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Empathy as Sacred Ethic: A Chaplain's Perspective on Difficult End of Life Cases

Peter L. Bauck
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EMPATHY AS SACRED ETHIC:
A CHAPLAIN’S PERSPECTIVE ON DIFFICULT END OF LIFE CASES

By
PETER L. BAUCK

A Thesis Submitted to the Faculty of
Luther Seminary
In Partial Fulfillment of
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ABSTRACT

*Empathy as Sacred Ethic: A Chaplain’s Perspective on Difficult End of Life Cases*

By

Rev. Peter L. Bauck

Because of our increasingly intercultural world, it can be difficult for patients, families, and medical teams to decide on what they should do for patients who are, in the medical team’s opinion, near the end of life. The family and medical team can hold disparate beliefs and values around what they should do for the patient. Ethics committees often get involved in these difficult end of life cases. These cases are also emotionally charged, especially for the family as they wrestle with the intensity of their loved one’s situation and try to decide what to do. Because of the emotional intensity and the potential for dissimilar beliefs, I argue the medical team must empathize with the family. Current models of making end of life decisions do not stress the importance of empathy, especially in emotionally charged difficult end of life cases.

To address this lack of empathy, I develop normative guidelines to help medical teams practice empathy. As a practice, empathy helps the medical team practice neighbor love. Neighbor love is a way to love the family as they want to be loved—a holistic love that coalesces around the experience of the family and sees them as worthy of respect. Empathy may also help these cases reach a resolution that ends with a plan of care in place as well as mutual respect and love between the family and medical team.
ACKNOWLEDGMENTS

Most importantly, I dedicate this to my loving, patient, and caring wife, Kristin Bauck. She has been a constant source of support during the evenings and weekends spent writing and reading. I also want to thank my family and friends. Without my community of saints, I could not have finished my degree. They keep me going and give me hope. My advisor, Rev. Dr. Jessicah Duckworth, has helped shape me as a scholar, and I am forever indebted to her selfless time and attention. Lastly, I want to thank all of my faculty mentors for their role in my scholarly pursuits: Cristina Traina, Carla Dahl, Theresa Latini, Gary Simpson, and Amy Marga.
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<td>IPMR</td>
<td>Intercultural Practical Moral Reasoning</td>
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<td>EOL</td>
<td>End of Life</td>
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<td>CT</td>
<td>Computed Tomography</td>
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<td>ICP</td>
<td>Intracranial Pressure</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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PART ONE

SETTING THE STAGE
CHAPTER ONE
INTRODUCTION

Scope of the Project

I want to provide a rich definition of and guidelines for practicing empathy from the perspective of a chaplain. More specifically, I will address the importance of practicing empathy in patient cases where the medical team and family\(^1\) hold disparate views on whether to pursue a cure through more aggressive treatment or shift the focus to palliation and comfort care as the patient goes through the dying process. I will refer to these situations as “difficult end of life (EOL) ethics situations” throughout the dissertation. On the one hand, from the perspective of the medical team, these are EOL situations, and on the other hand, the family may not view their loved one as an “EOL patient.” Practicing empathy is important in these situations for two reasons. One, in our contemporary diverse cultural context, people encounter other people who do not pursue the same goods or share the same worldview on what is Good. Two, emotions impact how people make moral claims. The practice of empathy in these situations can cultivate neighbor love by connecting the medical team to the emotions and values of a family that

\(^1\) At the outset, it is important for the reader to know that surrogate or health care agent are also terms used for the person involved in making medical decisions for the patient when the patient cannot make his/her own decisions. I will use the term “family” through the work because my composite case in chapter four deals with family making decisions for their father. Surrogates can be a variety of people: family, friends, guardian, or a person who knows the patient well. Different states and healthcare systems have different laws and policies around surrogates and medical decisions. I can only speak from my experience in Minneapolis and St. Paul, Minnesota.
holds to a different worldview, and help the family and medical team in the decision making process.

At the outset, I must state this is not a healthcare ethic, per se, but an exploration of the role of empathy as it applies to a specific type of situation that takes place in hospitals. There are many great volumes on health care ethics, theories of biomedical ethics,\textsuperscript{2} and theology and healthcare ethics,\textsuperscript{3} and my goal is not to provide a comprehensive theory of biomedical ethics or healthcare ethics. Though my interpretive moves draw on a wide range of theories, some of which make comprehensive and universal claims related to ethics, for my purposes these interpretive moves are aimed at difficult EOL situations. What follows will be the most useful to those interested in clinical ethics—the ethics decisions that happen at the bedside, in family care conferences, and in ethics committee meetings.

I also intend to write a Christian theological justification for the practice of empathy in EOL situations involving diverse staff, family, and patients. As a Christian theologian, ordained minister in the Evangelical Lutheran Church in America, and chaplain, I interpret empathy through the lens of Christian theology. As such, there are certain assumptions about the world to which I adhere. This does not mean, however, that Christians are the only people who can practice empathy, understand the power of empathy, or interpret it. From my own unique vantage point, my ultimate goal is to shed

\textsuperscript{2} Tom Beauchamp and James Childress, \textit{Principles of Biomedical Ethics}, 7th edition (New York, NY: Oxford University Press, 2012). This is one of the most popular textbooks to use in biomedical ethics courses.

light on the power of empathy in end of life discussions for those who practice and are interested in clinical ethics. For me, the discourse and language adequate to the challenge and depth of such a task is Christian theology. Many people can interpret empathy and argue for its importance without bringing theology into the discussion, but something sacred occurs when empathy is present with which people of a variety of spiritual traditions could resonate and agree. In the same way that a variety of religious, spiritual, and humanistic traditions have versions of the Golden Rule, I think many people would agree on the power and necessity of empathy in difficult EOL situations.

