The International Journal of Ethical Leadership

Volume 11 Article 16

2024

“Intersections in Clinical Ethics, Nursing, Law, and Liability"

Olubukunola Dwyer

Georgina Morley

Ben Schwan

Follow this and additional works at: https://scholarlycommons.law.case.edu/ijel

Recommended Citation

Dwyer, Olubukunola; Morley, Georgina; and Schwan, Ben (2024) ""Intersections in Clinical Ethics, Nursing, Law, and Liability"," *The International Journal of Ethical Leadership*: Vol. 11, Article 16.
Available at: https://scholarlycommons.law.case.edu/ijel/vol11/iss1/16

This Symposium is brought to you for free and open access by the Cross Disciplinary Publications at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in The International Journal of Ethical Leadership by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

Intersections in Clinical Ethics, Nursing, Law, and Liability

Olubukunola Dwyer, Georgina Morley, and Ben Schwan
November 13, 2023

FRED LEE: Thank you for taking the time to join us today. Welcome to "Intersections in Clinical Ethics, Nursing, Law, and Liability." My name is Fred Lee, and I am the vice president of programming of the Global Ethical Leaders Society, or GELS. Every semester, we host panels such as this one to discuss important issues affecting our world today.

SAKTHIRAM KUMAR: Hello everyone, my name is Sakthiram Kumar, and I'm the vice president of membership for GELS. GELS is a student group here at CWRU that is affiliated with the Inamori International Center for Ethics and Excellence. We are a diverse group of student leaders who meet weekly to discuss various ethical issues, from informed consent and end-of-life care to constitutional rights and reproductive justice.

LEE: Tonight, we are excited to begin our discussion about clinical ethics, a topic that is both immensely complex and important. Sakthi and I will be moderating our discussion tonight. As always, we'll begin with some discussion questions before opening the floor to questions from the audience at around 7:00. Without further ado, we'd like to introduce you to our esteemed panelists.

KUMAR: Dr. Georgina Morley. Dr. Georgina Morley is a nurse ethicist and director of the Nursing Ethics Program at the Cleveland Clinic. Dr. Morley is a clinical ethics consultant and empirical researcher. Her research is focused on examining the ethical experiences of nurses and testing measures to mitigate the adverse effects of moral distress. Dr. Morley is an internationally recognized scholar of nursing ethics and moral distress and has more than two dozen peer-reviewed publications and book chapters on these subjects.

LEE: Olubukunola Dwyer. Ms. Dwyer is a clinical ethicist and directs the Clinical Ethics Program at University Hospitals. In addition to that, Ms. Dwyer is a clinical assistant professor of bioethics at Case Western

Reserve University. Ms. Dwyer's academic background is in intersection with medicine and philosophy, with specific training in health law and clinical ethics. Ms. Dwyer's research interests have pertained to the various issues involved in adult and pediatric clinical ethics consultation.

KUMAR: And finally, Dr. Ben Schwan. Dr. Ben Schwan is a faculty member in the Department of Bioethics at Case Western Reserve University and a clinical ethics consultant for the MetroHealth System in Cleveland. Before landing in Cleveland, he completed a PhD in philosophy at the University of Wisconsin, Madison, and spent two years as a postdoctoral fellow in the Department of Bioethics at the National Institute of Health Clinical Center. Dr. Schwan's research and work focus on the nature of autonomy, the obligation to protect it, and the role that each plays in justifying practices in medical research and clinical care. Please join me in giving our panelists a warm welcome.

LEE: Without further ado, let's get started with a question for all of our panelists: What inspired you to pursue an intersectional career in clinical ethics and your area of expertise? Can you share a bit about your journey into this field?

DR. BEN SCHWAN: Hi! So yeah, my journey. I kind of stumbled into a career in clinical ethics—as was just mentioned, my background is in philosophy. I got a PhD in philosophy at the University of Wisconsin, Madison, and there, I didn't do any bioethics at all—I focused on ethical theory and philosophy of action. And I had this experience—I don't know if anybody in here does humanities—I had this experience when I would go home to my family at Thanksgiving, and they would ask what I was working on as part of my PhD program, and I would explain it, and if they stayed awake for it till the end, then they would tell me "Why does that matter" or "Who cares." I am drawn to theoretical issues, but then when I step back from my work, I would get frustrated—especially in grad school—about the lack of practical application. So I was really grateful for the opportunity as a postdoc at NIH to take some of the theoretical things that I had worked on, especially with respect to autonomy, agency, and responsibility, and start applying them to issues that would make more sense when I talked about them at the Thanksgiving dinner table. And so, while I didn't set out to do clinical ethics—my path was very much first an interest in philosophy—clinical ethics has given me an opportunity to pursue the kinds of questions I'm interested in in a way that very clearly matters.

OLUBUKUNOLA DWYER: So, I'm the lawyer of the group, and so no one will be surprised that I stumbled into clinical ethics with an argument. I'm Nigerian also, and one thing about Nigerians and Nigerian parents, they like to watch a lot of news stories. So I was watching *20/20* with my dad one night, and they were doing a story on children who were reaching adulthood, and the interesting thing about these children was that they all had genetic diseases. So there's a question of, We already provide so much support to these children in childhood, should we continue that support into adulthood? And they started discussing some of the implications about the possibility of them passing on these genetic anomalies to another generation and the ethics of that. I turned to my dad, I'm like I want whatever job where I get to discuss things like that. So that was my first insight into the world of ethics. I knew from a pretty young age that I wanted to do something in medicine, and then that argument clarified that there's an area in medicine where I get to argue with people and discuss interesting topics, so that's what I want to do. That interest did not waver through undergrad and into law school, and it was when I was in law school that I had my first real taste of doing bedside clinical ethics. Those experiences really reassured me that this was the path for me despite law school.

DR. GEORGINA MORLEY: I was chuckling because when I was also thinking about this question the word *stumbled* came to mind. I was also going to reflect upon how I stumbled into this career too and it seems like that's a common thread, and I think it can be a really common thread within bioethics because it is so interdisciplinary. I actually started out with a philosophy degree. I did a philosophy degree at King's College, London, mainly because I was really interested in philosophy coming out of school. I realized that I felt quite frustrated by, as I was graduating, a) I thought I needed a job, and it didn't seem clear that philosophy was going to give me a job, and b) I felt like I was a bit frustrated and felt like I wanted to have some kind of real-world impact. So I rolled the dice and thought, I'll give nursing a try and didn't really know how I was going to feel and if I was going to like it, but actually fell in love with nursing. So then I did a postgraduate diploma and a master's in nursing, and I think it was really my philosophy and ethics background that meant when I was practicing I saw these ethical challenges all the time and then got frustrated that nobody was really talking about it, and nobody was creating space to figure out What should we do, How should we navigate this? And then I had lots of my own experiences of moral distress as well.

