the linchpin (i.e., the peg or pin that holds a wheel on an axle, that keeps a wheel from slipping off an axle). This explanation is the third of seven brief 'Ethics 101' promptings I prepared for our surgery clerkship students. We circulate a prompting every couple of weeks during their 12-week surgery clerkship. I welcome your feedback about this way to position 'trust' in framing the ethical dimension of surgical care. Doug

What do we invite patients and their families to trust about us?

Douglas Brown, PhD

Trust is counter-intuitive . . . involves risk . . . is necessary to work . . . requires courage . . .

'Fiduciary' in ancient Roman law denoted the transfer of a right from one person to another person with the recipient's obligation to return the right either at some future time or on the fulfillment of some condition. The fiduciary held this right as a trustee with the responsibility to exercise the right on another person's behalf. In modern surgery, 'fiduciary obligation' refers to the trust patients place in their surgeons to act in their best interests. The surgeon receives the patient's trust because the surgeon possesses the special authoritative knowledge and technical skills to which the patient seeks access. Such knowledge and skills prompt the patient to seek out the surgeon in the first place. The vulnerability acknowledged by the trusting patient creates a fiduciary obligation for the surgeon who accepts responsibility for the patient's care.

A relationship this special must be rigorously safeguarded. Surgeons who prioritize their fiduciary obligation to patients seriously consider conflicts of interest. Surgeons are among a large and diverse work force that brings to the hospital numerous potentially conflicting priorities. Many surgeons are engaged in clinical research and in training/education healthcare learners, both being responsibilities that use patients as means to accomplish interests other than the patients' best interests. And surgeons have to navigate the availability of commercially-driven surgical innovations that far too often result in eventual injury to surgical patients and even skew professional organization's technical bulletin guidelines.

Accordingly, the ethical dimensions of patient care can be effectively framed by asking -- "What are we inviting patients and families to trust about their caregivers?"




Each response to this centering question puts into clinically familiar language one of the four basic intentions that are foundational to surgical ethics -- i.e., to avoid adding to the patient's pain/suffering (non-maleficence), to make a desired difference in the patient's well-being (beneficence), to align management plans with the patient's values and goals (self-determination), and to be fair in the use of limited resources (justice). When surgeons are able to follow through on these four intentions in an integrated way, the ethical dimension of their patients' care is sound, balanced, in harmony and the surgeons experience what brought them into a surgical career. For cases in which the ethical dimension of care is shaken or broken, the centering question -- "What do we invite patients and families to trust?" -- can be an effective starting point for determining which one or combination of the four intentions has failed to such a degree that respect has given way to loss of confidence, suspicion, adversarial defensiveness.

The trust upon which safe and beneficial care depends is a partnership/collaboration between surgical teams and patients (with their families and friends). In order for surgeons to follow through on what they invite patients and families to trust, surgeons need their cooperation, their participation, their assistance. Thus the companion question -- "What do surgeons need/expect from patients and families in order to follow through on what they invite patients and families to trust?"

What is routinely the role of patients and families?

The intent – to do what makes medical sense in a way that is compassionate, respects the patient's hopes/values, is fair.



Patients and families who collaborate --

- Give honest and complete information
- Cooperate with the management plan
- Have feasible expectations
- Consider the interests of other patients

As surgeons work to avoid harm, they need patients and families to provide complete and reliable information. As surgeons seek to deliver desired beneficial outcomes, they need patients and families to make a determined effort to adhere to the management plan. As surgeons establish goals of care that align with patients' values and preferences, they need patients and families to realize there are limits to what can be achieved. As surgeons strive to be fair in the utilization of limited resources, they need patients and families to consider the interests of other patients and families. These clarifications highlight the accountability patients and families bear for following through on the four basic intentions that are foundational to surgical ethics.

#31

For the 31st 'tactics and strategies' communication, I have inserted below a grid I created a few years ago as a two-step tool for identifying and differentiating ethically concerning decisions and/or actions in patient care --

Did ethically questionable decisions and/or actions cause (or contribute to) the morbidity and/or mortality in this case?

FOCUS	Avoid Harming Patient Further	Achieve A Desired Benefit	Respect Patient Goals, Values, Choices	Be Mindful Of Vulnerable Pts and Limited Resources
Patient-centered Care				
Education/ Training				
Research				
Institutional Interests				

If so, were the decisions and/or actions –
 Introduced into the case prior to the current admission? ____
 Intentional? ____
 The result of concentrating on a single focus? ____
 The result of understaffing and/or fatigue? ____
 The result of a breakdown in communication? ____
 The result of a conflict of interest? ____
 A failure to practice evidence-based medicine? ____
 Other (please specify)? _____

The first step is to associate the ethically concerning decision and/or action with the relevant ethical obligation/s (i.e., the four columns in the grid) and with the relevant organizational objective/s (i.e., the four lines in the grid). The second step is to highlight/underscore the primary contributing factor/s.

I have found this grid to be useful when training ethics consult teams as well as when developing the basic skills physicians/surgeons, residents, medical students, and nurses need for seeing/analyzing the ethical dimensions of patient care. I welcome your feedback about this grid as an aid in determining the focus and strengthening the precision of ethical analysis/discussion.

#32

For the 32nd 'tactics and strategies' communication, I have inserted below a case scenario and a proposal re cases complicated by the appeal/demand from patients and/or their families to "Just do everything". The reflections below summarize a primary project that emerged from my first years with WashU and Barnes-Jewish Hospital. Embedded in the hospital working collaboratively with the ethics committee members to strengthen the ability of the hospital staff to handle ethically challenging cases, I worked closely with the ethics committee's chair (Dr. Jonathan Green) and another of the ethics committee's members who anchored the ethics consult service (Dr. Laureen Hill) on ethically conflicted intensive care cases. Jonathan was one of the Medicine ICU attendings (and is now with the NIH). Laureen was Vice-Chair of Anesthesiology and one of the Cardio-Thoracic ICU attendings (and is now the Chief Operating Officer with New York Presbyterian-Columbia). You are free to make any use of these resources that you think might be educationally helpful. We are considering possible value and options for a wider circulation/availability of this summary/proposal and welcome your feedback/suggestions. Doug

A paradigm case

An 84-year-old female is brought to the emergency room in cardiac arrest. After twenty minutes of CPR, she is resuscitated and transported to the Medicine ICU. She is intubated, on mechanical ventilation, requires hemodynamic support with vasopressors, and is in acute renal failure. She is diagnosed with pneumonia and sepsis. After one week of aggressive treatment, she has not improved and has deteriorated into multi-organ system failure. She responds only to painful stimuli despite minimal sedation. She remains oliguric and on high doses of norepinephrine to maintain an adequate blood pressure. The medical team considers her prognosis to be grim. If she survives, she will likely be confined to bed, will be fully dependent on others for her care for the remainder of her life, and may be severely cognitively impaired.