The first three chapters are background and lay the groundwork for chapters four through seven. But chapters four through seven unfold in such a way that reflects my own journey in understanding empathy as a chaplain. There are three phases of my journey. First, my journey as a chaplain began in my post-graduate chaplaincy training in 2007-2008. It is there I became fascinated with end of life ethics cases and the practice of empathizing with patients, families, and staff. An end of life case study in chapter four represents this part of the journey—my initial experience of chaplaincy and empathy. Second, continuing on my journey, I began to reflect on and explore empathy when I began working as a staff chaplain in the fall of 2009 and when I started Luther Seminary’s Ph.D. program in the fall of 2010. After more exploration and reflection, I eventually arrived at a definition of empathy. Chapters five and six represent this part of the journey—interpreting empathy and arriving at a definition of empathy. Third, my journey with empathy is now more developed. After my initial experiences and thorough explorations, I am in a place where I have matured in my profession. I have developed a strong professional identity as a chaplain and feel comfortable making claims about
empathy’s importance. Chapter seven represents this part of my journey—making normative claims about empathic clinical practice in hospitals. We will now move into the first three chapters that lay the groundwork for my empathy journey.

**Contemporary Landscape**

Because of the changes in the global spiritual and communal landscape, there is increasing interaction with different worldviews within the same community (city, town, and institutions)—worldviews that could differ fundamentally in every way. Some have referred to this as late modernity or postmodernity. Ethical disagreements in communities are not new phenomena—as if in the modern period when communities were *more* culturally homogeneous everyone somehow agreed with everyone else. Cultures have never been completely bounded and demarcated units that were homogeneous in their praxis and belief. There has been and is a blurring of boundaries and cross-fertilization between cultures, as well as pluriformity and fluidity within cultures. The contemporary non-homogeneity is different because of the extent to which cultures from different parts of the globe interact with each other.

In *Cosmopolitanism: Ethics in a World of Strangers*, Kwame Appiah provides a philosophical and social description of the contemporary diverse context. Though I do

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4 Like Kathryn Tanner in *Theories of Culture*, I adhere to a more fluid and flexible understanding of culture. She terms this “postmodern,” but I find myself resonating more with the term late modernity, as Anthony Giddens describes it in *Modernity and Self Identity*. Modernism understood cultures as more internally holistic/complete. Wholeness results in shared values/beliefs, and cultural elements are systematically integrated. Post-modernism, per Tanner, understands culture to be much more fluid. I say I adhere to a late modern understanding of culture, because in practice and day-to-day life people see themselves into distinct cultures and draw strength form this. See Kathryn Tanner, *Theories of Culture: A New Agenda for Theology* (Minneapolis, MN: Fortress Press, 1997) and Anthony Giddens, *Modernity and Self Identity: Self and Society in the Late Modern Age* (Stanford, CA: Stanford University Press, 1991), 10-35.

not agree with his pragmatism, his description of the contemporary intercultural reality resonates with my experience as a hospital chaplain and a member of the ethics committees at urban hospitals. Theologians who focus their work on social realities and relationships have also been paying attention to and writing about the contemporary cultural diversity. For example, Emmanuel Larney’s pastoral theology acknowledges the tensions of doing theology in an intercultural (his word for the diversity) and global context: “pastoral theology is currently engaged within a global context…and pastoral theologians are convinced that truth and goodness lie in the tensions between opposing positions.” In the “tensions between opposing positions,” loving your neighbor is important.

Hospitals, as sites in which the contemporary cultural non-homogeneity is expressed, will continue to become more intercultural, and medical teams will continue to encounter dissimilar worldviews when addressing the question “What should we do in this situation?” This is not to say all ethical disagreements are between people from different parts of the globe. Intercultural disagreements can be between varieties of people, people otherwise assumed to be “like each other.” If we accept Appiah’s argument and my assessment, then the medical team will continue to encounter ethical strangers in the hospital and have to figure out what should be done. When ethical

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7 “What should we do in this situation?” is not the only moral question that arises when communities face a decision or challenge. One could also ask, “what ought to be the case?” or “who should I/we be?” My question solves problems and leads to different problems when compared with the other moral questions.
worldviews potentially differ to a large degree, answering that question and embodying neighbor love is far from simple.

How does this relate to the work of the medical team at the end of life? Part of Appiah’s argument and solution is that necessity takes over, that is to say, communities may not agree with each other completely, but they get used to each other through interchange and eventually have to decide on doing something. In my interpretation, and pushing back against “necessity,” decisions are reached through practical moral reasoning. Neither is moral reasoning driven solely by pragmatic necessity, nor is the reasoning the detached theological or philosophical equal regard of Gene Outka or John Rawls, respectively. Hospitals, as an example of Appiah’s diverse communities, might be driven by pragmatic necessity when figuring out how to care for patients, but questions and answers about what should be done in a particular case are connected to people’s deeply held values and have an significant impact on the shared life of the hospital community. More specifically, moral reasoning that occurs within end of life cases is a visceral and embodied process of figuring out what people should do in a situation. My stress on the visceral and embodied nature of reasoning comes from Francis Hutcheson, and other sentimentalist philosophers, who stressed that the basis of our ethics is benevolence and emotion. Here we see a more affective and interpersonal interpretation of ethics when compared to the paradigms of Rawls, Outka, and Appiah.

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8 Appiah, Cosmopolitanism, 78.

9 John Rawls, A Theory of Justice, revised edition (Cambridge, MA: Belknap Press, 1999); Gene Outka, Agape: An Ethical Analysis (New Haven, CT: Yale University Press, 1977). In terms of the former, I am focusing on the way he constructs the “original position.” While the original position requires that one consider others as one constructs a just society, one is not in relationship with said others in the original position. One is alone behind a veil unable to be in relationship. Empathy is part of the dialogue of care that takes place in relationship and cannot take place when someone is isolated.
The sentiments, and the accompanying interpersonal interactions, when considered alongside a more principled or pragmatic process of moral reasoning add a level of depth. From my perspective as a chaplain there is a particular sentimental approach that can aid the healthcare team when they face divergent worldviews in difficult EOL ethics cases: empathy.  