I'm from England, that's the accent, not Australia, which a lot of people often think, so I'll just clarify that. But we don't have clinical ethics services in the same way in the UK, so as I was doing my master's, my master's supervisors encouraged me to apply for a travel scholarship to come over to the States. I was lucky enough to spend some time with some really prominent nurse ethicists—the late Ann Hamric, Beth Epstein, Lucia Wocial, Cynda Rushton, Connie Ulrich, real leaders in the field. It was when I was with Lucia Wocial actually, that I was like, I want your job. This is the job that I need to be doing. I started my PhD, but really, the goal of my PhD was to be able to apply for a clinical ethics fellowship over here in the States. I had this moment of craziness at a bioethics conference when I was with Lucia Wocial and met Paul Ford, who is now my colleague at the Cleveland Clinic. He offered me a specialty fellowship, so I came over to the states in 2018. I did a nursing ethics fellowship at the Cleveland Clinic and then managed to convince them to hire me, so it was in some ways very circuitous, but at the same time it felt like I'd gone full circle in that way.

KUMAR: That's awesome, thank you, and probably a good subject to stumble into, in my opinion. Moving on to the next question, Can you provide an example of a particularly challenging ethical situation you've encountered in your role that exhibits the conflict between your two areas of expertise and share with us how you and your team approached it?

SCHWAN: We were talking about this a little bit before we got started here. There was a case pretty early on in my time at Metro. We can talk more about the particulars of the case if there's interest later, but in broad brush strokes, there was a patient who had attempted suicide. The patient was brought in, resuscitated, and brought into the ED and then ventilated, put on a ventilator, intubated. Then it was upon a chart review found that the patient had a DNR order in place, and the question was—I mean that happens sometimes a patient comes into the ED, and because things move fast in the ED, the patient gets intubated despite there being a DNR order that somebody hadn't noticed. You notice the DNR order, oftentimes, typically you palliatively extubate. In this case, there were a number of complicating factors, including, just to name a couple, after the suicide attempt the patient had called EMS, and so there was some indication that she didn't actually want to die. A number of features made it genuinely hard as to whether the team should palliatively extubate the patient, and in some sense respect that DNR order, or keep the patient intubated and

treat the patient given that they thought they could return the patient to her baseline in a few days, she had overdosed.

This was a case where I had a take on what the team should do. It was my view that the team should palliatively extubate. My training as a philosopher has always been that, in grad school, we got a position, and then you were supposed to defend that position, give reasons and arguments for that position, and try to convince other people why that position was right. My colleague, who was mentoring me, again I was early on the service, Monica Garrik, had to talk me down from pushing for the palliative extubation on the grounds that this was a case, given the details, about which reasonable people could disagree. A reasonable person looking at all the same facts that I was looking at could come to the conclusion that it would be wrong to allow this patient to die given the circumstances. Our recommendations as ethics consultants should reflect that. It should reflect that the team is ultimately the one who is responsible for the care of the patient. They're responsible for this decision, they're looking to ethics to find out which option, or options, are supportable, and if we think there are multiple options that are ethically supportable, then that's what we should say. There was this conflict between me thinking of my role as what I've always done before, trying to advocate for a particular position and thinking of myself as a consultant, not the person with the ultimate responsibility for the choice being made. I think that answers your question. That was a big learning moment for me.

DWYER: All right, so I'm going to talk about a case as well. This was a case that really demonstrated to me where ethics can fill the gap where the law does not exist. And when I say the law does not exist, I mean that there isn't a specific statute that covers the circumstance, and there isn't a specific case that you could refer to, and when I say case, I mean a legal case that you can refer to, to provide you guidance in how to navigate this situation. This was a situation where, unfortunately, the patient had come in after a bike versus car accident and fractured both of his femurs and needed surgery. Unfortunately, one of the complications from the surgery was catastrophic, and he ended up needing to be placed on ECMO, and there was a question of from a medical standpoint How do we determine if someone is possibly dead by neurological criteria while on ECMO, so there was a clinical uncertainty there. Trying to navigate the uncertainty of the clinical team and then their guidance to the family was an area where ethics tends to fill the gap.

How do you guide that discussion where the team has to explain to the family that we suspect that this is a diagnosis, but we can't tell you defini-

tively because there aren't clear protocols about how to manage this type of situation? Even if there were clear protocols, and the team eventually figured out how to confirm brain death, the question then became well, Do we have an obligation to keep him on at that point, what would be considered organ support, not life support because he's already been declared dead. There's also a question thrown in there too of Do we have to ask the family first before we do confirmatory testing? There's no law on that either. Also, just uncertainties amongst team members. I will never forget, one colleague actually came to me and said, "Well why can't we transfer him?" I had to turn to her, and I said, "Who would pay for that? He is dead. What would you be transferring him for?" His diagnosis would not change depending on which hospital he's at. It's not like the hospital down the street has a different treatment you can offer someone who was brain dead. That does not exist currently in our society. Navigating those gaps and providing the guidance to the team and then also being the ethicist who also has to assist with the family discussions as well. And also, talking to legal too, honestly. Because legal is like, well we don't know. Again there's nothing in the law, the case law, that tells us exactly what we should do in the situation. I find, like I said at the beginning, that ethics tends to fill that gap where there are questions that there isn't a precise answer to, and you're really helping to guide not only the patient, their family, and also your colleagues and how to handle and manage situations. Hopefully that answers your question too.

MORLEY: I guess I don't necessarily think about one particular case that springs to mind, but I'll reflect a little bit on what I would argue is potentially a unique element of my role. Because bioethics is so interdisciplinary, you do often come with a hat that you're bringing to your clinical ethics practice, whether that's philosophy, or law, or nursing. There are ways in which I think you have to be quite mindful of which hat am I wearing, is my background overtaking my thinking about this situation, and you have to be able to be really critically self-reflective in that kind of way. So I think I am challenged by—I refer to myself as a nurse ethicist, not a clinical ethicist. There's quite a lot of debate in the field as to whether that's an appropriate title, but for me I feel like it's really important because a huge part of what I do is educating nurses, advocating for nurses, advocating for the nursing perspective and ensuring that that is brought into the analysis. I think every time that I'm on the consult service, I have to be really mindful that I'm not coming at the case or my recommendations from a perspective

that is too nursing heavy. So that's about being really critical of myself and of my thinking and being really mindful about how to balance those different perspectives. I think that's something that I grapple with each day, and then also, managing the relationships between nursing and the consult service. There's a little bit of research that looks at why nurses place ethics consults, and it tends to be because of relational kinds of challenges, because of communication challenges, whereas others on the multidisciplinary team like doctors will place an ethics consult because they want an answer to a specific question. So that means, I think, that as a key stakeholder, when nurses consult us, they're coming with slightly different expectations than I think some of the other kinds of stakeholders who might be consulting us. Sometimes it's about helping nurses also recognize what our role is as a consult service that is providing recommendations and also helping them realize that sometimes there are these situations that we would love to fix but we can't because it's so messy. I think that's a unique aspect of my role that I am challenged with frequently.

