



CHAPTER 8

A Framework for Teaching Clinical Health Care Ethics

Abstract What to teach? How to teach it? These are the central questions for teaching professional ethics to trainees in health care, as they are for teaching any students in any subject in any field. The answers we present here and in the coming chapters build upon the criticisms of bioethics from sociology, history, and anthropology, as discussed briefly in our introductory chapter—and also on the discussions of the self, informal ethical discourse, and interpretive communities, as presented in Chapters 6 and 7.

Keywords Health care · Clinical ethics · Implicit ethical framework
Informal ethical discourse · The self · Interpretive community · Morality of ordinary practice · Touchstones for learning · Personal comfort and safety · Professional power and authority · Reflective practice

THE CHALLENGE OF EXTENDING TRAINEES' EXISTING ETHICAL FRAMEWORKS

Our fundamental assumptions are that health care trainees already know all the ethical principles they need, and that they've been using them their entire lives. Autonomy/freedom and justice/equality/fairness are regularly

recognized, whether explicitly or implicitly, in the lives of children, adolescents, and young adults.¹ They, like people of all ages, recognize the workings of benevolence/beneficence—intending and doing good. Even what appears to be the distinctly medical principle of “do no harm”—re-described by bioethicists as *nonmaleficence*—is well familiar to small children, as when they are playing a bit too rough with siblings or friends or a pet, and are cautioned, for example, “Don’t hurt your brother!” Nonmaleficence also has a ready equivalent in cautionary notes such as “let’s not make things any worse” (typically used in human contexts) or “be careful not to cause any further damage” (typically used in nonhuman contexts such as trying to fix a bit of plumbing).

The pedagogical challenge is to extend each trainee’s existing—informal—ethical framework to the new context of clinical health care. Expressed in the language of Chapter 7, the task is to enable health care trainees to join their respective interpretive communities. This task has various substantive dimensions:

1. The trainee, previously a lay person (at least in most cases), is taking on a *new role* as, for example, a doctor, nurse, social worker, or clinical psychologist.
2. In that role one is generally expected to provide the type of *professional services* associated with that role, such as medicines or surgical procedures, nursing care, social services, or therapy (all of which come in myriad forms, depending upon the setting and one’s precise position).
3. The professional services are to be provided to particular persons, usually described as either *patients* or *clients*.

And all of these elements are organized within a particular setting, which itself has three elements:

4. the *institutional setting* (including *work culture*) in which the clinician-patient encounter occurs,
5. the overarching *health care system*, and
6. the *social/political system* in which all of the preceding are located.

To return to the themes of our first chapter, each of these six elements—professional role, professional services, patients/clients, institutional setting, health care system, and social/political system—has a sociological,

historical, and anthropological/psychological dimension that can help to enrich the trainee's existing ethical thinking. If all goes well, the outcome will be a new ethical persona, with a newly integrated constellation of thought, emotion, and action.

The immediate question for each trainee—and more broadly for each interpretive community—is, of course, how to extend what he or she knows to this new milieu. It's *not* a matter of coming to know ethical principles that one didn't know before. It *is* a matter of seeing how the person one is can learn to think effectively within, and to act effectively in response to, the ethical challenges presented by this new setting. Another way of putting this is that the closer that health care ethics remains to each trainee's existing ethical framework and its foundations in the self, the easier it will be for trainees to extend that framework to their work in health care. Learning is always easier and more effective when it builds upon what one already knows.

But how is that to be done? Our response comes in two parts. In this chapter we discuss some general considerations relevant to the question, and in the next two chapters we discuss various potential formats for teaching clinical ethics. But before we proceed with either of those tasks, it will be helpful to look at how cases were used in “The Terminally Ill Patient: Ethical, Legal, Psychological, and Social Issues,” a continuing medical education course that the first author (SS) previously taught at Harvard Medical School. The course was open to professionals in all fields of health care; the attendees were all clinicians, and from various fields. Their common goal was to increase their understanding of terminal care and provide better, more humanly responsive care to their patients.