Some may gravitate to sympathy. I do not find sympathy helpful in difficult end of life situations. There is also a great deal of confusion around the difference between sympathy and empathy. I will briefly define how I understand the difference and why sympathy is not helpful in EOL situations. My definition of empathy will come in chapter six, but for now I will make a few brief claims here. Both empathy and sympathy have to do with experiencing the feelings and thoughts of others, but the difference lies in what we do with those thoughts and feelings. Sympathy literally means, “with-feel.” The prefix “sym” comes from the ancient Greek “syn/sym” that means “with.” Sympathy, therefore, focuses more on the feelings within oneself that the other’s pain stimulated or triggered. Karsten Stuber says it in the following way:

Rather, sympathy is seen as an emotion sui generis that has the other's negative emotion or situation as its object from the perspective of somebody who cares for the other person's well being (Darwall 1998). In this sense, sympathy consists of “feeling sorrow or concern for the distressed or needy other,” a feeling for the other out of a “heightened awareness of the suffering of another person as

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10 Other theologians have made an argument for empathy. My claim that empathy can play a role in bridging diversity is not a new claim. See H. Edward Everding and Lucinda A. Huffaker, “Educating Adults for Empathy: Implications of Cognitive Role-Taking and Identity Formation,” Religious Education 93, no. 4 (1998): 413-430. Cathryn Cornille notes the importance of empathy in interreligious dialogue. In the context of people who do not share the same beliefs, empathy can transpose the experience of another onto the self and one can potentially use analogous experiences from one’s own history to understand another. See Cathryn Cornille, “Empathy and Inter-religious Imagination,” Religion and the Arts 12 (2008): 102-117.
something that needs to be alleviated. (Eisenberg 2000a, 678; Wispe 1986, 318; and Wispe 1991).\(^{11}\)

This is where sympathy’s weakness lies. It might sound well and good to feel someone’s feelings along with them—especially in emotionally charged EOL situations—but the lines between the self and the other can get blurred and one’s own feelings cloud the feelings of the other. The other’s feelings and experience become our experience instead of standing alone as the other’s experience. One might care for the distressed person and want to alleviate suffering, but that desire is caused by the feelings triggered within oneself not the distressed person’s feelings or experience. Empathy, in contrast, literally means “in-feeling.” This might sound more intrusive and clouding than sympathy, but empathy attempts to set one’s own feelings and thoughts aside and “feel into” the experience of another so that experience can stand on its own. In order for one’s happiness or sadness to be empathic, it has to be happiness or sadness about what makes the other person sad or happy; one’s own happiness or sadness about the other’s emotional state is not empathic. I will say more later, but for now note that when we empathize, we are present with and walk alongside others so as to understand their particular situation separate from our own feelings. Let us return to the importance of empathy.

Interpersonal human interaction in its variegated forms happens each day. These interactions are saturated with conscious and less conscious sentiments and affections. Smiles, hand holding, greetings, hugs, tears, anger, hate, laughter, listening, and desires are all part of the conscious and less conscious matrix of human interaction in the hospital. Further, empathy is an important element in these human interactions as people try to relate to and care for each other. When someone is in distress, one might approach that person to try to provide comfort; when someone is overjoyed about a meaningful experience, one might approach him or her to share in and understand his or her joy. The connection in the painful and joyous experiences occurs through empathy. I will argue that understanding another’s mental state and sharing in an emotional state through empathy is one of the ways in which connections between people are formed in difficult EOL situations.

From my perspective as a chaplain, this is how neighbor love is cultivated. More principled and pragmatic approaches to difficult ethical issues are important, but without the interpersonal, affective, and empathetic, they lack an important element of the human experience and what it means to be created in God’s image.

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12 It is not my intention to ignore the line of thinking connected with Thomas Hobbes: people are naturally selfish and the laws and social customs are only a veneer overlaid this immoral core. Though not completely convincing, Hobbes and others touch on an important part of human nature. I do not agree with Hobbes and would argue that compassion is innate. For examples of this discussion in psychology see Susan Dwyer, “How Not to Argue Morality Isn’t Innate: Comments on Prinz,” *The Evolution of Morality: Adaptations and Innateness*, vol. 1 of *Moral Psychology*, ed. Walter Sinnott-Armstrong (Cambridge, MA: MIT Press, 2008), 418. Jesse Prinz had argued in a previous essay in the same volume that morality is something learned either a general purpose conditioning mechanism or a new learning for a system that evolved for other purposes. Susan Dwyer argues humans have a moral faculty in the brain, or a general faculty/module that develops the capability to morally think.

13 This line of thinking is supported by research. See Alan Sroufe, “Attachment and development: A prospective, longitudinal study from birth to adulthood,” *Attachment and Human Development* 7, no. 4 (2005): 349-367. The results of this study were also published in book form but this article is a good summary of the book.
Communities of God’s people across historical contexts are built on the connections between people. When the question, “What should we do in this situation?” arises and there is disagreement in ethical worldviews, empathy can cultivate neighbor love within the medical team and help the family and medical team decide on a plan of care with a sense of mutual respect and love for each other.

In chapter four, I will provide a concrete example of an ethical disagreement that frequently arose at the end of life in my work with families in hospitals as a chaplain and on the ethics committees. The case will focus on a disagreement between the medical team and family. The family’s beliefs and values will differ from the medical team’s, which will serve to illuminate one example of the “ethical strangers” to which Appiah refers. These disagreements were often over definitions of what it meant to be alive, what type of end of life care was right or wrong, and how much or little medical care was warranted before the suffering was considered too great. There was also a dynamic of distress in these situations. The patient and family were in physical and emotional pain, the medical team came to the family and cared for them, and the medical team tried to understand what the family was experiencing.\(^{14}\) The role of the chaplain in these situations, as I have practiced it, is to tease out the values and beliefs of all involved—tease out by listening with empathy, patience, and compassion. I will come back to these ideas and struggles in chapter four when I focus on a case study. For now, I will move forward to look at my proposal for a solution to these ethical divides that medical teams

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\(^{14}\) Power and hierarchy are important dynamics when talking about empathy. The context in which empathy occurs is rarely one of parties meeting each other on equal terms: caregivers reach out to those for whom they care, someone in distress receives help from another, or many other situations. Empathy is in response to a need or distress in another person, and it is in the hands of the people responding to the distress out of care and concern to empathize with those in distress.
and ethics committees encounter. I hope, along with Larney, that goodness lies in the
tensions between opposing positions.

