FEATURE ESSAY

To Befriend Suffering Strangers

Hospital ethics begins before the dilemma: in how clinicians see, listen to, and remain present to people whose lives have been fractured by illness. Its deepest challenge is not only deciding what to do, but learning how to be with suffering strangers.

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> *"Ethics" involves not just "what to do" about problems but "how to be" with persons.*

What should we do? "Ethics" in the hospital seems to focus primarily on resolving difficult dilemmas in complex cases created by the uncertain benefits of medical technologies. Should we remove mechanical ventilation from a critically ill, unconscious patient whose condition has not improved for weeks, but whose uncertain personal preferences and unfinished "family business" prompt troubled family members to disagree? Should we comply with a protective wife's request not to disclose his terminal prognosis to her already anxious husband, as he prepares for a much anticipated overseas trip to their only daughter's wedding? Should we require the overwhelmed 15-year-old mother of a moderately impaired, premature newborn to calculate risks and benefits, and then to consent to experimentation on her baby? Seasoned clinicians in medicine, nursing and allied health can recall similar case scenarios, each complicated by conflicting ethical obligations.

ABOUT THE AUTHOR

Dr Philippe Foubert served as Hospital Ethicist to the Mater Hospitals Complex and taught moral theology, bioethics, and clinical ethics.

> *"The challenge of hospital ethics is to develop the moral vision and practical skills to befriend the suffering strangers who have fallen into our hands."*

ETHICS AND THE DILEMMA

Inevitably, clinical ethics - a hospital-based practice within the wider field of bioethics - must evaluate such moral quandaries and ambiguous situations. There is plausible realism in this way of framing what "ethics" is about, for clinical staff, patients and family members often do face tough choices trying to balance burdens and benefits in treatment plans. Clinical ethics case consultation can help this search for ethically sound conduct, by fostering moral dialogue and discerning judgment among the diverse company of caregivers gathered at the bedside of a patient.

Moral Imagination

But we should not permit the urgency of resolving ethical conflicts in such cases to pressure us into forgetting a fundamental insight: that "hospital ethics" truly begins as a clinical activity of moral imagination through which we see each patient as a suffering person, a wounded body/spirit whose integrity is threatened by the fragmenting impact of the wreckage that illness or injury have wrought upon personal existence. Suffering is not just physical pain but personal anguish over what patients have already lost or may yet have to surrender of their public, private and secret selves.

True healing is not just technically competent restoration of physical function but therapeutic attention, based on authentic personal presence to the suffering person. The hospital should not be just a "body repair shop" but a "house of hospitality" in our journey through an embodied existence destined for an encounter with decline and death.

The hospital can be a genuine moral community of compassion, rather than a technological crucible in which treatments paradoxically produce even more suffering, only as we rely upon this recognition to discipline our seeing as we "manage our cases".

Moral Strangers, Moral Friends

Historically, "ethics" meant training in the virtues required to live in a manner befitting human destiny: reunion with God. But we live now amid a polytheism of moral perspectives. In the "enclave of the stricken" known as the hospital, clinicians often meet patients and family members as "moral strangers" who do not share a common vision of true human flourishing, which moral friends can use to resolve ethical disagreement in the plan of care. We start from different cultural, religious and professional traditions, as well as from distinctive life histories and inner worlds. Frequently, hospital "ethics" is linked with anxiety and anger as we struggle to reconcile divisions within ourselves and with each other over what we ought to do.

Despite these differences, which amplify the moral distance that disease creates, good clinicians can make moral friends of patients by taking time to listen to the stories patients tell, acknowledging their concerns, explaining their condition in understandable language and providing reassurance. Through their stories, patients create empathic bonds that are the very heart of friendship between themselves and their clinical listeners.

The Patient's Story

As my friend Arthur W. Frank wrote, reflecting on his own experience with cancer and heart attack in The Wounded Storyteller:

But who among clinicians has the patience for stories? And is not friendship rather too lofty an expectation given the necessary confines of our "professional" role? Clinicians already pressured by caseload, conferences and colleagues seldom feel they have sufficient time or space to engage in "deep and meaningful" discourse with patients often too sick to say much anyway.

> *"People suffering serious illness or injury need to tell stories to find a way through their suffering, because illness has destroyed the map they used previously as a guide for living. They need to learn to 'think differently', and they learn by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared. Seriously ill people are wounded not just in body but in voice. They need to become storytellers to recover the voices that illness and its treatment often take away."*

The Artful Use of Clinical Time

Yet the College of Physicians just reaffirmed once more - in the January 1998 Annals of Internal Medicine - that "Dialogue is the core clinical skill" and that "It is time for all clinicians to take the dialogue between patient and physician as seriously as they take prescriptions, tests, and surgery." The reason is that the "artful use of clinical time" creates moral connections between clinicians and patients despite the crush of caseload that so often serves as a convenient excuse to avoid cutting to the heart of the matter: empathic communication improves the quality of patient care.

What patients most want from clinicians, besides competency, is confidence that their suffering is understood. Clinicians who take even a modest measure of time to elicit and to listen to their patients' stories of suffering show the very essence of the form of friendship possible in the hospital. Whatever we must do about dilemmas, "hospital ethics" and clinical practice are finally about the moral awareness and practical skill needed to befriend suffering strangers.

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