PAPER

Sturdy for common things: cultivating moral sensemaking on the front lines of practice

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ABSTRACT

This essay argues that the field of bioethics should concern itself especially with the process of making moral sense that unfolds among clinicians, patients and family members during common but high-stakes conversations occurring on the front lines of practice. The essay outlines the parameters of a bioethics grounded in the moral experience of patients, families and practitioners. It challenges ethicists, educators, and clinician leaders to commit themselves to advocating and developing creative approaches to learning that will cultivate the moral sensibilities of frontline clinicians in this critically important domain of practice.

> we ordinary beings can cling to the earth and love
> where we are, sturdy for common things.
> —William Stafford, "Allegiances"[1]

As a little boy growing up in my family, when I showed any inclination towards thinking I was better than other kids, my mom would caution me not to become too big for my britches. If she were alive today, listening to me describe the world of contemporary healthcare ethics, I think she would say that bioethicists are too often neglecting the common things faced by clinicians—things like treating patients and families the way we might wish to be treated, and helping them sort out complex moral choices when life deals an unexpected blow. I can see her, with furrowed brow, concluding that ethics for regular folks is something healthcare systems are at risk of *forgetting*, and that our first priority should be to *remember* what really matters to patients and families. As I have devoted the majority of my adult life to clinical practice but now spend most of my time as a medical educator focusing on the ethical challenges clinicians face, I imagine Mom might end our conversation with a loving admonition: Don't forget where you come from.

So, motivated by filial responsibility, I argue in this essay for a bioethics that fits its britches, one grounded in the moral experience of clinicians, patients and families and aimed at vesting practitioners with the moral sturdiness necessary for negotiating the 'blooming, buzzing confusion'[2] of everyday ethical challenges. There are a number of theoretical vantage points that can inform such a bioethics—virtue ethics, hermeneutics, discourse ethics, narrative and phenomenological approaches, to name a few. Most importantly, we need to be guided by what Arthur Frank calls an "ethics of experience at the flashpoint, where the stakes are highest."[3] We need a bioethics—and corresponding approaches to learning—grounded in the moral and ethical demands of clinical practice, in workaday conversations among patients, families, and clinicians.

INVITATIONS TO MAKE SENSE

Frontline practice invites clinicians, constantly, to make sense of who they are, what they believe, and what matters to them as human beings. In their everyday conversations, they are challenged to appreciate and decipher what is at stake, morally speaking, in the local moral worlds[4] occupied by patients, families, and clinicians themselves. This need to make sense is especially salient for patients and families when accustomed frameworks of meaning are challenged[5 6] or disrupted: a newly married couple learns that the child they are expecting will grow up with Down syndrome and must 'choose' whether to carry the pregnancy to term; a Shakespearean scholar and long-distance runner receives the 'bad news' that he has been diagnosed with early-onset dementia; a young mother, single and managing with limited resources, must 'decide' whether to withdraw her premature infant, whose brain haemorrhage is steadily worsening, from technology she was led to believe would save her.[7] When such life-altering events are in the offing, and their relationships with clinicians are trustworthy, patients and families turn to practitioners for help making sense of their shaken-up moral worlds. Striving to put their dilemmas into words, they seek to locate, through the talking, a patch of steady moral ground on which to stand. Laurie Zoloth reminds practitioners that they are obligated, at these times, to reach beyond themselves to make contact: "We are not alone; what we say must make common sense—sense in common."[8] Common sense of this kind is never a fait accompli; rather, when it comes about, it is a relational achievement. When conversations lead to sense in common, words discover newly working meanings as they traverse the boundaries between self and others. Indeed, recognising conversations as moral opportunities is implicit in the Latin root of the word, 'conversari,' which means to live in a place or to dwell with.