LEE: Thank you, thank you very much. So one thing you'll notice is that we try to reflect the diversity and the advantage of having multiple hospitals in the neighborhood, and so the next question is, How does your hospital foster a culture of ethical reflection and decision-making within the healthcare team? And what strategies have proven effective in this regard? Are there any best practices you know of that are in use at other hospitals that you would like to see yours adopt? So again, we don't have to go down the line, if you came up with an idea, feel free to do so.

DWYER: All right, so one thing about our program is that we have maintained the fact that anyone, and we mean literally anyone, can place an ethics consult, and I think that's a feature of most clinical ethics programs around the country thankfully, and the fact that you can also place an anonymous consult. This is one of the reasons why we have maintained a pager system, despite it being very old-fashioned, because we know that there are still times where people are concerned about repercussions of placing ethics consults. I know that, yes, a lot of institutions are moving towards EMRs, electronic medical records, and so it gets harder to maintain anonymity in those settings, and also for family members if they want to place an ethics consult, they don't exactly have easy access to an EMR to put in an ethics consult order, versus just picking up a phone and asking the operator for an ethics consult. So I'm glad that our institution has chosen to maintain that

and again, I think my colleagues on the panel here, that their institutions also make that available for everyone.

As far as the fostering relationships between the institutions, I see it on a pretty regular basis that we don't hesitate to call each other when we need to transfer a patient. If we think that maybe the patient-provider relationship at our institution isn't the greatest with this patient, maybe they'll do better than the other institution. We have no problem with trying to facilitate that. I know especially amongst the ethics departments at the various institutions, we all know each other pretty well, we see each other at various conferences throughout the year, we send emails to each other. I mean, there are common topics that we all deal with, and so we do not hesitate in emailing the entire group around the city and saying, Have you dealt with this issue? What have you guys done to work towards a common resolution or something like that? Or maybe we can work together to come to a common resolution. So, I'm just glad to say that I feel fortunate that I work here, that we don't have an adversarial relationship with the institutions around here.

MORLEY: So I guess I'm going to pick up on a slightly different piece of that question and think about the ethical climate and how we work to foster that. Because again, I see that as a really core component of my role of—I need to speak for myself only— but of clinical ethics as a field more broadly, I think we do have a real responsibility to helping to try and foster a solid ethical climate and make sure that we have good collaboration between different members of the team. So I think we try to be really mindful, not only through our ethics consultation service, which I think we have pretty solid use of our consult service at the Cleveland Clinic, and it's a service that has been around for a lot longer than I have been at the clinic. So I guess that's one way in which I think we really work with teams and we perceive ourselves as standing shoulder-to-shoulder with the clinicians. It's not that we're coming in as the "ethics police" and saying "this is what you should do." I've spoken to the powers that be, and this is the answer. We're really working with the clinicians to try and identify what those ethically supportable pathways are, and using their expertise and their knowledge to help us work through these really complex situations as well. So I think that's one piece that's really critical to making sure that we have a good environment and that people feel like they want to keep consulting us and coming back for advice. Because if we were intimidating or if we came across as the ethics police, then I'm not sure people would

want to use our service anymore. So there's a way in which also our jobs are at stake within that one as well.

But then I think another key thing that the clinic has done, and this is kind of my role as the Director of the Nursing Ethics Program, is they have invested resources as well, in nursing ethics, which I think again shows real willingness to invest in an ethical climate. Our nurses are there caring for patients each and every single day, so I think it's really critical that we provide them with ethics education. So there's been some really fundamental kind of investment in the Nursing Ethics Program as well, which I think really shows their willingness to really try and build the ethical climate of the organization, although it's not perfect, by any means.

SCHWAN: So if I can keep all these things in my head, I'll say three things that I think we do at Metro to foster an ethical climate really well, and then three things that maybe we could do better. There was just going to be one thing that we could do better, but the comments that I just heard prompted me to think of two more. Okay so the—first a caveat, I mean there is a bit of a sampling bias, we interact with the teams that consult us, and so we interact with teams that are interested in doing ethics consultation, so I can't speak to everybody that's at Metro but generally speaking, I've been really impressed by the sensitivity to ethics issues displayed by members of the medical team. And maybe that sounds cavalier, like I should have had a baseline higher expectation of the ways in which doctors would pay attention to this kind of thing, but Metro as the safety net hospital for this area I think people come, they—One reason people work at Metro, one of the reasons people want to work at Metro, is because they want to serve that patient population, they want to serve that community and that's so ingrained in the mission of Metro and the culture of Metro that that has providers attuned to ethical issues in a way that I think is really helpful. I also think that, at least in the cases that we're consulted on, I see a really—something I find really encouraging, I don't know that we do anything in particular to foster this, but it's a thing that happens that I think helps us come to good, ethically supportable resolutions to the problems we're consulted about. There's a kind of—we all know that medicine is very hierarchical, there's a hierarchy on the teams that take care of patients, but there's a kind of a flattening of that hierarchy, very often when ethics comes in. We bring in different perspectives, we talk to the nurses involved, the residents involved, the attending, spiritual care, social work, palliative care, and there's not the same hierarchical decision-making procedures when there's an ethics consult, than there—as there might be for

other medical decisions, and that seems really healthy to me. Finally, the last thing I wanted to say that I really appreciate about Metro, I don't know how things are at Cleveland Clinic and University Hospital, but I do know I have colleagues at institutions in other cities where the ethics consult service has a very adversarial relationship with legal, and I'm very, very grateful to work at a place, at Metro, where legal and ethics work very well together. When legal is consulted, very often times they will direct the team to go talk to ethics first, and find out what ethically the team should do and then come back to legal to find out if that's legally supportable. Whereas in other institutions, my sense is that legal is very much trying to minimize risk as opposed to finding what's ethically supportable and minimally legally defensible, and I think that's a very healthy thing that goes on at Metro. Three things that we could do better, I do—and something we've been trying to do over the past two years is we get disproportionately few consults from nurses, and so we've been doing a lot of work over the past couple years to try to get more outreach to nurses. We have this Coffee with Clinical Ethics, where nurses come and they can talk to us about ethical issues, but it's been slow, we still get far fewer consults from nurses than any other member of the team, and that's something we'd like to improve. I also think that maybe we would benefit from advertising our service more. While it's true that our service, anybody can consult us, we don't advertise our service as much as I think maybe we could, to patients and families. A vast majority of our consults come from the teams, and I think that in some cases, a patient or a family member prompting an ethics consult can be really helpful and valuable, so that's something that we can work on. The last thing I wanted to mention that we don't do, that I think we ought to do, and I'm curious if anybody else has experience in this, we often times—we're consulted in cases as they happen, we give recommendations, but there's not—we don't always participate in the cleanup of any mess. We don't often do debriefs, ethics debriefs about the very complicated ethical cases that we're involved in, and I think those could be really helpful for teams. Not just for them processing the experience of the ethically complicated case they were involved in, but also helping them prepare for similar cases that they might confront in the future, and that's something that we have an eye towards working on moving forward.