CASES FROM THE “MORALITY OF ORDINARY PRACTICE”

In that continuing education course, the main cases (one per plenary session, plus shorter, subsidiary cases for the breakout sessions) were factually rich with details about the patient, his or her family, the health professionals involved, and the settings in which care was provided. Notably, the cases were also complete; that is, the patient had died, so there were no questions such as “Whose rights are at stake?” or “Who decides?” or “What should be done?” Instead, the cases presented opportunities for course participants to sort through—ethically, legally, psychologically, and socially—factually complex situations about

the “morality of ordinary practice,” and to think about and discuss, in the first person, their own perceptions of each case: What was done and why? How well were the facts of the case (broadly construed) taken into account by the patient, family, and health professionals involved? What were the perceptions of the patient and family? If I had been the doctor (or the patient, or the family), would I have done the same thing or something different? If the latter, why? Were the settings in which care was provided the appropriate ones? Was the outcome what I would call a “good” or “acceptable” one? What could have been done, if anything, to improve the outcome?

The features of this approach are important to spell out.

- The cases were specifically designed *not* to generate discussions of ethical rights and principles per se and also not to generate conflict. Instead, the goal was for course participants to look at each clinical situation from the perspective of how to provide good, appropriate, humanly responsive medical care. Discussions within such a perspective do not require assertions of rights or the reference to ethical principles. Ethical ideas are often implicit in the case—as in “the patient decided [or wanted or refused]” or “the doctor explained” or “the family initially was initially opposed but, after having some time to adjust, accepted what the doctor had recommended.” But describing any of these phenomena as involving ethical rights or principles simply adds a layer of analysis by substituting the unfamiliar and relatively abstract vocabulary of rights and principles for the more tangible descriptions of what is happening on the human level, which involves wants, emotions, wishes, disappointments, surprises, and so on. We have an immediate understanding of what is involved in these human phenomena, whereas the language of rights and principles draws most people into unfamiliar territory in which their intellectual footing is, at best, unfirm.
- The cases were specifically designed to generate self-reflection, probing questions and discussion, and possible rethinking. It is here that this mode of presentation shows itself to be connected with each course participant’s individual thought, emotion, and action—that is, with the self. The course participants were challenged to evaluate their own beliefs and to compare them with those of others: Would I have done that? Could I have done that? Would any of the rest of us have done something different? Why didn’t the doctor

in the case do something more (or something less)? Importantly, any potential rethinking was, as it were, a victory for the self. When persons changed their minds about some aspect or other of a clinical situation, it was because they had looked critically at their existing perceptions or responses and seen that something better was available. By contrast, in classroom discussions in which conflict is encouraged, changing one's position can be perceived by oneself and others as a *defeat* or *sign of weakness*, meaning that honest, thoughtful reflection and the emergence of new thinking come at a *cost*. The safety of open discussion and critical self-reflection—and the possibility of growth—has been lost.

- All of the six elements mentioned in the preceding section—professional role, professional services, patients/clients, institutional setting, health care system, and social/political system—were potentially in play for every main case. In this respect, the approach used in the course can be reasonably understood as addressing the concerns of the sociologist (Fox), historians (Belkin and Brandt), and anthropologist (Kleinman), as well as bioethicists Callahan and Churchill, as discussed briefly in Chapter 1. The more relevant information on such matters that the presenters and course participants brought to the cases, the better. Participants' understanding of the clinical situations would be richer; they would be more likely to engage with the many dimensions of those situations; and they would be in a better position to integrate any new learning into their future work with patients. Just as importantly, this information on sociology, history, and anthropology/psychology (all broadly construed) was inescapably integrated into the course participants' ethical understanding of the cases presented and interwoven with their own ethical thinking.