Daily, clinicians are invited by patients and their families to discuss life choices that range from difficult to morally impossible.[9] To be productive, these exchanges must take place in safe moral spaces[10] where what matters to stakeholders can be respectfully identified, mutually understood, and collaboratively sorted out. In today's increasingly pluralistic world, in which it is unwise to assume that moral positions are universally shared, such spaces comprise 'cultural border zones'[11] in which it is possible to engage meaningfully across lines of difference. Sadly, invitations from patients and families can go unnoticed by practitioners because of a paradox built into clinical education. Clinicians learn in their professional training, necessarily, to approach medical crises as routine events. Helping patients and families make moral sense of their situations, however, means joining them in the *un-routineness* of their experience, always at one particular moment. This requires that clinicians strive to encounter each situation—and each conversation—with fresh eyes, a ready heart, and the visceral appreciation that "no one can possibly know what is about to happen: it is happening each time, for the first time, for the only time."[12]

Routinisation of disaster[13] notwithstanding, good clinicians manage to deal in these ways with patients and families all the time; extraordinary conversations are the stuff of ordinary practice. The problem is not that these conversations do not happen; it is that, in the context of how knowledge is typically organised in healthcare settings, they seem to insufficiently *matter*. Conversations comprise a complex and intricate flow of interactions, data which our prevailing methodologies are ill-suited to recognise. This strikingly important empirical evidence—what clinicians, patients and family members actually *experience* in these moral events—passes by, more often than not, without examination.

This unfortunate pattern of evidence blindness[14] does two things. First, it induces a level of academic incuriosity about the dynamic gestalt of human relationships and interactions in which high-quality healthcare *happens*. Second, it contributes to a dysfunctional state of affairs in which healthcare organisations can outwardly promote patient and family-centeredness while internally maintaining systems that, at best, operate insufficiently informed by human interactions and, at worst, treat them "as if they were a form of waste."[15] In 1927, a revered physician-educator inspired generations of doctors-in-training with the insight that the secret of the patient's care is in caring for the patient.[16] Francis Peabody's assessment is no less true today, but through the lens of reigning epistemologies, it would seem the relational evidence he valued is too often deemed irrelevant. Academic and organisational inattention to how people go about making moral sense in healthcare does more than deprive patients and families. It hurts clinicians as well, because these encounters are what enable their own sense of moral sturdiness and ethical integrity to develop. By repeatedly helping patients and families find moral anchors as they manoeuvre on shifting sands, practitioners gradually discover their own capacity to do the same. This reaching across clinician–patient boundaries, especially when ethical compasses point in different directions, creates the opportunity for what Richard Zaner calls "that critical reach beyond self that alone lifts the person into moral cognizance."[17]

LEARNING FROM CONVERSATIONS

Consider the following scenario. An elderly patient, nearing the end of a full and productive life, whose advanced care planning consists of one set of wishes communicated to his wife, a second to his son, and a third to his daughter. A loving wife who cannot bear the thought of losing her life partner of 50 years. Two adult siblings, one who insists that 'everything' be done, while the other argues it is time to "let Dad go." An attending doctor who is optimistic that a particular new treatment just might help. A cohort of bedside nurses who feel strongly that continued aggressive treatment will only cause more suffering. Each of these stakeholders is striving to make moral sense of their situations; each holds a position grounded in moral integrity.

Many clinicians, when given the chance, are keen to explore the nature and nuance of these kinds of morally charged conversations. For the past ten years, my colleagues and I have created interactive educational programs for implementation in a wide range of adult and paediatric settings,[18–22] in which practitioners are given the time and space to enact and reflect upon these kinds of conversations. Our working assumption when exploring such scenarios is that, by respecting and validating the disparate moral positions held by stakeholders (our own included), clinicians can move from a place of impasse to one in which the burden of decision-making may be shared, and some degree of common moral sense discovered.