KUMAR: All right, thank you. We will now transition to questions tailored to each panelist's expertise. However, as always, if anyone on the panel wants to chime in and add some of their own thoughts, and share any insights they have, please feel free to jump in whenever. Starting with Ms. Dwyer. As legal

recommendations prioritize reducing liability and ethical recommendations emphasize patient and family interests, there are differing goals of legal and ethical recommendations. In your view, how can these recommendations be effectively integrated to create a holistic healthcare decision-making approach?

DWYER: So thankfully it isn't too often that law and ethics conflict with each other in what I do. I'm actually trying to think of a situation recently where it's happened. I can't really think of one, and thankfully, like Ben was saying, that our institution, our program has a really good relationship with our legal department too, legal and risk. If there is something that comes up clinically, our departments, legal doesn't hesitate to refer those situations to us, and we don't hesitate to inform legal when something is happening as well. I'm not saying that it never happens but the times when it does, it usually just takes a discussion between the two departments for things to work themselves out, for us to come to a conclusion. There of course are times where you may have a provider who just says, "I just want to know what I'm legally allowed to do or what I legally have to do," and it's like, yes that's important but that's not the only consideration here. Like I said earlier, sometimes it's helpful that you can help not only provide recommendations and guidance to the providers, specifically when there is a relevant ethical issue that happens to also have a legal spin to it, but when you work in collaboration with legal you can show the person who's asking for the assistance that you can do both. You can meet both goals of both doing what's ethically supportable and also what's legally acceptable in navigating these situations.

LEE: All right, thank you! The second question, this one's for Dr. Schwan. Given your experience, what role do you believe autonomy should play in the decision-making process both in medical research as well as clinical care, and are there situations where autonomy should be overridden in favor of other ethical principles?

SCHWAN: So I have lots of hot takes about autonomy, and some of them might be a little bit controversial, so don't think of me as speaking the received view in clinical ethics. What role does autonomy have to play? I think autonomy plays and should play a very important role in the clinical setting. I think though that sometimes the role of autonomy gets overstated, and so I'll just make a quick conceptual point because I can't help myself. So we sometimes in bioethics give this gloss on autonomy, that autonomy demands respect, and we don't qualify it in any way so it's, "Autonomy demands respect, period." But that's just like, I think a moment's reflection reveals that's not true.

There's this class, there's this example I give when I teach about autonomy. If I were to walk into a tattoo parlor with my wife and tell the tattoo artist that I have autonomously decided that my wife shall have my name tattooed on her forehead, it would be very strange for the tattoo artist to think, "Oh he's made an autonomous decision. I have a weighty reason to respect it." That would be, I hope you all agree, that would be crazy. And what that shows is that respecting autonomy is, while it might be very important, it matters what the relevant person is making a decision about. The language that I use when I write and teach about this is that respecting autonomy is important so long as a person is making a decision within their sovereign domain, and I think both on the theoretical level, philosophers have not paid enough attention to the boundaries of the sovereign domain, and I don't think bioethicists and clinical ethicists have either. I think this is a really important area to be thinking about when the reason to respect autonomy is in play because there are places in medicine where it's not clear whether somebody's making a decision about something that's properly theirs to control or not properly theirs to control, when they're making decisions about things that are kind of on the edge of medical appropriateness, for example. I think the reason to respect autonomy is really complicated. Is it ever okay to override autonomy? I'm inclined to think that the reason to respect autonomy is very weighty but it can be overridden. That's a controversial view among bioethicists. For what it's worth though I think that we, as a matter of fact, in the clinical setting override people's autonomy all the time when we determine that they lack decision-making capacity. There's a standard view on which patients who lack decision-making capacities simply aren't autonomous, or autonomous in the right way that their decisions demand respect, and that seems incorrect to me. I think this is another area that I'm really interested in, both for in practice and on the consult service, but also academically and thinking about the nature of the reason to respect autonomy for patients with impaired decision-making abilities and under what conditions is it, all things considered, acceptable to override such patients autonomy.

KUMAR: So that discussion of autonomy is definitely an important one when it comes to the broader field of clinical ethics, so we want to return to this group question once again regarding surrogate decision-making. Oftentimes in the clinical setting, surrogate decision-making is necessary for patients who may not have capacity to make those decisions. So what are your approaches when you're trying to evaluate a patient's capacity, and how do you reconcile capacity and this idea of informed consent? This is for the entire panel as well, just to clarify.

MORLEY: We wouldn't assess. As a clinical ethicist at the Cleveland Clinic, we would not assess capacity. I don't know if that's different for any of your practices, but we would discuss with the clinical team if it's a particularly complex patient situation, and they're really struggling to evaluate decision-making capacity, we might discuss aspects of that that are making it complex, and help them work through that evaluation but we would not do our own formal capacity evaluation.

SCHWAN: We don't do capacity evaluations at Metro either. The ethics consult service doesn't anyway. My understanding is that it is very rare for ethics consult services to do capacity assessments. But it's not never. At NIH, the ethics consult service does do capacity assessments, and so I did participate in some while I was there.

[Technical difficulty]

SCHWAN: Helping teams think through—we take it as an input into our recommendations, whether the patient has capacity or not, based on whether the team tells us the patient has capacity or not. Sometimes the team has a hard time determining capacity, they can consult psych or geriatrics to do a formal capacity assessment. But then once the capacity assessment comes in, we take that as kind of an input into our reasoning. The thing is that oftentimes we have to caution teams about, and this is in that same vein as I was just talking about when I was talking about autonomy. Just because a patient has been determined to lack capacity does not mean, at least in my view, that their decision no longer carries any moral weight, that there's nothing wrong. They lack capacity, so there's nothing wrong with overruling their decision, that's not right, that's too quick. There's still something, and I'm have in mind at least four cases that I've been consulted about, there's still something wrong with cutting off somebody's limb when they're saying, "No don't cut off my limb," even though they might have significant psych issues that are impacting their abilities to understand, appreciate reason, and communicate. Taking away someone's control over their own body is problematic regardless of their mental capacity. Now again I think sometimes it might be, all things considered, permissible to usurp control but it's a little more complicated than I think our model of capacitated or not oftentimes suggests. I didn't say anything about surrogacy, and I don't know if that was part of the question too.