**Empathy and Moral Reasoning**

Given the strong emotional responses involved in the EOL reasoning process, I
will argue that empathy is a practice that can help cultivate neighbor love in EOL cases.
Though there are many different possible angles one could take when addressing the
EOL moral reasoning process in the current cultural context, I will focus on empathy.
There are many definitions of empathy. The following definition will grow out of
chapters four through six of the dissertation, but I want the reader to have a flavor for
where my argument is headed.

Empathy is a practice that develops out of the developmental antecedents in early
childhood experiences with the caregiver as a result of the dialogue of care with
one’s caregivers and feeling felt. In adults, this results in the ability to understand
the mental and emotional states of others and a desire to respond to their distress
with acts of care, in which we can think of God as present calling us to love the
neighbor as they want to be loved.

I will not go into the myriad of possible definitions. Beyond my focus on
hospitals and EOL situations, empathy is far from a narrow area of study in academic and
public life. Within the disciplines of philosophy and psychology (and its various sub-
disciplines), for example, there is extensive research going on related to empathy,
compassion, and altruism: counseling psychologists and counseling pastors discuss
empathy in the therapeutic encounter,¹⁵ University of Chicago’s Center for Cognitive and

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¹⁵ Helen Reiss, “Biomarkers in the Psychotherapeutic Relationship: The Role of Physiology,
Neurobiology, and Biological Correlates of E.M.P.A.T.H.Y.,” *Harvard Review of Psychiatry* 19, no. 3
(2011): 162-174; and Leonard Hummel, “Heinz Kohut and Empathy: A Perspective from a Theology of the
Social Neuroscience is doing research on moral neuroscience,16 Stanford University has a Center for Compassion and Altruism,17 University of Minnesota’s Extension Center for Youth Development researches the role of social and emotional learning in the lives of youth,18 political philosophers discuss the role of empathy in public deliberation,19 and philosophers take on the relationship between empathy and the ethics of care.20

Beyond the research centers, the overall sense is that the presence of empathy within dialogue about social injustices and difficult communal decisions will help when there is an impasse (e.g., in the United States the racial injustice highlighted by the shooting and death of Michael Brown).21 In terms of communal life, empathy will aid in understanding the experience of another person and/or community, thus allowing one to understand the particular issue at hand from their perspective. Taking the perspective of others creates shifts in ethical frameworks as the others’ frame is incorporated into a community’s existing framework.

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Stating that empathy and emotions play a role in communal life and EOL situations hinges on the fact we can argue emotions play a role in making moral claims. I argue that, yes, emotions are part of the building blocks of a particular community’s worldview and are how a community’s morals are constructed. Emotions lead to moral claims through physiological and cognitive processes. Combing the theories of Daniel Siegel, a psychiatrist, and Jesse Prinz, a philosopher, we can see how emotions lead to moral claims.\(^{22}\) Emotions are the bodily reactions and energies that are not yet categorized into a sentiment; they are vague and based in a physiological sense awareness that something is stirring and we need to be on alert. These stirrings are then further refined into a sentiment. Simply put, sentiments can be negative and we have a feeling of disapproval towards the object or experience, or they can be positive and we will have a feeling of approval. Sentiments of approval or disapproval are further categorized into a judgment about the stimulus or object. The judgment pertains to whether something is right or wrong. Therefore, to think something is right or wrong is to have a sentiment of approval or disapproval based in the bodily energies and dynamics, which lead to making moral claims. In this sense, emotions are our basic experience that are further refined into our convictions, values, and beliefs; any communication about the latter during EOL discussions in hospitals needs to be carried out with empathy for the former.

Empathy allows the understanding of the emotional world of others, especially as

it is connected to the ethical problem under consideration in EOL ethics consults.23 Growing out of their emotions, the family and medical team have developed a belief about what is right and wrong in a particular case. These cases are saturated with anger, sadness, grief, guilt, and compassion combined with different moral frameworks about health and end of life. As I already stated, the emotions are connected to the moral claims of the family. Having empathy for the distressed family, in particular, will aid the medical team in understanding how the stirrings, sentiments, and judgments lead to moral claims about what care plan is right or wrong for their loved one. Following the line of thinking related to other public issues, the presence of empathy in these situations could create an understanding of moral frameworks and the visceral pains and hopes of others. However, I want to push this a little further and dig a little deeper.

I would like to add a theological perspective to the philosophical and psychological views explored so far. Empathy is a sacred ethic. I will argue that empathy is part of the visceral moral reasoning process calling the medical team to love the neighbor. We can think of this call to love and empathize with the neighbor as the presence of God. In the specific situations under consideration here, the team should strive to empathize with the family in order to embody God’s love in the form of honoring the neighbor’s (i.e., patient and family) dignity as persons with values, relationships, and meaning. My push for empathy stems from the dual love commands in Mark 12:30-31:

And thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind, and with all thy strength: this is the first commandment. And

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the second is like, namely this, *Thou shalt love thy neighbor as thyself*. There is none other commandment greater than these.\(^{24}\)

It is from the commandment to love thy neighbor where my push for empathy in EOL ethics consults comes. Loving the neighbor as thyself—an ethic of neighbor love—arises out of the interpersonal encounters within the muck and mire of life.

Loving another as “thyself” is only part of the solution in situations at the EOL in hospitals, however. Seeing, hearing, and responding to another through one’s own lens and needs would not be loving the neighbor as they need to be loved. Like my critique of sympathy, the Other can be eclipsed by how one would want oneself to be loved. Seeing oneself in another and loving the other as one would want to be loved is a humanizing first step, but it is empathy that moves one to love another as they want to be loved. Loving the neighbor in this way does not mean acting, giving, and relating to the neighbor exactly as they want and doing everything they desire. What I mean by “loving the neighbor as they want to be loved” is a way of being in relationship that does not eclipse the thoughts and feelings of the neighbor—present with and walking alongside others so as to understand their particular situation. Loving the neighbor as they want to be loved is a love that coalesces around the experience of the neighbor; it sees the neighbor as a unique being worthy of respect, of being honored, and loved holistically.

How does one cultivate neighbor love to love the Other as they want to be loved?