As noted above, the cases were specifically designed to promote intellectual and emotional exploration. Another reason why discussions proceeded as smoothly as they did is that the course participants were experienced clinicians with the background knowledge required to understand the full dimensions of the clinical situations presented. In addition to having mastered at least the fundamentals of their own fields, they understood that each health care setting has its own goals and constraints, that these goals and constraints need to be taken into account in any effort to address problems (ethical or otherwise) that arise in that setting, that patients and their families come in endless varieties

(culturally, socially, religiously, politically), that the capacities of patients and families to understand health care and treatment differ dramatically, and that clinical situations are often not as straightforward as they appear. As experienced clinicians they also understood that keeping an open mind is a remarkably valuable asset—one that helps them both to solve problems and, indeed, to avoid them in the first place. They were, in short, mature members of their respective interpretive communities within health care.

When all of the above background factors are taken into account, what emerges is a picture of clinicians who are able to understand and assess the details of clinical situations, to see what is potentially problematic in the situations as presented, and to focus their attention on those potential problems. In a group setting, what drives discussion—especially in a well-constructed or -chosen case for teaching—is the likelihood that different clinicians will see the factual details in different ways and that, as the clinicians describe and discuss their own perceptions, they will come to see the case from a broader, more nuanced perspective. As these perceptions evolve and deepen over the course of the discussion—or over the course of a real-life clinical situation—the exact parameters of any problems presented by the clinical situation will themselves change. And what seemed a problem at one point in the discussion or treatment may somehow disappear into the background and become much less important, whereas other problems, invisible or unnoticed at first, may unexpectedly coalesce and take center stage.

What's important about this process, as mentioned earlier, is that it's basically a process of personal exploration and discovery. In a formal course this process is carried out in a group setting, as it also often is when clinicians practice in institutional settings or as members of a team or group practice. In coming to understand the various dimensions of such situations, participants aren't fighting or opposing each other, and they're not winning or losing. What they are doing—in the process of analyzing and responding to the situations confronted (whether in the classroom or in real life)—is deepening their own understandings of themselves and the human demands and nuances of health care.

The following clinical situation illustrates the evolving cross-currents that can be seen in a single case.

Jim, a 38-year-old stockbroker and partner in an investment bank, has treatment-resistant AIDS that has continued to progress despite university

hospital-based medical care and enrollment in a series of experimental programs. His partner David has been progressively more involved in communicating with Jim's doctor and (for home care) his nurse and social worker. On a recent home visit, Jim's nurse and social worker, who work as a team, found David clearly distressed, presumably because Jim's condition was, they learned, beginning to deteriorate rapidly. On a subsequent visit, however, the team was met at the door by Jim's father, whom neither Jim nor David had ever referred to, and with David nowhere in sight. The father proceeded to criticize the care that Jim was receiving, blamed David for Jim's illness, and then claimed that the reason Jim was dying was that he had been misdiagnosed with AIDS and was dying of some other unrecognized, rapidly progressing disease. The nurse and social worker, stupefied, were about to respond when Jim's mother came in from the kitchen, asked her husband to have a seat in a comfy chair, and suggested to the nurse and social worker that they go for a brief stroll. The mother explained that the father had refused ever to recognize Jim's sexual orientation, that the father's admitting the diagnosis of AIDS now would be tantamount to admitting that he had alienated himself from his son due to his own insensitivity and prejudices, and that he had therefore lost the opportunity to share some large part of his own life with his now dying son. A final bit of information was that the father, in his late 60s, was showing early signs of Alzheimer's disease and had lost his intellectual and emotional adaptability. After returning to the apartment, the nurse and social worker told Jim and his mother and father than they would be back in a few days with an updated care plan. They also asked the mother to contact David and tell him that they would be in touch with him shortly.

As with many clinical situations discussed throughout the book, the above situation bristles with human conflicts of one kind or another—for example, between Jim and his father, David and Jim's father, Jim's father and mother, and the father and the health care team—not to mention the father's obvious internal conflict concerning his son and the father's attitude toward gays. Notably, too, one's understanding of what is going on, and why, changes sentence by sentence, with each newly added fact. All of these matters could potentially be described and discussed in terms of formal ethical discourse—the language of academic ethics. But the case can actually be thoroughly described without any formal ethical terminology. By the same token, the many problems and conflicts can be identified and addressed in ordinary language and, if and when necessary, by using informal ethical discourse. It is a deeply human situation, and the solutions to its many problems are, indeed, human rather than theoretical or intellectual.