DWYER: So we do capacity assessments for UH. I will say it does not come often, but it does happen. When teams disagree, like I've had times where two different teams have come to do different determinations about

capacity, and we were almost called in to kind of referee, be the tiebreaker. Over in peds, they don't usually do capacity assessments, and so when they occasionally have an adult patient who we need to do a capacity assessment on, sometimes that may be ethics that does it because our peds psychiatrists don't feel comfortable with doing that. So there are just certain unfortunate systematic constraints, or system issues, that cause us to do them but in general, thankfully, we don't do them that often although I have come across other programs that do them pretty often. In fact that may be even the majority of their consults. Not us, but other places. When we think about surrogate decision-making, in fact this was something that came up recently about both patients and assessing their capacity. How do you assess capacity of a patient who refuses to engage in the discussion? Does that mean that they automatically don't have capacity, or do we assume that they do because the default is that everyone has capacity. When we think about surrogate good decision-making, myself and my colleagues were talking about the fact that it almost depends on the level of risk and I think that actually applies to decision- making for patients too, especially ones that are not engaging in a conversation with us, where we could adequately assess their capacity. If it's something that the medical team thinks is a relatively low-risk decision, regardless of what decision they make, fine. We will allow that patient to make the decision, same thing with the surrogate. But as the level of risk increases, our tolerance for not participating in the process decreases. And that goes for both the patient and the surrogate. I think it's even more heightened when you're dealing with a surrogate because of course they're making a decision on behalf of the patient, and if they have no justification that they can provide us for why they're making that decision, and it's a high-risk decision, we feel a lot more uncomfortable with allowing them to make that decision. So that's my take on that.

MORLEY: Well I think that that discussion is interesting that there's that variation. I've only been an ethicist at the Cleveland Clinic, so um I think it highlights how clinical ethics is still this young field, and how we're still working out what clinical ethics as a practice should look like in various different settings, so that was a real learning point for me. I didn't even realize that other centers did capacity evaluations. That's really interesting.

DWYER: Yeah I mean, we've even had psychiatry tell the team "call ethics to do the capacity assessment," which I'm like, come on it should be you guys, really?

SCHWAN: So as this is another area where I have perhaps an unconventional take, again because I think it's uncommon for clinical ethics consultation services to do capacity assessments. It seems to me that it ought to happen. I don't think ethics consult services should be the only ones doing them, but I think it ought to happen more often than it does, and I think it ought to happen more often than it does, for part of the reasons that you were just suggesting. Sometimes, what's complicated about whether a patient has capacity or not are facts about the patient's psychological capacities. Their abilities to understand, appreciate reason, and communicate. And if that's so, and the team needs help assessing capacity then it just strikes me as obvious that psych is the one to help with that. But I agree with what you were saying, that sometimes the risks of the decision are a factor in determining whether the patient has capacity or not, and what level of risk makes it acceptable to deny decisional authority to a patient with a certain level of decisional ability strikes me as an ethics question, and so when risk is one of the contributing factors to whether we're granting or denying decision-making capacity, that seems to me clinical ethics ought to be involved in those kinds of capacity assessments. But that is very much not the standard practice, so far as I know.

DWYER: Right and let's not also forget a surrogate's capacity because that sometimes is an issue too, that we have a surrogate that we're just like, I don't think you should be acting as a decision-maker here.

MORLEY: That never happens in the Cleveland Clinic [laughs].

LEE: Awesome, thank you very much, that was super interesting to see the different perspectives and how the different hospitals and institutions work. We're going to go back to the individual question for Dr. Morley, and so the question is, As the Director of the Nursing Ethics program at Cleveland Clinic, what are the key objectives and priorities of the program and how does it support healthcare professionals in addressing moral distress?

MORLEY: I'm actually going to very explicitly refer to my notes because I want to make sure that I get in all of the aims of the program, because we do have a few key aims. So it is to really create and sustain a network of nurses with specialist interest in ethics. We want to educate them so that they can respect a multitude of values. It's to help caregivers, nurses, and other healthcare professionals to recognize and address the different subcategories of moral distress. It's to help nurses thrive through the provision of ethics education

so that they can enhance the ethical climate of the Cleveland Clinic. Then our final aim is really around empirical research and scholarly work, and it's to create a program of research excellence in nursing ethics and empirical bioethics with this particular focus on moral distress. We really are focused on a multi-pronged approach, and we have collaborators in the Center for Bioethics in the Nursing Institute and then also within research as well, to help support those key objectives and aims. We really want nurses to have exposure to ethics education. One of the things that we have just wrapped up and we have one previous nurse from the Cleveland Clinic in the audience who went through our moral spaces nursing ethics education program. We had a seven-month program whereby nurses went through ethics education, so now they can serve on their units as kind of an ethics resource. That's part of how we're really building this network of nurses across the Cleveland Clinic, and that's across all of our various campuses. That's not just Main Campus, that's all of our regional hospitals too. Within that, those nurses also get education on moral distress, how to recognize it, how to address it, and we're really focusing on trying to provide peer support. I did some research a couple of years ago, and we found that nurses really utilized, unsurprisingly, peer support as a tool for moral distress, but it wasn't as helpful as it could have been. We've developed some steps, some tools for nurses to use to support one another when they're experiencing moral distress, and also other healthcare professionals that they're close to as well, so that might be residents, or fellows, or even the attending physician, they can walk through these steps with them. Our approach to moral distress support is multimodal. We recognize that moral distress is a really complex phenomenon that exists in the clinical setting, and we're never going to be able to eradicate moral distress. I don't really think that we want to fully eradicate it anyway because it shows that we're still caring beings, caring clinicians, and impacted in the work that we do. We really try to utilize the ethics consultation service as one approach to addressing moral distress, recognizing that it's helping to address the moral event that's causing the psychological distress. That's the conceptualization of moral distress that we use within the clinic, so we have peer support, we have our ethics consultation service, and then we also do moral distress reflective debriefs as well.