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\(^{24}\) Text quoted is from the King James Version (italics mine). One of my frustrations with practical theologies is the lack of attention to a thorough exegesis of the biblical texts quoted within their theories, particularly the broader historical context in which the texts took shape. In the same breath that I mention this frustration, I regret I will not be able to provide an in-depth exegesis of this text. Adela Yarbro Collins, for example, extensively explores the textual and philosophical history of these verses drawing on the LXX, Qumran texts, Hebrew Bible, Greek philosophy, and the Hellenistic Jewish philosopher Philo of Alexandria (d. 45-50 C.E.). She demonstrates how first century Jewish interpretations of the law (i.e., Mark 12:30-31) were indebted to Greco-Roman paradigms of virtue ethics. See Adela Yarbro Collins, *Mark* (Minneapolis, MN: Fortress Press, 2007), 566-575. Her historical interpretation is one among many others.
in the midst of diverse ethical worldviews when trying to answer questions of what should be done at the EOL? Though there are many ways in which neighbor love can be cultivated, empathy is a critical component. *Cultivating empathy in difficult EOL cases fosters neighbor love. Not only does empathy foster neighbor love, but also it is required at the end of life from the medical team and nurtures a love that coalesces around the thoughts, feelings, relationships, and beliefs of the family.* Cultivating empathy, in my interpretation, occurs in a specific way. *Empathy occurs in the dialogue of care between and within the staff, families, and patients at the hospital, in which we can think of God as present, moving the medical team to love the family as they want to be loved in the midst of diverse ethical worldviews.* In thinking of God as present, I am referring to the possibility that our quest to practice empathy and love is not totally of our own volition: “And the harmonious working of all these factors is guaranteed solely by the fact that in all of them God himself, the origin and goal of our destiny to communion with him, is influencing us.”

The divine created intention is not solely within humans or solely external to humans. God is connected to us and we are connected to God, the practice of empathy and neighbor love is a goal with which humans and God are involved. As humans, we are grounded in God and touched by grace. I will unpack these claims and

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25 Does mutual understanding through empathy lead to neighbor love or is neighbor loved already required before one can empathize? In my interpretation it is the former, but there are good reasons to support the latter claim as well. One might be part of a family or community that adheres to neighbor love as their primary value. In this way, neighbor love as a cultural value could drive the empathic process. Further, with empathy moving people to love the other as they want to be loved, there are moments where critical reflection is required. Just as there are dangers with loving the neighbor as *themselves*, there are dangers with loving the neighbor as *they want to be loved*. The self-centeredness merely gets shifted to the other in that we now assume they ways the other wants to be loved are always fruitful.


27 Ibid., 60.
Looking Ahead

What follows will be an interdisciplinary analysis of empathy grounded in a composite case study that highlights my thesis above. The analysis and case study will assist in arriving at greater clarity of my interpretation of empathy and how it helps difficult EOL cases come to a resolution. Further, I will use a version of Don Browning’s fundamental practical theology as an interpretive framework. Browning’s fundamental practical theology follows a particular pattern that helps religious communities decide how they should reshape their current practices when faced with the question: what should we do in this particular case? Browning stresses that the life of a community and its practices are what drive any detached theoretical reflection and analysis of what is happening in a community, and the aim is always to reshape practice. He argues for this practice-theory-practice pattern in contradistinction to models and patterns that begin with detached theory and apply that theory to change practice. An example of the latter involving empathy would be a hospital ethics committee that reads the latest psychological interpretation of empathy and simply pulls this theory into their ethics consult practices without first looking at their specific context as a healthcare community, a healthcare community in a specific setting with a specific patient population.

28 In answering these questions, one could take many different approaches. For example, it is important to note a crucial aspect of neighbor love that my interdisciplinary exploration of empathy leaves out. Neighbor love is much more than empathy and requires public advocacy that focuses on transforming the structural and social injustices that plague society. Empathy, as I said, is necessary for neighbor love but is only a first step in achieving a more complete theological response to the command of love thy neighbor as thyself.

29 Don Browning, A Fundamental Practical Theology: Descriptive and Strategic Proposals (Minneapolis, MN: Augsburg Fortress, 1996).
Because of his practice-theory-practice approach, Browning’s interpretive paradigm is useful for clinical ethics in a hospital setting. We will look at a case study and how it unfolds (practice), reflect on empathy and the case study through three paradigms (theory), and then I will suggest normative guidelines to help hospitals practice empathy at the EOL (practice). I will use select current research to do the interpretive work of empathy and the case study: the philosophy of Martha Nussbaum, the psychology of Martin Hoffman, and the theology of Wolfhart Pannenberg. Hoffman and Pannenberg will illuminate how empathy can expand one’s circle of understanding and love the neighbor as they want to be loved; all three of the thinkers will deepen how care and empathy happen between and within people and communities; and Pannenberg’s anthropology will elucidate how a theology of God’s presence within the caregivers and their care deepens our understanding of empathy. What will arise out of the interdisciplinary exploration of empathy and the case study is a definition of empathy and normative guidelines for those involved with clinical ethics. Guidelines require the specifics of a particular context to be of any use, so I leave it to particular contexts to work out how these guidelines will live within their community. I will, however, provide some suggestions for how hospitals can bring them to life.

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30 One may wonder why I am offering guidelines for hospitals and ethics committees when I disagreed with principle based and detached rationalistic paradigms of practical reasoning. One may not be wondering this, but I think it is appropriate to respond in some way. In many ways, the question of principles and ideologies or affective experience becomes a “chicken or the egg” question. For example, one might ask me why I think empathy is a desirable quality to cultivate, and why “loving the neighbor as s/he wants to be loved” is a valid goal for communities. Focusing on cultivating empathy is a normative move and based on the dual commandment in Mark 12:30-31. To this argument, I would say one has made a good point. If there is a principle within my line of reasoning, then it is as follows: empathy should be cultivated in communities. I cannot deny this. However, my guidelines are flexible and will have come out of a composite case study based on years of experience in hospitals. Normative guidelines are not the same as universal principles. Saying that empathy ought to be cultivated in communities is not to make a declaration about every time and place empathy occurs. Further, empathy itself is a fluid and flexible interpersonal dynamic and does not demand specific behavior.
The composite case arises out of my work in hospitals, which has provided me with multiple situations of ethical disagreement between the medical team and the family at the end of life. Chaplains are involved in EOL cases for many reasons beyond the general therapeutic listening I mentioned earlier. When a patient’s clinical picture declines, chaplains will often visit the patient and family again or make an initial visit. This decline often causes more distress in the family and they might need more emotional support and to draw on their spirituality to help them cope. Chaplains, officially inter-faith chaplains, are trained to provide emotional and spiritual support to patients and families of all belief systems. Briefly, spirituality refers to values, beliefs, and the ways people make meaning and find hope in their lives. Chaplains attempt to help people draw on their spirituality while going through a health crisis. The family can always refuse this support. Specifically related to difficult ethics cases and EOL, chaplains are often the staff members that provide grief support to the family; EOL cases are usually accompanied by distraught family members and sometimes distressed staff, so chaplains provide emotional support to both staff and family; and chaplains are often members of the hospital ethics committee because of their training in listening to and discerning the values and beliefs of a family.