There are several key ingredients to our approach to learning. By protecting the vulnerability of participants and providing a safe space in which to take risks, we create an atmosphere of trust, curiosity, and peer support. By employing improvisational actors to act as 'ethical understudies' for patients and families and by enabling practising clinicians to talk to the actors, we achieve fidelity to the world of practice. By encouraging the actors to reveal their moment-to-moment feelings and actions based on their genuine responses to the practitioners with whom they are talking, learners can see more clearly the evidence in front of them and appreciate each conversation as unique rather than routine. By including participants from different disciplines and managing hierarchical dynamics within the group, we increase the likelihood that practitioners with quiet voices will be heard. By bringing to light specific interactions in which a practitioner's compassionate and respectful approach leads to a softening in the seeming rigidity of a family member's moral stance, we rediscover the caring that is at the heart of effective clinical practice. These pedagogical principles are presented in more detail elsewhere.[23–25]

We have found that practitioners frequently emerge from our workshops with a new appreciation of their existing relational knowledge that has probably been incompletely recognised or validated. They are surprised by discovering how much they already know but didn't know they knew. When brought to their attention, underground pools of practice knowledge, previously tacit, become available to them in new ways. Ludwig Wittgenstein describes the unusual nature of this knowledge, and why it is useful to be reminded of it: "Something that we know when no one asks, but no longer know when we are supposed to give an account of it, is something that we need to remind ourselves of."[26] At the same time, in the process of gaining greater *certainty* in practice knowledge, clinicians also learn how and when to sit with being *un*certain. As scientist and Nobel Laureate Richard Feynman notes, "If you know that you are unsure, you have a chance to improve the situation."[27] We have found that knowing needs to operate in tandem with not-knowing[28] in these conversations, because without this balance, practitioners will create insufficient room for patients and families to establish their own moral footing, as they prepare to live with choices they never imagined having to make.

In our educational work with doctors, nurses, and other members of the healthcare team, we have strived to design learning interventions that are faithful to and respectful of frontline practice. We try to heed the advice of Karl Weick, an organisational scholar who has spent his career studying how people make sense of practice in healthcare and other high-reliability organisations:

> Whatever vocabulary you choose, listen to the people who keep showing up every day. Remember that their engaged world feels different than your detached rendering of that world. Never fall into the trap of feeling that you know better than they do, what they are really up to. That's the sin of hubris. And when you commit it, we all sound like fools.[29]

Practitioners deserve educational interventions shaped as carefully as possible by the clinical worlds they actually inhabit, rather than detached renderings of that world. They deserve safe and creative opportunities to learn about practice from the inside out, with appreciation for the unique and unpredictable ways in which people make moral sense together.

WHAT IS BEING ASKED?

The domain of clinical practice in which clinicians strive to make moral sense in collaboration with our patients and their families is a demanding one. This realm of practice asks, first, that practitioners convey to patients and families—by means of their presence, words, and actions—that they inhabit the same moral universe, even on those occasions when there are different points of view. Second, it asks that they re-access sensibilities they may have forgotten—things like being comfortable with uncertainty, being open to the never-before-encountered, being mindful of experiential evidence one has been taught not to notice, and being willing to share in the shouldering of moral burdens.[30] Third, it asks that clinicians better understand how authority gradients operate, so they can mitigate the silencing effects of hierarchy on those who choose deference as a safer strategy than speaking up. Fourth, it asks practitioners to keep on their front burners the awareness that, in this complex medical world we have created, anyone—clinician, patient or family member—might tomorrow be faced with ethical choices none of us should have to make.

In closing, what specifically should be expected from those of us who are invested in supporting frontline clinicians in this essential domain of practice? Borrowing the words of Robert Frost, "It asks a little of us here/It asks of us a certain height."[31] Ethicists, educators, and clinical leaders who care about these matters must hold themselves accountable for designing innovative and respectful learning interventions aimed at improving the competence of clinicians in making moral sense with patients and families. To accomplish this, a more comprehensive and illuminating spotlight must be aimed at the complex challenges of frontline practice, because that is where the most pressing ethical questions—if not the most exotic ones—will continue to present themselves in the decades to come. With our clinical and educational priorities straight, we can go forward, collectively generating the wisdom and resilience we need to enter these conversations grounded, attentive, and sturdy for common things.

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