We've started training a group of facilitators both internal to Cleveland Clinic, but then also we've started training external facilitators, so people from other healthcare systems that are really interested in implementing our model. They're also now using our approach to moral distress reflec-

tive debriefing, and that was an intervention that we developed in 2019, we developed in collaboration with our employee assistance program, so with licensed independent social workers. So we partner together and we go into the unit, we go into the clinic, into the clinical space, and we create this safe space for caregivers, for healthcare professionals, to come and talk to us about their morally distressing experiences and the idea is that we're partnering with somebody that has expertise in supporting psychological distress, recognizing that as a nurse ethicist, as a clinical ethicist, that's not necessarily where my expertise lies. I can validate somebody's emotions, I can be supportive in that moment, but I'm not an expert in supporting the distress that somebody might be expressing. So we have this very systematic intervention that we go through, we have stages that we're working through, and the aim is really to get the healthcare professionals to talk about their experiences of moral distress to offload that and recognize that they're not the only ones experiencing moral distress because often it's something that a whole number of people within the team have experienced, and then we really want to get them to engage in perspective taking. So thinking about that ethical challenge from the perspective of another healthcare professional because I think often we can get very stuck in our own views and our own way of thinking about the challenges that we encounter. Then we have like a tiny bit of ethics education that we sprinkle into our debriefs as well, but that's really not that's not the core. It really is just to create that safe space, so that's kind of the key aims of the nursing ethics program, and we're continuing to grow and focus on really sustaining these resources across all of our Northeast Ohio hospitals.

SCHWAN: Quick follow up for you, so I mentioned we've been doing coffee with clinical ethics, where we bring in coffee we set up someplace, and we give nurses the opportunity to come chat with us about ethics issues. The theme of our first coffee with clinical ethics—and they can talk about whatever—but the theme was moral distress, and we became aware through our conversations with nurses during that first coffee with clinical ethics of this phenomenon. I'm curious if you've seen it, and then if you've addressed it. So there was a senior nurse talking to us about how when she trained, her supervisor had been at Metro for twenty-five years, and the nurse manager on that unit was very intentional about creating space for especially new nurses to deal with the distress that comes along with the job. But that kind of management and the knowledge about how to manage the distress of other people on the team is something that comes

with experience, and the claim was that—I remember exactly how she put it— she's like, but now we have baby nurses training baby nurses because we've had so much staff turnover in recent years, and there's just not people at the top of the nursing hierarchy with the knowledge and expertise to provide space for one another and to deal with their distress in the right kind of way. And so I'm wondering if you maybe—not within exactly those terms—if you've noticed that as a contributor to moral distress among nurses and if you have thoughts about how to deal with that particular source.

MORLEY: Yeah, the pandemic, as with all healthcare professions, saw a huge turnover in nursing and—in many ways—decimated the profession, and I think it's going to take a really long time for us to rebuild. And so yeah, there are now more experienced nurses that have either left the profession entirely, or they've moved to areas where it's just less morally distressing, it's less acute, it's more kind of day surgery type things, you now don't have to work nights and weekends anymore, and that's also a huge factor. So, you see these new nurses, these newly qualified nurses that haven't necessarily been taught the skills of how to create that space—either for themselves or for others, and I think this should be a real onus in nursing programs. I guest lecture for the nursing school a couple of times each year, and I think that Case does a really nice job of integrating some, they have a solid ethics core, and then they very intentionally integrate moral distress into that education too. I think it's about providing the tools, and that's one of the reasons that we developed our peer support tool and the steps, because the idea is—I mean yeah, ideally you would have some form of ethics education underpinning that but—it's a series of questions so that you can have this discussion in kind of a more productive way. In nursing there's this real idea of the coffee room chat, the coffee room conversations, often where you'll go in, and you'll sit down, and you'll say what on earth are we doing with this patient? Like what is happening? And you're asking your why, why, why, kind of questions. And there's an extent to which it's helpful to vent and to share those feelings, but if you can then have that discussion with a peer, that's like—okay I'm going to validate your emotional experience, but I'm also going to ask some questions about like how can we actually do something now with these steps. Because it's recognizing there's this learned powerlessness or helplessness I think sometimes within nursing, and so thinking about how do we move away from that and so, baby nurses are perfectly capable of doing that too, it's just that they need to be given those tools.

KUMAR: Thank you all for your insightful reflections on clinical ethics and your experiences. I'm sure a lot of people have noticed already, but we are going to be moving on to our Q&A section, and we have two microphones—one on each side—so if anyone has any questions, please feel free to go up to that microphone and ask away.

AUDIENCE MEMBER: When you were talking there was a lot of mention about law, so my question is, Is law-making informed by ethics and is there an instance in your work where the law did not align with the general ethics of the situation, and also how did you deal with that? And I was just asking also, Are clinical ethicists involved in lawmaking and if not, do you think that will be a good initiative by the government?

DWYER: I think I'm going to start with your second question. There's actually been a lot of effort, not only amongst ethicists, but also I think medical professionals in general, that we should be doing more to get politically involved. Actually, there's an email subscription thing that a lot of ethicists belong to where you occasionally will get a petition or something that folks should sign up on. But I do think that in general there are some areas where ethicists do get involved. Take for instance this current revision that is being worked on for how we determine if someone's dead by neurological criteria. There are a number of ethicists on that panel working on things like that. Gun violence is another one that a lot of people are looking for ways to become more politically involved. There really isn't, or I haven't seen, a direct path for that to happen. You don't see an ethicist running for Congress. Anyone? No. We can sponsor actual legislation. I haven't seen that at the local level or the federal level. I'm not saying it can never happen, but currently I'm not aware of anyone doing work like that. To answer your first question, I think when you look historically, I think that ethics came before law. That's what leads me to believe that ethics tends to inform law, but I think that they definitely have a very related relationship now. Like I was saying before, the law—there's no way, and in fact a lot of people would say it would be a bad thing if law governed each and every aspect of our lives. I don't think that's possible, and so ethics tends to fill that gap because we recognize that the law—it just can't, and I don't think anyone would want to live in a society where the law governed every single action that we did throughout our day and every thought we had in our head. I think ethics is the one that helps guide us in doing what we, not only as a person, an individual person within a community,

how we act and govern ourselves throughout our daily lives. I think to a certain extent ethics informs the law, not to say that it is the end-all be-all. Thankfully, like I said before, they don't often conflict and usually you can find a recommendation that meets both doing what's right and also what's legally appropriate or legally acceptable in a lot of situations. I have yet to confront a situation where that was impossible. There are times that have come close, I had a case where the legal recommendation—and when you think of a legal recommendation, it's always to protect whoever the client is right? To give them the most coverage for whatever legal lawsuit might come about. Sometimes, that can potentially conflict with what's ethically appropriate, and an easy example is at the end of life. If you're dealing with a situation where, to as much of a certainty that you can possibly have, that what we're doing for a patient clinically is not going to result in their benefit, that they're not going to get better, unfortunately, despite our best efforts, there's a concern of can we legally withdraw treatment in a situation like that? The law kind of falls short. There isn't clear legal guidance of "can you withdraw." But the law does allow for clinical decision-making within those contexts when we know there are limitations to our abilities that we can limit what we offer when we know it's not providing benefit to a patient anymore. That's just one example. I don't know if either of you guys want to add to that.