A recurring ethical problem/challenge

Caring for such a patient can be simultaneously the most challenging, the most rewarding, and the most frustrating experience for physicians and support staff as well as for the patient and family members. When successful, an opportunity for reflection and closure is created for the patient and family and also for the health care team. Yet too often the experience deteriorates into turmoil and conflict.

Studies have repeatedly documented dissatisfaction with end-of-life care as provided in acute care hospital settings. Flawed communication remains the norm. To illustrate with the 84-year-old female patient, a typical discussion between the attending physician and family members of the patient might proceed as follows. After morning rounds, the physician meets with the patient's husband in the ICU consultation room to discuss his wife's care. The physician begins:

"Mr. Smith, your wife is very ill. She suffered extensive brain damage when her heart stopped a week ago. Her kidneys have failed. Her blood pressure is very low and is requiring strong medicine to keep it in a safe range. She is unable to breathe without the breathing machine. Right now intensive life-support is keeping her alive." The physician then asks the patient's husband, "If her heart stops, what would you like us to do?" Mr. Smith responds, "I don't understand, doctor. What do you mean?" The physician continues, "Well, if her heart stops, do you want us to try and restart it?" Tearfully, Mr. Smith answers, "Of course, Doctor. Won't she die if you don't? I love her. We have been married fifty-four years. . . ." The physician continues, "Well, what about dialysis, should we start dialysis if her kidneys do not improve? And do you want us to continue with the blood pressure medicine if her blood pressure drops further?" Now very distraught, Mr. Smith responds, "Doctor, I want you to do everything".

The physician returns to the ICU, feeling frustrated that the care team is continuing interventions they know are non-beneficial. The husband is confused and upset. He feels less in control, less able to help his wife. He does not understand what the doctor was asking him or why.

Assessing the problem

We formed a multi-specialty working group of physicians, nurses, and other hospital staff – all of whom were intimately involved in the care of critically-ill patients – to assess the need for improved communication with patients and their families. A consistent theme that arose in numerous interviews and focus groups with staff was the use of the hospital's 'Level of Care Treatment Orders' form, a pre-printed order sheet that had been designed for the medical staff to use in documenting and communicating to the nursing staff the medical interventions that were or were not to be performed in the care of a patient. With a checklist of fifteen different interventions ranging from CPR, defibrillation, and endotracheal intubation to antibiotics, x-rays, and blood draws, this form focused on therapeutic options in a convenient menu format. We discovered that, instead of being used as an orders sheet for the nurses, this form was frequently being presented to patients or their family members by a member of the medical staff. A point by point discussion followed, in which the family was asked to choose which therapies they wished their loved one to receive. The consequences from this deeply flawed process were several and serious – e.g.,

- family members were essentially being asked to develop the patient's treatment plan;
- physicians were failing to develop logical therapeutic strategies, handing off critical decisions instead to family members;
- the treatment plans that were being implemented often did not make medical sense (e.g., CPR but no intubation) and were not linked to feasible outcomes;
- the perception that anything less than everything possible is a diminished 'level' of care was being reinforced;
- attention to the patient's goals and expectations for a hospitalization was inadequate or nonexistent;
- patients and their families (who were being asked to make decisions far beyond their knowledge or understanding) were frequently confused;
- caregivers routinely became demoralized and defensive (as indicated by references to a patient's care as 'flogging', 'abuse', 'wasteful', 'futile', 'torture', 'insane', 'brutalizing').

The need to remove/eliminate the 'Level of Care Treatment Orders' form/approach and in its place to develop an alternative approach that would clarify feasible patient goals, establish a focus of care, delineate decision-making responsibilities, and provide a rational framework for code status orders for cases involving decisions about the use of life-sustaining intensive interventions was apparent and urgent.

Developing an alternative

After numerous cycles of feedback and revision over eighteen months, an alternative approach – based on a 'Goals of Care Directive' template we created (see below) -- was submitted to the appropriate medical and administrative committees for approval/adoption. This approach and the accompanying template was then introduced in the hospital's ICUs and eventually integrated into the EMR.

(next page – Goals of Care – Communication Template)

Goals of Care -- Communication Template

[most recently revised draft]

PART A: Document Goals of Care

Based upon comprehensive discussion between the patient _____ (or surrogate) and the treating physician, the following explanation best describes the patient's current goals of care: _____

EXAMPLES include but are not limited to: “return to prior living situation at previous functional status” or “return to prior living situation after physical therapy” or “remain in my home” or “be free of pain or breathlessness” or “maintain my privacy and dignity” or “be able to interact with my loved ones” or “attend my granddaughter’s graduation”.

NOTE: “Do everything” is NOT a goal of care. Ask the patient (or surrogate) what ‘everything’ is intended to achieve.

NOTE: To set realistic goals, the patient (or surrogate) needs a clear description of what to expect.