In the case above, the conflicts and human disconnections were ones that complicated the delivery of care but that were likely to have no impact on the actual care delivered. In the following case, the conflicts and cross-currents create a situation in which all those involved have done their best, though with uneven results throughout, with no effective resolution and no closure.

A 14-year old, indigenous boy has been in foster care with a single Caucasian woman since the age of 2. He had been taken into care because of severe abuse and neglect, and has a mild case of fetal alcohol syndrome. In primary school he experienced attentional difficulties, behavioral impulsivity, and separation anxiety regarding his carer, with whom he has become increasingly violent as he has grown. His contact with his biological family has been minimal.

Over the years, the welfare service has had recurrent conflicts with the boy's carer over such matters as her style of parenting (which involved indulging or bribing the boy to behave better), her requests for more assistance (including financial), and her inability to maintain the boy's regimen of medications prescribed for impulsivity, aggression, and anxiety.

The situation deteriorated when the boy transitioned to high school. The only available high school had many students with externalizing behaviors. The boy became increasingly more oppositional, eventually refusing to attend school. Perceptions of the situation diverge widely:

- His carer developed a fixed belief that the boy was unable to cope with school because of his fetal alcohol syndrome, and she has become a prominent, media-savvy advocate for improving services for fetal alcohol spectrum disorders.
- The high school counselor perceives the boy, when in attendance, as coping well, as liking the small class where they have placed him, and as enjoying some contacts with indigenous male mentors. The counselor feels that the carer is encouraging the boy to avoid school.
- The boy's therapist also experiences the boy as doing well when in attendance at school, as enjoying developmentally appropriate challenges, and as welcoming invitations to function more independently.
- The welfare agency, because of recurring conflicts with the carer and their view that the present situation is likely to deteriorate further, is seeking an alternative placement. The main complication is that the only feasible placement identified is in another community with extended family that the boy does not know, with no high

school, and with a local indigenous dialect that the boy does not understand. The agency itself has no idea how the prospective plan can be made to connect up with the need for the boy to take his place as an adult male member of his particular indigenous community, which requires, among other things, that he go through the appropriate initiation rites, of which he has no knowledge and no preparation.

- The boy himself is afraid of any change and feels that he “can get his mother [i.e., his carer] to get him out” of anything that would provoke too much fear or anxiety in him.

In describing the case, the boy’s psychiatrist notes, “No optimal outcome was possible. We were operating in the gray zone, constantly making decisions involving difficult trade-offs. How do you walk a compromise line all the way through?”

As with the case above (the stockbroker with AIDS), much of this case could have been described using the language of ethics, but there was no need to do so. The conflicts and problems were real, and they were discussed and, insofar as possible, addressed in the terminology of the relevant interpretive communities.

TOUCHSTONES FOR LEARNING

In courses oriented around lectures and readings, topics and materials are established in advance and are typically slow to change over time. But in any other teaching format (see next chapter), the choice of materials and methods are much more flexible. In this section we discuss what we call *touchstones for learning*, and in the next section we discuss some general goals and constraints in teaching clinical ethics to health care trainees.

When the first author taught ethics clinically in Harvard-affiliated hospitals, he encountered an oddity about how people stored “ethical” information. If he asked doctors, individually or in groups, whether there were any *ethical problems* that they were worried about, the answer was almost universally *no*. But if he asked doctors if there were any *cases or situations that were bothering them*, the answer would be an immediate and resounding *yes*. For example: Mr. Smith was doing much worse than expected, potentially because of an incorrect diagnosis by the primary care physician; one of the nurses was complaining about the treatment given to Mrs. Jones; the chief resident was worried

about a junior resident's difficulty drawing the line between a patient's medical problems and his personal problems (the latter being beyond the scope of the resident's work); the children of a dying patient were pushing for much more aggressive care despite the patient's unequivocal rejection of further care; and hospital administration had cut back funding for a new, much needed program that was already in the hiring stage.