My composite case explores a patient who had an anoxic brain injury and remained in critical condition in the ICU for the duration of the hospital stay. He was in a minimally conscious state with occasional seizures. He was unable to communicate or care for himself, and he would never be able to indicate he knew who he was or whom he was with, according to the medical team. The family decided to have a tracheostomy and feeding tube and had him cared for in a nursing home. The medical team completely
disagreed with this decision. The patient ended up going to a nursing home in a
minimally conscious state (unable to verbalize, unable to acknowledge the presence of
others), fully dependent on staff for cares. Cases such as these are often stressful for the
family and the medical staff because of the tension around the dissimilar ethical
worldviews. Both the family and the medical staff care deeply about the patient and are
concerned with his or her well-being. When there are ethical disagreements at the EOL,
hospital ethics committees are consulted in hopes of resolving the disagreement—not to
issue a verdict on what the plan of care will be for the patient but to facilitate a discussion
between the family and medical team.

Ethics committees and the medical team will often use a particular method to
help resolve the disagreement. One of the most popular methods today comes from the
book *Clinical Ethics* by Albert Jonsen, Mark Siegler, and William Winslade.31 Both the
Minnesota Center for Healthcare Ethics and Mayo Clinic’s ethics committee in
Rochester, MN, use the method outlined in the book to help resolve ethical conflicts.32
The pragmatic and thorough approach of the authors is attractive for those in clinical
ethics. The authors propose four topics that need to be clarified in reference to the patient
in order to make a decision in clinical medicine: medical indicators, patient preferences,
quality of life, and any contextual features that impact the decision. I don’t take issue

31 Albert Jonsen et al., *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical

32 I spoke with a member of Mayo Clinic in Rochester, MN about the ethics committee and this
person confirmed the use of the *Clinical Ethics* book. The Minnesota Center for Healthcare Ethics is a
center sponsored by Fairview Health Services, HealthEast Care System, and Sisters of Saint Joseph of
Carondolet. The center provides ethics education and consultation services to the clinical sites of all three
of its sponsors. In the past, the center has done work with the Minnesota Department of Health and
University of Minnesota around ventilator distribution in a pandemic, and published work on various issues
in healthcare.
with these four topics, per se, but the approach in Clinical Ethics, along with other approaches,\textsuperscript{33} lack an appropriate acknowledgment of the visceral and emotional decision making process of the family. The pragmatic and in-depth approach of the authors is very helpful in resolving ethical disagreements. Nonetheless, their needs to be a fifth topic in my interpretation; they need a topic about empathy, or at least a more significant acknowledgment of its role in making EOL decisions when there is ethical disagreement between medical team and family.\textsuperscript{34} The absence of empathy in this clinical ethics paradigm is not because end of life deliberations lack affect or love-of-neighbor from the medical staff, but the decision making process is often employed by the medical staff from the perspective of loving the neighbor (in this case, the family and patient) as thyself (the medical staff’s opinion). What about the experience of the family? The family and patient are the ones in more distress in this situation. The distress the medical team feels caring for the patient is weighed differently than the distress of the family and patient in this case. Though it is fruitful for the family to enter into the experience of the

\textsuperscript{33}Thaddeus Mason Pope, “Dispute Resolution Mechanisms for Intractable Medical Futility Disputes,” \textit{New York Law School Law Review} 58 (2013/14): 347-368. Pope, a prominent legal scholar on medical futility, makes the case that 95% of medical futility disputes can be resolved with better communication between the medical team and patients/families on what a particular patient’s wishes are for medical treatment with a poor prognosis. The other 5% of intractable cases can be resolved by replacing the surrogate if they are going against the wishes of the patient. There is good legal precedent for replacing the surrogate in these cases. Similar to Jonsen et al., I agree with the content of Pope’s resolution process, but he too fails to emphasize the importance of affectivity and empathy in intractable EOL cases.

\textsuperscript{34}Religious ethicists have noted the importance of empathy in medical training and as a characteristic that contributes to the excellence of a physician. See Lenny Lopéz and Arthur J. Dyck, “Educating Physicians for Moral Excellence in the Twenty-First Century,” \textit{Journal of Religious Ethics} 37, no. 4 (2008): 651-668. While these authors are not addressing my claim about EOL ethics cases specifically, their claims support my more general claim that the medical team needs to embody empathy. See also Neil Pembroke, “Empathy, Emotion, and Ekstasis in the Physician-Patient Relationship,” \textit{Journal of Religion and Health} 46, no. 2 (2007): 287-298. The following quote from page 297 summarizes his position: “Empathy, when it incorporates both cognitive and affective elements, has the power to produce a deep level of connectedness between patient and physician. Ekstasis and communion, then, are the fundamental moments in clinical empathy.”
medical team, the medical team needs to empathize with the family. Given the importance of empathy from the medical team in the critical care literature, it is surprising the authors of Clinical Ethics do not mention it.\textsuperscript{35}