Discuss and document if the patient wants aggressive life-support measures stopped and wants treatment instead to focus on comfort and dignity if any one or combination of the following is the most likely outcome:

___ being permanently unconscious (i.e., completely unaware of surroundings with no chance of regaining consciousness)

___ being permanently unable to remember, understand, make decisions, recognize loved ones, have conversations

___ being permanently bedridden and completely dependent on the assistance of others to accomplish daily activities (e.g., eating, bathing, dressing, moving)

___ being permanently dependent on mechanical ventilation

___ being permanently dependent on hemodialysis

___ being permanently dependent on artificial nutrition (tube feedings) and/or intravenous hydration for survival

___ death likely to occur within days to weeks and treatments are only prolonging the dying process

___ other (specify): _____

PART B: Document Focus of Care

Based upon the above understanding of the patient’s goals of care:

The focus of care will be to restore the patient to a level of function compatible with the goals outlined above. Specific testing and treatments will be ordered by the patient’s physicians with the intent to achieve these goals.

The focus of care will concentrate on the patient’s comfort. Treatments that serve only to prolong the process of dying or place undue burden on the patient will not be initiated or continued.

PART C: Recommend Resuscitation Status

1. Based on the patient’s current condition, prognosis, and comorbidities, and after weighing likely benefits, harms, and goals outlined above --

The treating physician **does / does not (circle one)** recommend CPR in the event of cardiac arrest.

The treating physician **does / does not (circle one)** recommend intubation in the event of impending respiratory arrest.

The treating physician at this time **cannot make a definitive recommendation (circle)** regarding CPR or intubation.

2. These recommendations have been discussed with the patient (or surrogate) with reassurance that if resuscitation is not performed, treatment will be provided with the goal of comfort and dignity: **Yes / No**

3. For the patient (or surrogate) who decides to be resuscitated (i.e., Code 1) despite the treating physician’s recommendation against such, the treating physician has discussed the likely immediate consequences of CPR if successful: **Yes / No**

4. **Person with whom to speak if the patient lacks decisional capacity:**

Name: _____ Relation: _____ Phone Number: _____

The first and anchoring step calls for the treating physician to learn from the patient and/or family members the goals and expectations for care. The patient and/or family members may propose specific affirmative goals and expectations for care (which should be documented verbatim when possible). In addition and of similar importance, many patients and/or family members are able to identify conditions that would be unacceptable outcomes of the hospitalization.

After identifying and clarifying the goals and expectations for care with the patient and/or family members, the treating physician guides the discussion to the second step – i.e., to reach consensus on the appropriate focus of the treatment plan (i.e., comfort care or restorative care). It is the responsibility of the treating physician to develop and implement a medically sound plan that is consistent with the values, goals, and expectations of the patient. It is the responsibility of the patient and/or family members to provide accurate information to the treating team as to the patient’s values, goals, and expectations and to remain sufficiently present/informed about the patient’s care to weigh the burdens to the patient associated with the treatment plan. In this way, a productive ongoing discussion can ensue, without unreasonable responsibilities being placed on the family and with appropriate medical decision-making being assumed by the treating physician. All medically appropriate therapies that are consistent with the patient’s values, goals, and expectations should be implemented. Those treatments that are not efficacious, not consistent with the patient’s values, goals and

expectations, or highly likely to leave the patient with an outcome deemed unacceptable by the patient and/or family members should not be introduced or initiated.

The treating physician readdresses the goals and expectations for care with the patient and/or family members and alters the treatment plan (1) when there is a significant change in the patient's condition or prognosis, or (2) if after a trial of therapy it is clear the previously established goals and expectations for care cannot be reached. At this point, the treating physician speaks further with the patient and/or family members about achievable goals and modifies the focus of care and treatment plan accordingly (e.g., a patient with severe pneumonia/ARDS and initial goals to return home to independent living who cannot be weaned from mechanical ventilation following a protracted ICU course and multidrug resistant infections).

This 'Goals of Care Directive' approach provides a framework for code status decisions. A physician order is placed in the orders section of the patient's medical record when the treating physician determines that initiating ACLS protocols is not consistent with the patient's values, goals and expectations. This order is deliberately and intricately linked to the discussion of the goals of care and the focus of care with the patient and/or family members. The specific elements of ACLS need not be individually discussed with the patient and/or family members. If attempts at resuscitation are appropriate in the event of cardiac arrest, all medically indicated interventions should be done. The circumstances to which a 'No Code' order applies are very narrow. The intention is that a 'No Code' order should be applied only to situations of complete cardiac and/or respiratory arrest – i.e., no pulse, no blood pressure, and/or no respirations. All other situations -- such as hypotension, supraventricular tachycardias, respiratory distress -- should be individually addressed and treated in a manner consistent with the patient's goals and values. The management may or may not include aggressive measures, depending on the specifics of each case.

Conclusion

What would using this 'Goals of Care Directive' approach and template contribute to the communication with the 84-year-old female patient's husband? The attending physician finds a quiet place near the ICU to speak with the patient's husband and begins --

"Mr. Smith, I would like to speak with you about your wife. First, do you have any specific questions?" Mr. Smith answers, "How is she doing, Doctor?" The physician responds, "Unfortunately, not well. When she was brought to the hospital, her heart had stopped. In the emergency room, the doctors were able to restart her heart, but she has suffered brain damage and some of her other organs, such as her kidneys, have also been badly damaged. Right now intensive life support is keeping her alive." The physician pauses for Mr. Smith, now tearful, to gather himself. Mr. Smith reflects, "That sounds terrible. We have been married 54 years. I can't imagine life without her." The physician admits, "I can hardly imagine how difficult it must be for you to see your wife like this. I need to know more about her, I need to understand her better, so that we can make a plan that is best for her. Can you tell me about her? Did she work?" Mr. Smith clarifies, "No, she stayed home and cared for our children. She was always very active though. She loved to garden and help out with church activities. She always was watching one grandkid or another. . . ." The physician comments, "It sounds like she was a very busy person, and that you have a very close family." Mr. Smith agrees, "Yes, she always has to be busy. Our family means the world to her." The physician explains, "Unfortunately, because of what has happened to her, I don't think she will be able to recover sufficiently to return to those activities." Mr. Smith asks, "What do you mean?" The physician continues, "If she survives this hospitalization, she will almost certainly have to go to a nursing home. She will not be able to care for herself or interact much with her family." Mr. Smith reacts, "Oh no, we have talked about that. She would never want to live that way. Her mother was in a nursing home for years and it was very hard on my wife. She has frequently told me and our children not to keep her hooked to machines." The physician pauses, then begins to discuss a plan consistent with this understanding, "Given what you have just explained, continuing what we are doing right now doesn't make a lot of sense. We should instead focus on keeping her comfortable. She is likely to deteriorate further. If she does, we will let her pass peacefully. We will not attempt to restart her heart. Do you have any questions?" The husband replies, "Thank you Doctor, please make sure she doesn't suffer." The physician responds, "We will. Do you want me to be with you when you speak with your children?" The husband accepts the offer.