All of the above situations raise what are, in effect, ethical issues even though they aren't identified (or, in practice, analyzed) as such. They're just "problems." Moreover, one of the reasons that these problems are experienced as "problems"—rather than simply being addressed as a matter of course—is that they actually *do* involve ethical issues; if the problems were merely technical, medical, or scientific, they would likely already have been solved or at least addressed in some appropriate way. Also worth noting is that the "invisibility" of these ethical issues (i.e., seeing them as "problems" but not as specifically ethical problems) is exactly what we would expect based on our discussion of interpretive communities in Chapter 7. The ethics of health care is embedded in the setting and, indeed, in the professionals who work in it. Trying to separate out ethics from everything else is to distort the ethical issues, whose contours are integrally connected with, and can be understood only in the context of, the health care setting itself.

Another way of understanding the same point is that professionals working in any particular health care setting typically encounter and analyze problems in instrumental terms related to that particular setting and to particular patients or colleagues or institutional demands. If all goes well, goals are achieved; appropriate care is provided; and both health professionals and patients end up feeling satisfied. But if the goals aren't achieved, or if appropriate care isn't provided (or if something goes wrong with it), or if health professionals or patients end up being dissatisfied, then the question is why that has happened: what has gone wrong? Ethical principles or other abstract concepts may be involved—and surely many bioethicists would try to analyze the various dimensions of the situation using rights or principles or other abstract concepts—but that's not how the problems or shortcomings are experienced, and that's not how they're solved.

So, the question is, if ethical issues are not, in the clinical setting, generally perceived as *ethical* issues but merely as problems of one kind

or another, how does one identify them and then address them? The answer is actually given, at least in part, in the paragraphs above. To identify them, one just needs to ask the correct questions: the *touchstones for learning*. In addition to “has anything been bothering you” or “has anything gone wrong” (as above), one can ask any or all of the following: What has puzzled you? Surprised you? Bothered you? Disturbed you? Upset you? Angered you? Unexpectedly challenged, delighted, or disappointed you? Has anyone been acting in a way that puzzled, bothered, or distressed you? These and similar questions can be asked from the day that trainees set foot in professional school, and the answers will change day to day, month to month, year to year.² Trainees’ skills, strengths, weaknesses, challenges, vulnerabilities, and so many other things will vary over time. There will always be something new to discuss, and then potentially to address, in relation to the goals, standards, and practices of the respective interpretive community.

CREATING THE SPACE FOR REFLECTION AND DISCUSSION

From our perspective, the baseline data for teaching ethics to trainees in health care (or in any other field) are their own thoughts, emotions, and actions. The touchstones for learning discussed above are an excellent way of tapping into those data. But the circumstances need to be supportive, too. We suggest that the following aims and constraints be incorporated into the teaching program, as they were into the continuing education course discussed earlier in this chapter.

- *Teaching tied to current needs and experience.* Trainees in health care encounter new challenges and situations of one sort or another every day. Teaching is most effective if it can be tied into these situations, which trainees will be very highly motivated to understand and address.
- *Exploration of own thoughts, feelings, and opportunities for action.* In the end, what will matter to trainees is whether this work on the ethics of clinical practice proves to be something that they carry with them after they have completed their training. Trying to understand what other people have thought or written about such matters may potentially have some impact but may also have no

impact at all, being too abstract, external, outside the self. What will have an impact is learning that is centered on understanding one's own self in interaction with others and one's own particular professional environment.