Empathy is clearly needed in these EOL cases where there is disagreement. Empathy of a particular sort, however. Empathy is, on the one hand, a practice that can help bridge the divide in ethical disagreements so that all involved can compassionately arrive at a solution as to what to do in a particular situation. It is powerful moment of intimacy and intersubjectivity in which the love of God is present drawing people together to love each other. Empathy is, on the other hand, capable of being misused and there needs to be an awareness of its limits. I will use the composite case study as a way

to ground the dialogue within the interdisciplinary conversation and arrive at a constructive understanding of empathy—both its limits and its possibilities.
CHAPTER TWO

CLINICAL ETHICS AND SENTIMENTALISM

Before moving into my methodology, I want to provide a brief summary of one paradigm of clinical ethics and a history of the role emotions have played in moral philosophy and theology. Why these two things in one chapter? By stating empathy is a helpful practice to embody in difficult end of life ethics cases, I am stating that the emotions and the accompanying interpersonal dynamics—be those referred to as care, compassion, approbation, and benevolence—have a central role in these cases reaching a resolution. Ethics committees and hospitals employ approaches to clinical ethics in hopes of resolving ethical disagreements that often lack empathy. I will summarize a paradigm of clinical ethics, demonstrate where I think it lacks empathy, and then provide a brief history of the role of emotions in moral philosophy, psychology, and theology so as to demonstrate the role that emotions play in making moral claims and the need for empathy, especially in EOL cases in hospitals.

Providing a brief history of empathy and as it relates to sentimentalism presents some issues. First, empathy is at the same time an old and modern word, and draws on a number of contemporary intellectual trajectories. It is translated form the Greek: em + pathos, literally feeling into. The English concept of “empathy” started out in German psychological circles as Einfühlung, which means feeling-in or feeling-into. Two, the history of philosophy, psychology, and theology is also inextricably linked; the distinctions between them are a product of contemporary academic and social contexts.
Given the blending of disciplines, my interdisciplinary review of emotions will be blended. My historical summary will also be selective in that it will focus on thinkers and topics related to an ethic of neighbor love and empathy.\textsuperscript{36}

**Clinical Ethics**

As I indicated earlier, the paradigm of clinical ethics in *Clinical Ethics* by Jonsen et al. is one of the dominant paradigms of making ethical decisions in clinical settings, especially in my context of Minneapolis and St. Paul, Minnesota. The paradigm of Jonsen et al. focuses on a particular decision making process that covers four topics: medical indications, patient preferences, quality of life, and contextual features. Each of these topics must be addressed when making ethical decisions in clinical settings. I will briefly summarize each of the first three topics and demonstrate how this paradigm lacks empathy and fails to acknowledge the role that emotions have in families making decisions about their loved ones at the end of life. The first three topics have a strong focus on the relationship between the medical team and family in the context of day-to-day medical care. The fourth topic, however, focuses more on hospital policy and public policy in the context of justice issues, such as the distribution of healthcare resources. This is not to say there are not justice issues and policies at work in EOL cases when the family and medical team interact with each other, but I want to focus more on the affective elements of the relationship between the family and the medical team. My hope

\textsuperscript{36} I will only be able to highlight the intellectual and cultural tradition of Europe, countries bordering the Mediterranean, and the United States of America. This has typically been called “western,” but such a designation sounds silly to me because “west” is an arbitrary directional descriptor. I recognize this bias leaves out many marginalized voices deemed insignificant by the forces of history, power, and dominant cultures.
would be that when justice issues are at work in EOL situations, empathizing with the family would contribute to equitable care planning for each family.

Even if the authors agree with me that EOL ethics consults require empathy, they do not stress it in their model. The first three topics are interdependent even though I will parse them out separately. The authors intend their model to be used in a wide variety of clinical situations, but I will focus on EOL. In the process of an ethics consult, the medical team and ethics consultant are supposed to cover these four topics with a patient and family.

**Medical Indications**

The authors begin with medical indications. Regardless of the presence of empathy, any ethics consult in a hospital needs to include a thorough discussion of the clinical picture and prognosis of the patient. The medical team needs to make sure that the patient and family understand the diagnoses, the prognosis, and have all of their questions about their loved one’s diagnosis and prognosis answered. The authors give the following definition for medical indications: “medical indications are those facts about the patient’s physiological or psychological condition that indicate the forms of diagnostic, therapeutic, or educational interventions that are appropriate.”\(^{37}\) Appropriate treatments are guided by the principles of beneficence and nonmaleficence—the duty to benefit and do no harm to a patient. As the medical team weighs treatment options, they consider how much a particular plan of care will benefit or harm a patient.

\(^{37}\) Jonsen et al., *Clinical Ethics*, 10.
In the EOL case under consideration in chapter four, the main question that the medical team will be trying to answer is whether a plan of care is beneficial or overly burdensome for the patient. A critical and severe diagnosis that comes with a very poor prognosis is always hard for the medical team. They have to balance curing the patient with not causing unnecessary suffering; when a cure is not possible, the team wants to make sure the patient is comfortable and free from pain and anxiety in the dying process. We can see this balancing act in the authors’ stated goals of medical treatment:

1. cure of disease.
2. maintenance or improvement of quality of life through relief of symptoms, pain, and suffering.
3. promotion of health and prevention of disease.
4. prevention of untimely death.
5. improvement of functional status or maintenance of compromised status.
6. education and counseling of patients regarding their condition and prognosis.
7. avoidance of harm to the patient in the course of care.
8. providing relief and support near time of death.\(^{38}\)

To some extent, these goals represent a continuum ranging from more aggressive curative measures to end of life care. As we will see in chapter four, our patient in chapter four suffered a non-survivable brain injury, to use the medical team’s term. The family and medical team were faced with deciding what they should do for the patient given his poor prognosis. In the process of exploring which of the goals of medicine are

\(^{38}\) Ibid., 16-17.
reasonable for a particular patient, there is no mention of how the medical team should listen to the family, demonstrate care and compassion, or empathize with them. Granted the “medical indications” topic does not focus on the emotions, values, and beliefs of the patient and the family like the subsequent topics will, but the current topic does focus on the goals of treatment and the assessment process of the medical team. Assessing a patient requires listening to the patient and family, so the medical team can hear the whole story from the patient and family. A proper assessment based on the physiological and psychological facts, especially in emotionally charged EOL life situations, requires a disposition of empathy and compassion for the patient and family. The medical team must empathize with the emotions and experience of the family if they hope to benefit the patient. The authors fail to stress the importance of empathy and interpersonal connection in fully understanding the medical indications.