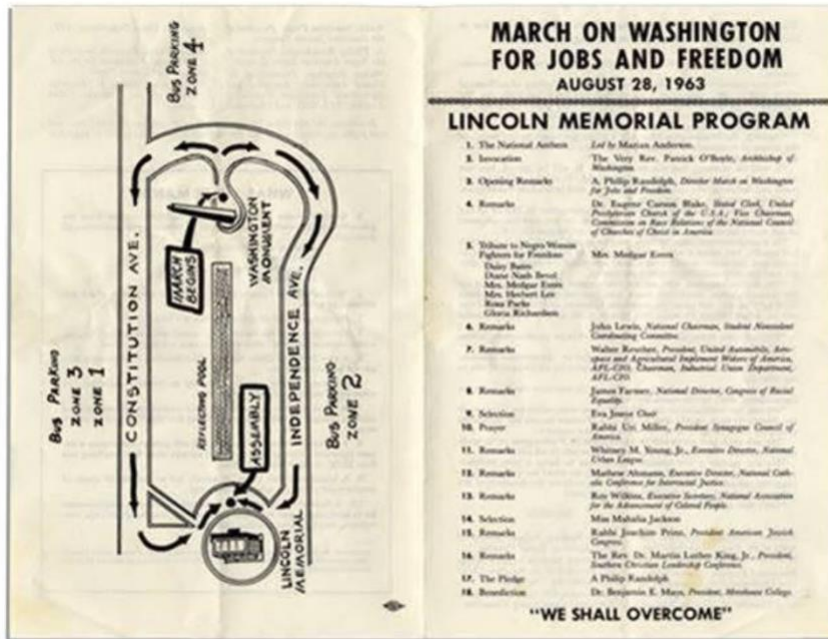
This idealized conversation is not outside the bounds of reality or experience. Approximating this conversation requires a skilled and individualized approach with every patient and family. Some cases will be more difficult than others. Some cases will still end in frustration, despite everyone’s best efforts. However, by utilizing this ‘Goals of Care Directive’ approach and template, we propose that such collaborative and respectful communication can become the norm rather than the exception.

#33

For the 33rd ‘tactics and strategies’ communication, I have inserted below a set of reflections on the 28 August 1963 *March on Washington for Jobs and Freedom* that I e-mailed recently to my wife and to our three daughters. I am sure you are having similar conversations with your family and friends re pursuing social justice. Earlier this week and with the encouragement of our department leadership, I sent the reflections inserted below to the 25+ faculty members in our department who facilitate small group discussions with our clerkship students as part of the professionalism/ethics curriculum we integrate into each surgery clerkship. You are free to make any use of these reflections that you think might be educationally helpful. Doug

[Sent 29 August 2020 to my wife and our three daughters]

Given that yesterday’s *March on Washington 2020* aligned with the 28 August 1963 *March on Washington for Jobs and Freedom*, I chose to watch a moving PBS documentary last night about the historic protest gathering of 250,000+ in DC from across the country fifty-seven years ago. Today I have worked through various internet resources searching for a more granular understanding of that epic event, which (as the image below indicates) surrounded John Lewis’ and Martin Luther King’s gripping messages with a very carefully organized and choreographed program.



The day’s ‘march’ began mid-morning with the crowd drawn together by notable celebrities and various musicians at the Washington Monument. The crowd then marched down the national mall to/ward the Lincoln Memorial. I now realize that King’s ‘I have a dream’ speech was positioned to be the penultimate point for those present. Before the Civil Rights Movement’s key leaders departed the stage to walk to the White House to meet with President Kennedy, the two principal organizers of the March on Washington – Bayard Rustin and A. Philip Randolph (honored on the cover of the 6 September 1963 issue of *Life* – see below) – called the crowd to the ultimate point.

[6 September 1963 issue of *Life*]



Rustin very deliberately announced the eight demands the leaders would shortly present to the president. The crowd shouted enthusiastic approval after each demand.

[Rustin] *We demand -*

1. *That we have effective civil rights legislation.*
2. *The withholding of federal funds from all programs in which discrimination exists.*
3. *That segregation be ended in every school district in the year 1963.*
4. *The enforcement of the 14th Amendment, the reducing of congressional representation of states where citizens are disenfranchised.*
5. *An executive order banning all segregation in housing supported by federal funds.*
6. *That every person in this nation - black or white - be given training and work with dignity to defeat unemployment and automation.*
7. *That there be an increase in national minimum wage so that men may live in dignity.*
8. *Ultimately that all of the rights that are given to any citizen be given to black men and men of every minority group.*

Randolph then majestically read the march's pledge to the energized crowd.

[Randolph] *"Will you stand? The Pledge -- Standing before the Lincoln Memorial on the 28th of August in the centennial year of Emancipation, I affirm my complete personal commitment to the struggle for jobs and freedom for Americans. To fulfill that commitment, I pledge that I will not relax until victory is won. I pledge that I will join and support all actions undertaken in good faith and in accord with the time-honored democratic tradition of non-violent protest, of peaceful assembly and petition and of redress through the courts and the legislative process. I pledge to carry the message of the march to my friends and my neighbors back home and arouse them to an equal commitment and an equal effort. I will march and I will write letters. I will demonstrate and I will vote. I will work to make sure that my voice and those of my brothers ring clear and determined from every corner of our land. I pledge my heart and my mind and my body unequivocally and without regard to personal sacrifice to the achievement of social peace through social justice. How do you pledge?"*

[Crowd Response] *"I so pledge."*

Here is a link to a recording of the statements first of Rustin and then of Randolph. I encourage you to listen to these 12:57 minutes and imagine standing with that packed and exhausted crowd.

http://openvault.wgbh.org/catalog/A_27BB06E300874F279030125D1216C8B5#at_13.451_s

Would we that day have responded – “I so pledge”? What would “I so pledge” have meant then? What does “I so pledge” mean today?