- *Socratic approach with probing and open-ended questions.* Asking the right sort of questions will encourage trainees to explore their own thinking and feelings, and will encourage more freewheeling discussion. Directed questions make it too easy to provide superficial or “correct” answers. If a question doesn't make the trainees think, it's the wrong question to ask.
- *Use of “natural” language.* As discussed in Chapter 6, using the language of informal ethics, coupled with the language of everyday life to discuss thoughts, emotions, and action, is the goal here. Anything else will distance trainees from their own experience, the foundation (in our view) for learning in ethics that will last a lifetime.
- *Encouragement of open exchange of ideas and concerns, at and between all professional levels.* It is helpful to return, in this context, to the touchstones for learning discussed above. That is, whenever trainees (or teachers or senior colleagues) encounter a situation that, for example, bothers or disturbs or surprises them, it should be considered appropriate to ask (and to discuss with peers or with someone higher or lower in the professional hierarchy) why the situation is triggering such a response. Presumably, not all such questions will be asked all the time; the questions can be asked when timely and not too distracting; and, over time, trainees and their seniors will all learn to ask better, more focused questions as previously unquestioned phenomena come more to everyone's attention.
- *The earlier the better.* Bad habits die hard (Wear 2006), and the failure to confront bad habits serves to perpetuate them. As noted in *Grace Under Pressure* (a dramatic presentation that we will mention occasionally in the next two chapters), some types of “bad behaviour,” such as bullying and sexual harassment, are, in effect, “protected because I guess I knew that no-one was ever going to pull me up on it” (Williams and Dwyer 2017, p. 18). But it's best that bad habits not become habits in the first place. So, by legitimating and tolerating open questioning early on, professional schools would enable trainees to learn habits that can set the stage for better, more expansive learning, more respect for, and understanding

of, their own feelings and those of others, and much-needed attention to otherwise neglected parts of the learning and professional environment.

We also suggest that, with the exception of the inevitable core lecture course (see Chapter 9), the standard format for teaching and discussing ethics, conceived along the lines above, should be small groups ranging from five to fifteen trainees (if at all possible). The small size ensures that each trainee will have an opportunity to participate, while the presence of other group members encourages a diversity of viewpoints, which is especially helpful for expanding a person's own ideas and perceptions. As this process proceeds, trainees' currently fast thinking will be challenged by the situations presented or by the thinking of others. That fast thinking gives way to slow thinking, which leads, over time, to new patterns of fast and slow thinking (see Chapter 6). These patterns will be ever changing throughout the course of training, generating new and richer patterns of what we have been referring to here as informal ethical reasoning.

PROBLEMS OF POWER AND AUTHORITY

We have used bullying as an example above because it is an instance of much broader, much more difficult to address problems relating to power and authority. Especially during their first years working in clinical settings, trainees find themselves trapped between speaking up and remaining silent. The cost of the former is a potentially career-endangering (or, early on, grade- or placement-endangering) response from more senior clinicians. Since grades, placements, and, indeed, the shape of professional careers depend so much on the evaluations of senior clinicians, speaking up may come at a very high—unacceptably high—cost. But the cost of remaining silent is also high. In the short term, it compromises both learning and one's sense of self. In the longer term, and as instances of self-imposed silence recur and recur, the professional self can be blunted; creativity can be lost; and trainees may come simply to accept the way things are. And because what goes around, comes around, trainees—when they themselves have reached positions of authority—may well expect the same sort of silence and implicit obedience from their juniors.

Stopping this destructive cycle—with no good escape, at present, for trainees—requires institutional action, not just discussion. The latter

would, if it involved senior professionals, likely just generate more silence from trainees. What is needed, we think, are direct interventions aimed at any clinicians specifically involved in clinical training. Raising awareness of the diverse ways in which senior clinicians exercise their power and authority is the first step, but they also need to learn to deal with their own feelings about, and their responses to, being questioned or even challenged by junior colleagues and by residents. Awareness alone, without some further opportunities to understand how and why one might respond in the way one does, is simply not enough.