SCHWAN: So I have one case where it was clear to me that the right thing to do was not legally permitted. It was one of the harder cases to work through for exactly that reason. To try to think through what should be done given the restrictions the law was placing on us, and I—this is one of the harder cases to talk about. There's a woman who, she was young—in her early twenties, I believe—who had overdosed on insulin. We don't know if it was intentional or not, but she was not going to recover. The family was from out of state, they all came in, and they were ready to withdraw the life support to let her pass, but there is a law—so, some laws are bad. I think, generally speaking, laws are informed by ethical considerations, but in Ohio it's not legal to withdraw life support from a pregnant person if there's a chance, I don't know the exact language of the law, there's a chance that the child could be born alive. This woman was only eight weeks pregnant, but she was not yet, according to the OB consultant, in the process of a miscarriage, which, according to the legal research that our team did, was that was the criterion for there not being a chance that the baby would be born alive. And so we had to tell the family "No, you

can't say goodbye yet," and it was hard for the family. It seems like it was very clear that the right thing to do in that case was to withdraw support, but the law wouldn't let us. Now, how much the team might be, we're not the ones with the hands on the patients, maybe some providers in some circumstances would be willing to take on substantial legal risks to do the right thing, but again, in our role we identify the ethical considerations, we consult with legal for the legal considerations, and then virtually always what you try to do is come up with the most ethically supportable way forward within the constraints that the law provides. Usually, those constraints don't rule out what you would independently think is the best option, but that was the case that I was involved with in which they did.

MORLEY: I would say that my experience resonates with that, you know we've had a few cases where I've been deeply frustrated by the constraints that the law has created. I guess my personal way, or maybe it's also my professional way of working through that, is to focus on supporting the team with the moral constraint distress that they're then experiencing too. Recognizing that I can at least leave the bedside, but the majority of that team are going to be there on the unit continuing to provide that care, and that's really, very difficult, and that obviously creates a weight that then I think impacts and causes many healthcare professionals to step away. I think once you have that accumulated over time, that's one reason—moral distress—is one reason why healthcare professionals move away. I don't know what the answer is, but it would be nice to be able to navigate some of these situations better. I think that we have a good relationship with our legal team too, and often we'll be working together, but I think there are sometimes these hard stops that are beyond unfortunate.

DWYER: So, I do want to know that there is variation amongst institutions about how much legal risk they're willing to take on. We actually had a similar case to the case you mentioned where we chose to go to court to get permission to end the pregnancy. It wasn't a withdrawal of life support, but to end the pregnancy for a patient who had already indicated that she wanted to end the pregnancy and unfortunately got in a car accident before she could move forward with those wishes. It was a case of her recovery would be jeopardized by the pregnancy if it were to continue. I honestly was pleasantly surprised to see that our institution was willing to take that to court, and fortunately we won that case, and were able to really advocate on behalf of the patient, but if she was at another institution I don't know if

that necessarily would have happened given the political climate of the state we're in right now. But again, referencing back to the variations amongst institutions, again, legal tolerance is one of them, where you do have to navigate — for ethicists too, how tolerant is your legal department to take on these types of risks, to gain a bad reputation. Believe me I have gotten that question from an attorney, from one of our attorneys, of like, this will make us look bad, and I'm just like but this is what is the right thing for the patient. Even if that potentially means, not necessarily doing something legal, but at least pushing the question, so sometimes that's necessary too.

AUDIENCE MEMBER: We've been talking a lot about, and not we, you guys, have been talking a lot, and you specifically, Dr. Morley, have been talking a lot about distress, and physician distress, and distress among teams of physicians, and teams of nurses, and you talked about ethical training and how individuals can obtain an ethical toolkit, and I wanted to ask all of you guys whether you think having an ethical toolkit within teams, like What kind of change does that bring about? Is that something that should be implemented at a much larger scale? Is that something you guys want to see among physician teams, among nursing teams? Just to see what you guys think about that.

MORLEY: Thank you for the question. I think having ethics education is critical for all healthcare professionals, and I think one of the ways we perceive ourselves at the clinic as an ethics consultation service is that we're there for those situations where healthcare professionals have—they've done what they can do, and they're at their limits of their ethical knowledge and skills, and they really need an expert, and that's not to say that we don't get what we would regard as easy or run-of-the-mill kind of ethics questions, but I guess the idea is really that we want clinicians to be really empowered, and we want them to have the education to be able to work through these challenges. It's not like, oh I've encountered an ethics question, let me call the ethics consultant straight away. It should be really about the clinicians having that—feeling empowered to really navigate those challenges. Often what we see is moral distress occurs when clinicians are feeling powerless in some respects and unable to navigate that situation, so one thing that we do on our service is also when we're standing shoulder-to-shoulder with clinicians and helping them work through that challenge is also to provide some ethics education as well—and again, not in an "ethics police," preachy kind of way, but just so that if they encounter this again, hopefully they can

navigate it on their own—not to say that we wouldn't be happy if they called us again, but really that's our focus—making sure that they have all the tools that they need to work through those challenges. That's kind of the way I think about it. I know that there are some consult services in the world of clinical ethics that really focus on these day-one consults and catching the ethical issue straight away, and that challenges me a little bit when I think about the powerlessness and giving clinicians the tools to work through the issues themselves.

DWYER: So I would just like to add—not only giving them the tools, but making sure the tools remain in place, because one thing that we've noticed—and literature has captured this—you may get ethics education early in your career, but—and let's say you start off as a med student—you get ethics education, by the time you were in your fourth year of residency, that ethics education has likely disappeared. So making sure that there's a continuum of the ethics toolbox to help you navigate these situations is often key too. We try to hit folks at every stage of their career just to make sure that they are able to maintain that resiliency too.

SCHWAN: Just following up on those both of those points, I'm inclined to think of the toolbox as containing—it contains both things—but I'm inclined to think of it more as containing a set of skills than a set of knowledge, and just like with any other skill, to stay good at it, you have to keep practicing it. You don't need to get a PhD in philosophy to—you *don't* need to get a PhD in philosophy [Laughter]—to do clinical ethics consultation. [Laughs] You need to have the skills to be able to identify ethically relevant considerations that bear on a case and then have the skill to be able to structure your thinking about those things in a way to come up with principled resolutions about how to make trade-offs among those things. And again, of course knowledge matters, but I'm inclined to think the skill is much more important, and so, yes, education is really important at the beginning, but then creating opportunities for the exercise of that skill to keep it fresh I think is really important. And I also think that physicians and members of medical teams bear some responsibility too for continuing to exercise. It seems—[to other panelists] I'm sure you've had these experiences—it's clear in interacting with some physicians that they just think about ethics considerations a lot, despite not being on the ethics committee or part of an ethics consult service, they think about them, they attend to them, and then others offload that, and I think there's a sense in which the first kind of physician is doing it better.