Doug/Dad

#34

For the 34th ‘tactics and strategies’ communication, I have inserted below a set of reflections I e-mailed to my wife and to our three daughters the day after the death of Supreme Court Justice Ruth Bader Ginsburg. As memorials this week culminate today with Justice Ginsburg being the first woman to lie in state in the U.S. Capitol, I am sure you are having similar conversations with your family and friends re pursuing social justice. You are free to make any use of these reflections that you think might be educationally helpful. Doug

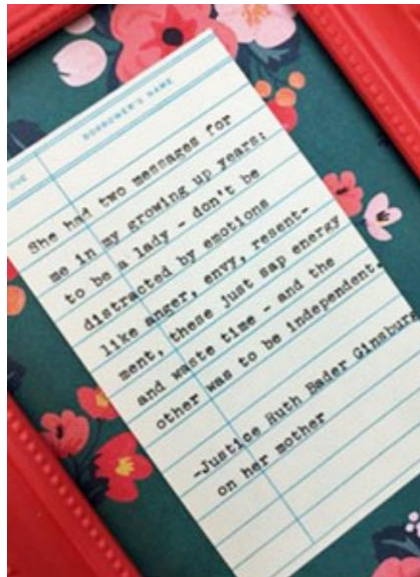
[Sent 19 September 2020 to my wife and our three daughters]



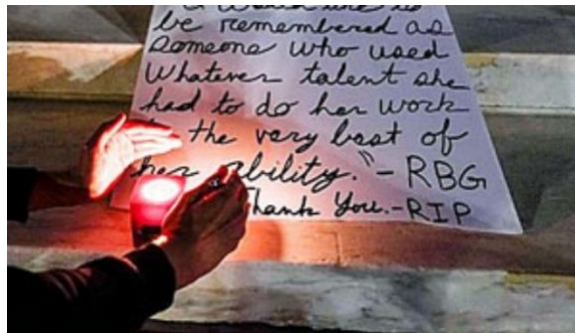
Good afternoon. I trust you are all well. Those who prioritize equality and justice as unparalleled/incomparable values and who sacrificially strain to achieve the most expansive/inclusive answer to the question “Who is my neighbor?” lost a senior leader last night with the death of Ruth Bader Ginsburg. To the end, she boldly embodied her admonition --



She became most widely recognized as a Supreme Court Justice for the past 27 years – witty, insightful, steady, penetrating, clear, . . . – in short, worthy of the utmost respect (in the etymological sense of looking back/again expecting more). As the daughter of Russian and Polish immigrants, she gave voice to/for the marginalized, the exploited, the disadvantaged, the diminished et al with remarkable consistency in every phase of her 87 years among us. She tirelessly championed women – their rights, their equality, their maturity, their contributions, their potential. I fully share her understanding of feminism. She traced her focus and her manner to her mother’s guidance, often attributing to her two centering messages --



A grateful admirer placed a candle last night near a hand-written copy of Ginsburg's own words about how she hoped to be remembered. As she said – "I would like to . . .



With dispositions ranging from reluctantly and with genuine appreciation for a fallen comrade to impatiently and with no more than a perfunctory glance toward/comment about the deceased public servant – DC politicians are predictably (and I suppose to a degree necessarily) already into the arguing/posturing about filling the empty SCOTUS seat. And the attention of the voting public with a pivotal election just weeks ahead will no doubt quickly shift toward their fight.

I intend to pause long enough to truly remember Justice Ginsburg. I encourage you to do so too. Why do we remember? How should we remember? What if we do not remember? -- these are critical questions for us to consider. Remembering well can refresh/enlarge/enrich our sense of self as we see our lives anew in the light of her life. Let us remember her with thanksgiving and contrition, with vulnerability and courage.

Doug/Dad

#35

For the 35th 'tactics and strategies' communication, I have inserted below the fourth of the six 'Ethics 101' promptings we distribute to our surgery clerkship students – one prompting every week or so during their clerkship – as the foundation for the professionalism/ethics curriculum we developed for our surgery clerkship several years ago. We encourage the clerkship students to consider the suggestions in each prompting as they rethink the tools they bring to the ethical challenges they are facing in clinics, in ERs, in ORs, in ICUs, and on the floors. The set of six promptings can also be used with residents and fellows. I welcome your feedback.

Doug

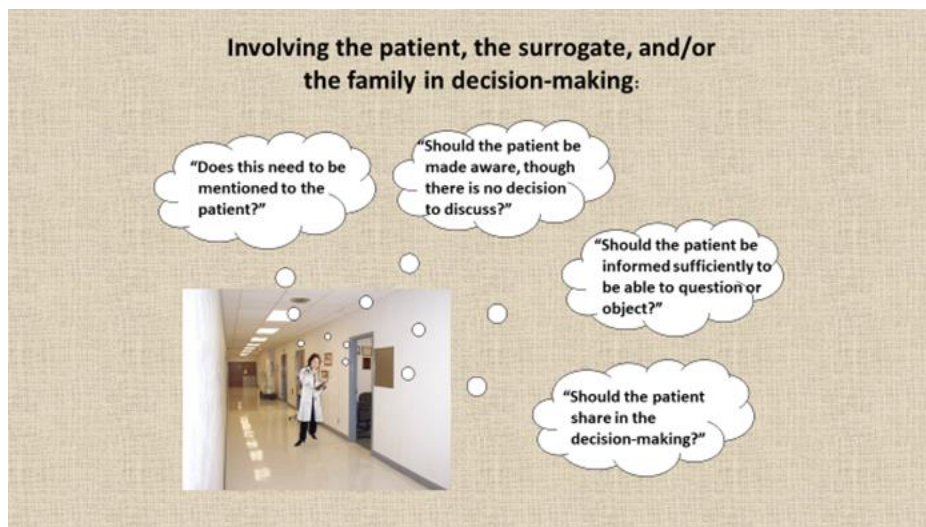
When/how should patients and their families be involved in decision-making?