One place to begin thinking about these issues and how to address them is with A. O. Hirschman's *Exit, Voice, and Loyalty* (1970). The main insight in the book is that, contrary to the common perception that voicing one's concerns or objections is a product of disloyalty or other form of ill will, *voice* is a form of loyalty that indicates an interest in improving a product—the prime example in Hirschman's book, but it could be an institution or game or way of talking in a group. Disloyalty (or other forms of ill will) is expressed through *exit*; that is, one drops the product (or institution or game or discussion) and moves on to something else. To make this relevant to trainees, *voice* currently often comes at too high a price for trainees, but *exit*, except for a decision to leave the field altogether, is unacceptable, too. This bind is created by supervising clinicians, not the trainees, and that's why direct interventions with staff are so important.

There is also a much broader matter at stake. Interpretive communities thrive on open, free expression. Indeed, such expression is the means by which interpretive communities identify and address challenges and problems, and the means by which they change and grow. Additionally within the field of health care, open and free communication enables trainees to ask questions, facilitates evaluation and criticism of health interventions, expedites adoption of new methodologies and treatments, and, by facilitating *voice* and the early identification of problems, helps to maintain professional morale and avoid burnout.

We have included, as Appendix 8.1, a young doctor's reflection on the difficulties of maintaining a sense of self and self-worth as a pediatric resident.

In her 2006 article, "Respect for Patients" (p. 88), Delese Wear notes that medical educators came to consider the term *hidden curriculum* of particular interest because it was useful in explaining "the unintended (and most often negative) attitudes, values, and behaviors acquired by medical students in spite of a carefully planned, formal curriculum."

The hidden curriculum is not limited to medicine, of course; all fields of health care have their distinctive areas of interpersonal and institutional behavior that have a pervasive influence on the fields but that are functionally invisible and not subject to the critical evaluation they need. We would hypothesize that much of what is currently hidden would come under examination and potential criticism if health care training programs (and health care institutions generally) embraced, as discussed above, the process of open, persistent questioning, as embodied in the touchstones for learning, while also creating and maintaining the requisite spaces for discussion and reflection.

One final, crucially important point. We have, in this chapter, been discussing the challenges of extending health care trainees' existing ethical frameworks to the new setting of health care. This process of learning will fall short, be seriously compromised, or simply fail unless trainees are able to maintain their well-being, mental health, physical health, and sense of self-respect through the process of professional education. To the extent that any of these cannot be largely maintained intact, the process of learning and how any particular trainee approaches, learns from, and integrates experience will be distorted, both short and long term. In this context we draw attention to, and agree with, a 2017 *BMJ Open* article, "Care Under Pressure," by Daniele Carrieri and colleagues.³ One of their central points is that many threats to the mental health of health professionals are institutional in character and that institutional interventions, which would require strong leadership from the top, are therefore required. We expect that training programs and health care institutions that are structured along the lines suggested in this chapter will do much to preserve the mental health of their students and professional personnel.

NOTES

1. In walking on the beach, we recently overheard the following as a father was talking to his two boys, who were vying for control of a toy: "In this family, we share!"
2. Such questions are sometimes incorporated into what has come to be known as *reflective practice* in health care (Carroll 2009; Senediak 2013) and into what is known as *personal practice in therapist skill development* (Bennett-Levy and Finlay-Jones 2018). For more on reflective practice, see Chapter 10. Terminology aside, the specific point we are making here and throughout the book is that such questions are effective means of

identifying and addressing ethical issues in health care—via the informal ethical thinking of health professionals—without any need to invoke formal ethics.

3. This article is discussed in more detail in Chapter 9.

APPENDIX 8.1: A YOUNG DOCTOR'S REFLECTION

Throughout my pediatric residency I had to manage physical exhaustion, unsafe workloads, and burnout, as well as my distress when listening to patients' stories and when caring for very sick children. Having a mentor to talk to really helps, but those relationships were hard to establish in the medical system where I worked. In our first postgraduate year, rotations last only ten weeks. In subsequent years, rotations generally last three months, sometimes six. Between the workload and the pressure to get things done, especially in a short rotation, it's hard for residents to find enough time to form decent relationships with attending physicians ("attendings").