LEE: Okay, so we're close to approaching time, but Kai, please go ahead and ask your question. This will be the last question before the panel will move on.

AUDIENCE MEMBER: All right, thank you. I found the idea of ethics existing where laws cannot put constraints on, and I was thinking of this possibility, of when left with ethical ambiguity, the opinions of every stakeholder matter, and I also thought if there is a pre-informed consent of the individual, it also should take part in the discussion. But as with law, pre-informed consent cannot specify in detail what someone should do for them in each and every single case. Do you think it helps to have general values of the person in mind to make a decision for them, or what would you like to know about their values or their views?

DWYER: So you're touching upon a key part of ethics consultation, the fact-finding part, where we try our best not only to talk to the team members, but also the patient and anyone else that we can really get in touch with, who's a part of the patient's care whether they're at the bedside or at home. We try our best to reach out and get those. I don't feel like social factors are enough, it doesn't capture enough of it. Just getting to know the patient more, to help navigate and guide what the decision-making should be around the recommendations that we make for those patients. Not to say that our recommendations are the end-all be-all, it's just a recommendation. It's up to the team, the family, the patient, to determine whether or not they're going to follow that recommendation. At the end of the day it is just simply that we provide the options and it's up to them to think about what best works for their life, their goals, their values, and then they go from there. We aren't the ones to dictate that. We try to gather that information to make it more relevant to the patient, specific information so that it's not just some recommendation out of left field that completely is not relevant to what's going on with them. But at the end of the day, it's not our decision.

MORLEY: Yeah, I think that's the misconception isn't it, that ethics is going to come in and say, "This is what you should do. This is the almighty decision." But so much of our work is helping teams and then also helping patients and families to work through—if we're thinking about a patient that doesn't have decision-making capacity, let's say they're incubated, ventilated, not able to speak for themselves. Helping that surrogate decision maker to think through what that person would choose if they could speak for themselves, and often surrogates don't really know. They're, for me, the best consults. They're the ones when I feel the most sense of satisfaction

and job fulfillment, when I'm actually working with a family member who is genuinely saying, "I really don't know what this person would choose." Sitting down with them and learning about their loved one and saying, "Tell me what this person enjoyed doing from day to day, how did they spend their time, what was important to them?" Of these different things, what was the most important aspect, and it's really about getting to know somebody. Providing that insight and that glimpse into their values and what's really most important for them, and that's part of our jobs that I think sometimes is a little bit unseen, and it's that crossover often with palliative medicine as well, that kind of decision-making support. But it's really crucial and I think for me, my favorite aspect of the job.

KUMAR: Thank you to our audience members for asking their insightful questions. Before we conclude our panel discussion, we'd like to sneak one super important question if the three of you don't mind, and that question is "What is one piece of advice that you would give to aspiring healthcare professionals who might face ethical dilemmas in their future careers?"

MORLEY: Any one piece of advice? [laughter] Can I have more than one piece? [laughter] If you're lucky enough to be in a healthcare institution that does have clinical ethics support and a clinical ethics consult service, or a clinical ethics committee, then I would say, get involved, get interested, get curious, and learn what it is that they do and how they can help you. I think that that is super important, and I find it really disappointing when I meet the odd healthcare professional that doesn't know that we exist and they're like, what? it would have been so helpful five patients ago if I had known that I could have this help and this advice. So I think that's my resource-rich view, but I think, coming from the UK where we don't have clinical ethics support at all in the same way, I think it is about, we've already talked about it, the education piece and just making sure that you are committing to that aspect of your practice because it is so critical. Every single decision that you make as a healthcare professional has some kind of ethical implication and recognizing that that's a key piece of practice and continuing to take that kind of lifelong learner approach.

DWYER: I hope this doesn't sound cliche but asking for help, because there's a lot of support out there. I feel like there's still very much a mentality in healthcare that asking for help is somehow a defeat. That somehow you're not smart enough, or you're not strong enough, if you have to ask for help, and that is absolutely not the case. Healthcare is not an "I" sport.

It's a team sport, very much a team sport these days. Utilize your team because there's no way that you will have the answer to how to navigate each and every situation, especially the hard ones, and so there usually tends to be support in some way one way or another. So don't be afraid to ask for that help and support, and going along with what Georgina was saying about if you happen to not be in a facility that has a very active clinical ethics program. I think everyone on this panel and most clinical ethicists out there will say, "We don't care if you're affiliated with our institution or not, we will still help you if you were to get a hold of us." Ethicists are not shy people. In fact I think it would be hard to do our jobs if you were a shy person, so we don't mind people asking us off-the-wall questions or something that sounds a bit crazy. In fact, we exist in the crazy, that's what we do. We only get called most of the time for the situations where "something's off with this, can you help me navigate this?" That's perfectly fine, and again we don't care about who you are or what background you have, if you needed help, most of us would be willing to pitch in and help.

SCHWAN: I'll echo a sentiment that I expressed before, and it would be to practice ethics. In particular, I think that the most frequent source of intractability in a case that we're consulted about, is a failure to understand someone else's perspective. Part of the practice is to try to keep, it's hard, but keep trying to step outside your own shoes and think about the case from the perspective of the patient, or from the perspective of the loved one, or from the perspective of the nurse on your team, or from the perspective of the physician or the resident or the spiritual care, whomever else might be disagreeing with you. But practice stepping outside of your own shoes and thinking about the problem from someone else's perspective because that can sometimes make what otherwise is an intractable ethical problem a little bit more tractable, and it takes practice.

KUMAR: Once again, we want to thank our amazing panelists for taking the time to visit and discuss clinical ethics with us. The Global Ethical Leader Society would also like to give a huge thank you to our adviser Beth Trecasa, who has been instrumental in making this event a success, and we'd also like to give a special thanks to Dr. French and the Inamori center for all of their support. I would also like to personally give a huge thank you to the GELS exec board for putting in a lot of hard work and making this event possible, and for making my last GELS event a good one. So thank you very much, and I hope next semester is great for all of you.

LEE: So since we're going off script, as you noticed this is Sakthi's last semester, and I'm sure if you've been at GELS, you know the amount of work that Sakthi puts in and how much love Sakthi has for ethics and making sure that our community is able to access resources to learn about ethics and practice ethics. Can we also give him another round of applause? And finally, we want to thank the MediaVision staff for assisting with setup and logistical support here at the Tinkham Veale University Center and GELS members who helped to run this event. Thank you all for coming out and we hope you have a wonderful night. If you found this discussion insightful please feel free to join us from 7 to 8 p.m. on Mondays in the Inamori Center for our general body meetings. That concludes our event, and let's give one more round of applause for our amazing panelists.