Surgical Ethics 101 Prompting #4

Douglas Brown, PhD

Consider the following encounter. A resident writes orders for a nurse to obtain several urine samples from a patient, including one for a drug screen. When the nurse asks for the urine samples, he tells the patient what tests will be conducted. When a drug screen is mentioned, the patient refuses to consent. The nurse tells the resident the patient would not consent. The resident scolds the nurse for mentioning the drug screen and tells him, "I don't care that he doesn't give consent. Go back in there and get the urine sample and send it. I will deal with the patient later." The nurse instead speaks with his supervisor.

This scenario highlights the frequent disagreements in the clinical setting over when and how to involve patients and their families in decision-making. Surgeons face four questions repeatedly in every case, with each question representing a decision about whether, when, and to what extent patients, family members, and friends should be informed and share in decision-making. These questions for presenting information to patients or their surrogates are (see below) – i.e., Does this need to be mentioned? or Should the patient be made aware, though there is no decision to discuss? or Should the patient be informed sufficiently to be able to question or object? or Should the patient share in the decision-making? These options represent the four phases in the century-long evolution of 'consent' in modern medicine.



Calling attention to how these four questions are answered repeatedly in a case after case reveals how few details in 'the plan for today' the surgical team reviews on rounds each day are discussed with patients or their surrogates and sheds light on the options other than shared decision-making they choose when information is delivered to patients or their surrogates. The pivotal consideration for ethically sound patient care centers on the surgeon's need to keep the management plan aligned with the patient's goals, values, and preferences. Any one of these four options may be ethically justified. But each of the four options necessitates separate/distinguishable ethical reasoning – e.g., What factors influence when/how a surgical team involves patients and their families? Can surgeons explain the ethical justification for each of the four options for involving patients, family members, and friends in decision-making? This analysis also opens discussion about the significance and the limitations of decisional capacity in determining when/how to involve patients, family members, and friends.

#36

For the 36th 'tactics and strategies' communication, I am sharing a few ethics education PowerPoint slides (inserted below) I have created for use with physicians, nurses, social workers, et al who are bearing the weight of the present pandemic surge that threatens to crush our healthcare delivery infrastructure. Yesterday I received the following case description

from a physician who will be a triage officer for one of the St. Louis community hospitals if the 'Alternate/Crisis Standard of Care Plan' has to be implemented.

I got a taste this weekend of what may be coming. On Friday my patient was on a ventilator and the pulmonary physician on the case told me they had offered transfer downtown the day prior for ECMO but the family declined. He told me the window of opportunity had likely closed. When I reached my office, I had a message that the patient's wife wanted to talk. She said the family now wanted ECMO management for the patient but had been told that transfer was no longer an option. I had to try on my triage officer hat and explain that resources are scarce and we have to trust the physicians in charge to do what is best for all involved during this pandemic. If triage officers are tasked with implementing this sort of decision over and over, we need to be very attentive to their emotional health!

When facilitating discussion of such patient care experiences, I often begin with images of threats to structural integrity (e.g., the fatigue or fracture of materials, the initiation/growth of cracks in the materials, the consequences of handling unexpected or overloading stress) to clarify the deterioration and risks caregivers face during a surging pandemic.



The two slides below offer a way to assess one's integrity. The first slide distinguishes indicators across a spectrum ranging from stable integrity to distressed integrity. The second slide traces some of the possible ethical implications associated with distressed integrity.



Assessing 'integrity stress' – ethical implications

Caregivers whose integrity is stable are capable of participating meaningfully in the decisions about patient care and can be counted on to be diligent in fulfilling their responsibilities. They may appear to be undisturbed by the situation. They come across as attentive, hopeful, self-confident. They ask insightful questions, make accurate comments about their patients, and have a sense of humor. Others who remain centered may nonetheless be struggling to maintain their balance and focus. They show signs of being fearful, upset, disoriented, impatient.

Caregivers whose integrity is distressed complicate the decision-making process and the management of patients. Some of these caregivers are troubled for inward as well as circumstantial reasons. They are losing confidence, motivation, hope. They may appear despondent or panicky. They may deny the reality of their situation. Other of these caregivers are despairing. They are immobilized, depressed, apathetic, fatalistic. Professionals with special training for such professional distress should be fully utilized in the care of these caregivers.

You are certainly free to use these educational slides in any way you think might be helpful as you (1) monitor your own integrity, (2) seek insight from close colleagues, and (3) remain attentive to the vulnerability of your co-workers (esp., early at-risk signs).

Doug

#37

Year-ending holidays create an invitation to pause for careful introspection. The crushing coronavirus pandemic plus the unprecedented political and social upheavals intensify the need to pause this year. I have inserted below adaptations I have made to four samples from a collection of poetic reflections authored by the French writer Michel Quoist (1918-1997), one of the many who came of age in Germany and in France during the chaotic years between the two world wars whose struggle with/for integrity I have closely studied for more than forty years. I continue to find through this study of integrity advantageous ethics education resources for understanding the ways we assign meaning in our lives when faced with acute or chronic conditions that threaten our sense of security and hope.

I was introduced to Michel Quoist's *Prayers* (1st ed., 1954) in 1976 during my doctoral studies. Quoist's *Prayers* is an internationally recognized work that reflects his experiences with existentially searching youth deeply scarred by the dozen Nazi years. I have returned to Quoist's *Prayers* for decades as a guard against superficial self-examination. Several worn copies are scattered through my personal library.

The four adaptations below are titled – 'The Subway', 'I Spoke', 'Eyes', and 'The Sea'. Why do I call them 'adaptations'? Quoist was a Roman Catholic priest who was a chaplain to youth in Rouen as well as a sociologist. I self-identify as 'not religious'. So I have had to transpose/recast Quoist's *Prayers* into wording that remains readable within a non-religious paradigm. Once transposed/recast, these probing reflections sharpen my self-examination. I am grateful and like to think Quoist would understand. I commend these four adaptations to you for consideration as you take advantage of the year's end pause.