Over time I learned which attendings were safe to talk to and which were not safe. The unsafe ones were those who viewed the issues that I was struggling with as personal weaknesses. These attendings trained us—by their example—not to feel or show emotion, and if we did, they communicated their disappointment and used guilt as a form of control. One time, when working a 12-hour shift covering *half the hospital* (all surgical and subspecialty medical patients in every ward)—after 2½ hours of sleep—I noted that my sleep deprivation made me unsafe to see patients: in one brief exchange I used the words "not safe at work," "burned out," and "beyond my breaking point." The attending's response was a raised eyebrow and a question: "Is your exam stress affecting your work performance?" I felt demeaned and dismissed. After that, I was always very careful in deciding what to say to attendings.

Safe attendings were those who saw these problems at work as ones we all experienced, as problems embedded in the medical system and in the role of being a doctor, and that all doctors—young and old—had to manage. These attendings saw the issues as having an ongoing, adverse impact on the well-being of doctors, and they did not pass judgment. Instead, they created a culture of debriefing and of "checking in" after difficult clinical encounters to see how I and my fellow residents were doing. These small acts went a long way in enabling me (and others) to speak up. They acknowledged the suffering we encountered every day, the horror of child abuse, our repeated close encounters with the deaths

of patients, and the many complicated feelings elicited by such events. It was, I was learning, OK not to be OK. With their questions, the attendings opened up a conversation, allowing me and my fellow trainees to feel the difficult feelings, to accept them, to talk about them when asked. Somehow, the mere asking of the questions made it safer for us. Having a senior doctor acknowledge our humanity was powerful and helped us, the junior doctors, speak out.

I was lucky to find a few mentors and to maintain my relationships with them over time. A good mentor is someone you respect and trust, and who you feel safe talking to about difficult topics. You value their opinion and advice. The hardest conversations are ones where your weaknesses come up. How are you going to be judged? A good mentor somehow takes that worry away. Talking about my wants, needs, and emotional responses—even acknowledging them to myself—was always difficult for me. They made me feel like a failure, a disappointment. But one mentor, in particular, made me see these personal experiences differently. It was such a relief. She wasn't just pushing me onto the treadmill of achievement, or the expected path, or the one she chose. Rather, she helped me to realize that there are many paths in medicine. She normalized my struggles and then challenged me to do what was actually right for me. A great mentor, like her, sees you and treats you like a whole person.

REFERENCES

- Bennett-Levy, J., & Finlay-Jones, A. (2018). The role of personal practice in therapist skill development: A model to guide therapists, educators, supervisors and researchers. *Cognitive Behaviour Therapy*, 47(3), 185–205. <https://doi.org/10.1080/16506073.2018.1434678>.
- Carrieri, D., Briscoe, S., Jackson, M., Mattick, K., Papoutsi, C., Pearson, M., et al. (2018). 'Care under pressure': A realist review of interventions to tackle doctors' mental ill-health and its impacts on the clinical workforce and patient care. *BMJ Open*, 8(2), e021273. <https://doi.org/10.1136/bmjopen-2017-021273>.
- Carroll, M. (2009). From mindless to mindful practice: On learning reflection in supervision. *Psychotherapy in Australia*, 15, 38–49.
- Hirschman, A. O. (1970). *Exit, voice, and loyalty: Responses to decline in firms, organizations, and states*. Cambridge, MA: Harvard University Press.
- Senediak, C. (2013). *A reflective practice model of clinical supervision*. Paper presented at Advances in Clinical Supervision Conference, Sydney, Australia,

- June 4–6. Reprinted in *Advances in clinical supervision: Innovation & practice* (2013). Parramatta: NSW Institute of Psychiatry. <http://www.nswiop.nsw.edu.au/conference/resources/monograph.pdf>.
- Wear, D. (2006). Respect for patients: A case study of the formal and hidden curriculum. In *Professionalism in medicine: Critical perspectives* (pp. 87–101). New York: Springer.
- Williams, D., & Dwyer, P. (2017). *Grace under pressure: Presented by the Seymour Centre for the Big Anxiety Festival*. Strawberry Hills, NSW: Currency Press.

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