Doug

Adapted from 'The Subway'

The last ones squeeze in. The door rolls shut. The subway rumbles off.
I can't move; I am no longer an individual but a crowd that moves like jellied soup in its can.
A nameless and indifferent crowd. I am one with the crowd.
I see why it's sometimes hard for me to rise higher.

This crowd is heavy – leaden soles on my feet – a crowd too large for my overburdened skiff.
Yet I have no right to overlook these people.
They are my community.
We move together toward the future in 'the subway'.

Adapted from 'I spoke'

I am afraid of speaking, for speaking is serious.
It's serious to disturb others, to bring them out, to keep them on their doorsteps.
It's serious to keep them waiting, with outstretched hands and longing hearts.
It's serious to keep them seeking for light or some courage to live and act.

Suppose that I should send them away empty-handed.
I have often spoken so badly.
I have often spoken to no purpose.
I have often tarnished my lips with hollow words, false words, cowardly words.

May my words instead be as the sowing of seeds,
So that those who hear them may look to a fine harvest.

Adapted from 'Eyes'

I am now about to close my eyes, for they have finished their work.
My vagrant glances have returned home, having strolled for a day in the market place.
Tomorrow, when I open my eyes to the clear morning, may they be ready to see.

May my eyes be clear and straightforward, giving others a hunger for purity.
May my look never be one of disappointment, disillusionment, despair.
May my look know how to admire, contemplate, adore.

May my eyes be firm and steady, never shutting to the afflictions of others.
May they also know how to soften in pity, being capable of tears.

May my gaze not soil the one it touches.
May my gaze not disturb, but may it bring peace.
May my gaze not sadden, but rather may it transmit joy.

Adapted from 'The Sea'

One day I saw the sea attacking the rocks, somber and raging.
From afar the waves gain momentum.
High and proud they leap, jostling one another to be the first to strike.
When the white foam draws back, leaving the rock clear, they gather themselves to rush forward again.

On another day I saw the sea calm and serene.
The waves came from afar, creeping, not to draw attention.
They stretched at full length on the sand to touch the shore with the tips of their beautiful mossy fingers.
The sun gently caressed them, and they generously returned streams of light.

Which am I?

May I avoid useless attacks that tire and wound without achieving results.
May I avoid angry outbursts that draw attention but leave one uselessly weakened.
May I avoid wanting always to outstrip others, crushing those in my way.
May I avoid the sullen, subduing look.

May I live my days calmly and fully, as the sea slowly covers the whole shore.
May I be humble as she is, silently and gently spreading out unnoticed.
May I wait for others and match my pace with theirs.
May each of my retreats turn into an advance.

#38

I am focusing the 38th 'tactics and strategies' communication on a few suggestions for your mindfulness and self-examination during Black History Month. This annual celebration of black culture and individual achievement was introduced in 1970 at Kent State University and had spread across the US by 1976 when President Ford recognized Black History Month as part of the nation's bi-centennial celebration.

One source I read each week during the year is the *St. Louis American*, a weekly newspaper published continuously since 1928 that reports local and national news through an African-American editorial lens. I was deeply moved by the obituary

in this week's edition for Dr. Lee Blount, Jr. (1932-2021). Dr. Blount was a St. Louis general surgeon with a 30-year career after finishing his Homer G. Phillips Hospital's surgery residency. And he was a highly respected civil rights activist, a remarkable community builder, an advocate for young people's exposure to the arts/humanities, and a sports enthusiast. I encourage you to read the obituary inserted below this e-mail. For more details about Dr. Blount, click on the following link --

http://www.stlamerican.com/news/local_news/lee-blount-surgeon-athlete-dies-at-88/article_12250052-5c0a-11eb-8f4a-fb8928847d81.html

I invite you to pause with me this month to be very intentional in identifying a Dr. Blount in your community, in your hospital, in your department you would otherwise not have seen/appreciated. I anticipate that our doing so can stretch our attentiveness and respect in each month of the year.

I also want to add the following titles to the reading list you are considering for Black History Month –

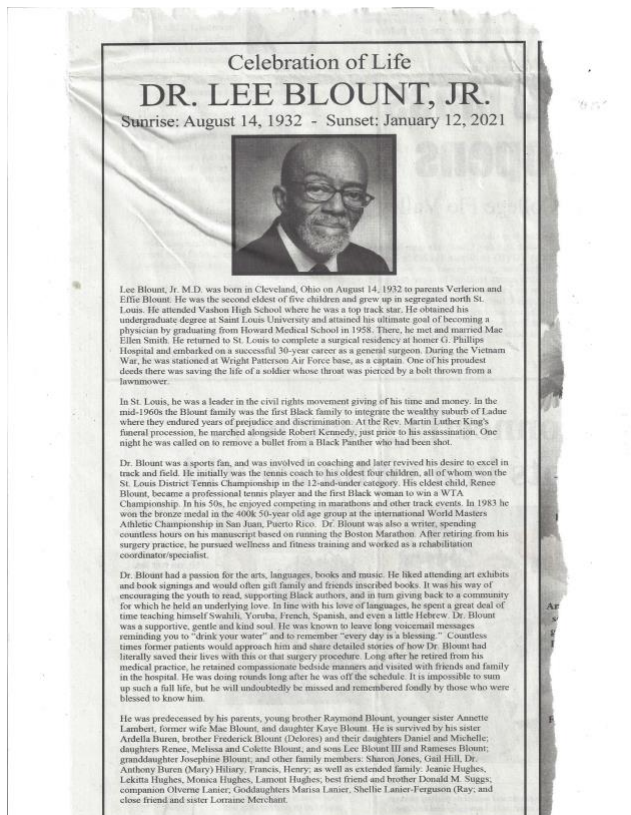
The Kidnapping Club: Wall Street, Slavery, and Resistance on the Eve of the Civil War (Jonathan Daniel Wells)

South to Freedom: Runaway Slaves to Mexico and the Road to the Civil War (Alice Baumgartner)

The Seeds of America Trilogy: Chains, Forge, and Ashes (Laurie Halse Anderson)

Be well and safe.

Doug



#39

No doubt you are aware of this week's JAMA editorial staff shakeup re a podcast denial of 'structural racism' in medicine. For the 39th 'tactics and strategies' communication, I want to support/encourage your discussions – informal

and/or formal – of this development by calling your attention once more to a values assessment tool the first draft of which I created many years ago while working as part of the leadership team for a community health center serving a truly rural and impoverished patient population in East TN/KY. Rather than simply state/post a claimed set of values, we created a values assessment tool to use in surveys, interviews, and focus groups with all of our staff members (i.e., physicians, nurses, and administrative staff) as well as with a cross-section of the communities/families we served. By soliciting their feedback re four criteria -- i.e., a proposed value of an institution or organization is true and experienced if/when the value (1) is clearly explained, (2) significantly influences decisions and actions, (3) is expected throughout the institution or organization, and (4) is encouraged/incentivized -- we dared to ask if our community health center's stated/claimed values were in fact true and experienced, realizing that we were inviting the staff and the communities/families to expect us to address barriers to prioritizing/strengthening any value/s in question. It is not enough to merely state/claim a value. I have inserted below the essence of this 'Values – Assessment Tool' – which can be customized for any institution or organization. Doug

Values – Assessment Tool

Please rate (1-5 scale, '1' meaning 'definitely yes' and '5' meaning 'definitely no') each value listed in the left column using the four criteria re how central/essential (i.e., 'core') you have found each value to be in your experience. Your assessment is to be descriptive – i.e., is there evidence in your experience that these values are in fact true and pivotal?

Proposed Values (listed one by one with brief commentary)	Is this value clearly explained?	Does this value influence decisions and actions?	Is this value expected throughout the instit / organization?	Is this value encouraged (i.e., are there incentives to honor and maintain this value)?	Comment/s
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

#40

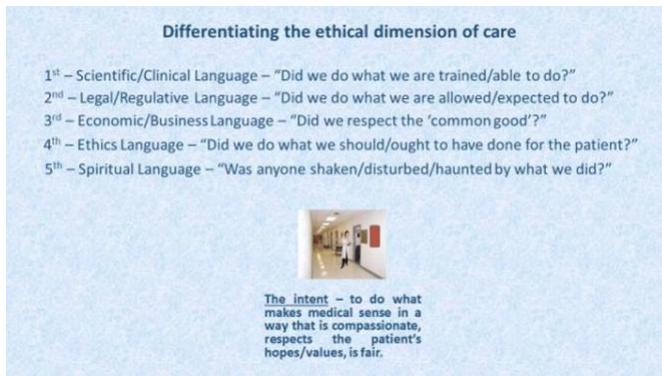
For the 40th 'tactics and strategies' communication, I am sharing with you two versions of a PowerPoint slide (inserted below) I created for educational purposes when differentiating the ethical dimension of care in a comprehensive/multi-faceted pause – informal or formal, individual or as a team -- to reflect on a case/surgery. Five dimensions of care are identified, with each dimension requiring a distinctive professional language to answer a specific question. The five questions are intentionally worded to concentrate on the core accountability associated with each dimension of care.

Differentiating the ethical dimension of care

- 1st – Scientific/Clinical Language – “Are we doing what we are trained/able to do?”
- 2nd – Legal/Regulative Language – “Are we doing what we are allowed/expected to do?”
- 3rd – Economic/Business Language – “Are we respecting the ‘common good’?”
- 4th – Ethics Language – “Are we doing what we should/ought to do?”
- 5th – Spiritual Language – “Is anyone shaken/disturbed/haunted by what we are doing?”



The intent – to do what makes medical sense in a way that is compassionate, respects the patient's hopes/values, is fair.



These two versions of the PowerPoint slide – one worded for ongoing cases, the other worded for retrospective review of cases -- draw attention to layers, complexities, and nuances too often missed/absent on rounds, in EMR notes, and/or during M&M conferences.

The use of the word ‘language’ points to the specialized vocabulary and syntax necessary for each of the five dimensions of care to be considered/discussed. Also, I use the word ‘spiritual’ in an existential sense that includes/respects those who self-identify as ‘not religious’ as well as those who self-identify as ‘religious’.

Physicians/surgeons, nurses, social workers, and allied clinical colleagues are necessarily most fluent with the clinical/scientific language. Those who staff risk management are most fluent with the legal/regulative dimension of care. Those responsible for operations and administrative supervision are most fluent with the economic/business dimension of care. Palliative care teams and chaplains are most fluent with the spiritual dimension of care.

For patient care to be authentically humane and just, all five dimensions of care need to blend, to weave together, to be evident, to be respected.

Doug

SUMMATION

With this summation, I am bringing to a close the ‘tactics and strategies’ series of communications I began in May 2018. As I explained at the beginning, I requested the opportunity to share with you selections from a reserve of ethics education resources I have created/organized for use as/when opportunities have come my way – e.g., staff meetings, teaching conferences, continuing education sessions, regional/national meetings, publications one-on-one or small group mentoring – to prompt medical students, residents, practicing physicians/surgeons, and faculty educators as well as nurses and social workers toward being respectful and toward exercising a social conscience in the practice of medicine. I deeply appreciate the privilege to send you every few weeks during the past three years a selection from this reserve of ethics education resources.

I have archived these communications and associated attachments. I will be pleased either to send you all of these archived materials or specific attachments of interest. You of course remain free to use, adapt, distribute any of these ethics education resources as you wish. I have also taken the liberty to attach two of my publications that together summarize the insights you and so many others have helped me gain over four decades embedded in teaching hospitals, medical school departments, research teams, and medical practices as an ethics educator and a qualitative researcher.

I will pass on to you additional potentially useful ethics education resources as I come across such. However, my planned communications at this point will transition to occasional requests for feedback from you about specific issues or cases.

You collectively represent such an important and pivotal presence/influence for strengthening/advancing the ethical dimension of surgical care. I look forward to assisting you further in developing creative ways to optimize your efforts. With utmost respect,

Doug