Patient Preferences

The preferences of the patient must also be the center of any medical discussion according to Jonsen et al., and this is especially the case in EOL situations where families wrestle with deciding between curative measures or pursuing a comfortable dying process. Jonsen et al. define patient preferences as follows:

By preferences of patients we mean the choices that persons make when they are faced with decisions about health and medical treatment…The patient applies her personal experience, beliefs, and values to the information and recommendation of the physician, who makes a best interests-based recommendation of interventions that might objectively improve the patient’s clinical condition.  

39 Ibid., 47.
Jonsen et al. note that the goal of medical treatment is shared decision making between the patient/family and the medical team. After the medical team has made their recommendation, the patient/family preferences should be honored among medically reasonable options. The ethical principle guiding this topic for the authors is respect for patient autonomy (i.e., in having their wishes for medical care followed), which is part of a larger principle of respect for persons: each person has moral value and dignity, and has the right to be respected by others.\textsuperscript{40}

Jonsen et al. cover numerous issues in this topic: informed consent, decisional capacity, surrogate decision makers, and others. I want to focus briefly on how they treat a patient in a similar situation to the upcoming case study. Our patient will be unable to make his own decisions and has not given his wife and family any indication of what his medical wishes would be if he were in such a state. For a patient in this condition, Jonsen et al. make the case that the surrogate decision maker (i.e., patient’s wife in our case) should use the best interests standard of promoting the best interests of the patient. The medical team, according to this model, would lay out a range of medically reasonable options that would meet the needs of the patient’s clinical condition (though not improve), the surrogate would state what she thinks the best interests of the patient would be, and decision would be reached in light of the patient’s best interests and the reasonable options.

In a case where the patient has a poor cognitive outcome (i.e., not able to indicate she knows who she is, or who she is with), the patient has likely been through a devastating experience and the surrogate decision maker is faced with making a decision

\textsuperscript{40} Ibid., 49.
in the midst of a traumatic situation. While there are reasonable options for particular
prognoses, the surrogate decision maker may not be worried about being reasonable and
may be overwhelmed, grieving, and anxious. Reason and emotion are not in opposition to
each other, but in instances like our upcoming case, the emotional states of the family
may inhibit thinking more reasonably. In order to learn about the patient’s preferences in
this situation, the medical team must listen to and empathize with the surrogate decision
maker if they want to decide on a plan of care for the patient. There is very little mention
of tending to the emotional elements of deciding among reasonable options and what is in
the patient’s best interest. The surrogate decision maker is likely experiencing intense
emotions around the initial incident and whatever consequences the plan of care have for
his or her life with the patient. These emotions are a central component of making any
plan of care decisions and important for building trust and rapport between the medical
team and the family, especially if one of the goals of medicine, per Jonsen et al., is shared
decision making between patient/family and medical team.

Quality of Life

Patient preferences are inextricably tied to a patient or family’s assessment about
what type of life is worth living. In EOL ethics consults, quality of life assessments are at
the center of the discussion. The medical team, patient, and family reflect on what type of
life the person would want to live given their prognosis. Jonsen et al. define quality of life
as follows:

One significant feature of all medical interventions is the aim to produce a state of
satisfaction for the patient who has sought treatment. Quality of life…refers to
that degree of satisfaction that people experience and value about their lives as a whole, and in its particular aspects, such as physical health.\textsuperscript{41}

They ask many questions related to how the medical team and family can and should make judgments about a patient’s quality of life, but one of their questions is particularly relevant to the upcoming case study: Do quality of life assessments of patients who will have restricted, diminished, or profoundly diminished quality of life raise any questions regarding changes in treatment plans, such as removing life sustaining treatment?\textsuperscript{42} Our patient in the upcoming chapter has suffered a traumatic injury with a very poor cognitive outcome and will fall under the category of profoundly diminished quality of life. In answering the above question, “patients and their physicians must determine what quality of life is desirable and attainable, how it is to be achieved, and what risks and disadvantages are associated with the desired quality.”\textsuperscript{43}

To their benefit, Jonsen et al. caution the medical team about imposing their own set of values and beliefs on a patient in a profoundly diminished state; different people value different kinds of experiences and conditions differently. By comparing the values of the medical team to the family, they indicate the importance of understanding the experience of the family. However, the nomenclature they use to describe these efforts lacks the necessary affectivity. The focus is on making assessments and value judgments, and clarifying the beliefs of the patient and family. Equal time and attention needs to be given to how the medical team can affectively hear the story of the family. As we will see

\textsuperscript{41} Ibid., 109.

\textsuperscript{42} Ibid., 127ff.

\textsuperscript{43} Ibid., 111.
in the historical summary in the latter half of the chapter, how the family feels will impact
the family’s process of making judgments. The fear, anxiety, and grief may be
overwhelming for a family in situation like the upcoming case study in chapter four.
These emotions are at the core of how the family will work through making any decisions
about treatment plans.

Empathy and Emotions in Ethics Consults

It should be clear by now that I think the clinical ethics topics outlined above lack
a focus on the emotions in EOL cases and do not stress the importance of empathizing
with the family as they try to decide what they should do for their loved one. Emotions
play a central role in how families make EOL decisions. The process of empathizing with
the family is how neighbor love gets cultivated—the medical team can love the family as
the family wants to be loved in this EOL situation. Empathy clearly has positive
influence on the relationship between the medical team and the family. In the context of
making life support decisions and EOL care in the ICU, families report feeling
understood, heard, and a greater sense of satisfaction with care when the medical team
empathizes.44 In a superficial sense, a family’s feeling of satisfaction does not
demonstrate the presence of neighbor love from the medical team. A family can feel
satisfied for a variety of reasons. However, in a superficial way the reports of family

44 See the following studies: Bert Molewijk et al., "Emotions and Clinical Ethics Support. A Moral
Inquiry into Emotions in Moral Case Deliberation," HEC Forum 23, no. 4 (December 2011): 257-268,
Business Source Premier, EBSCOhost (accessed May 23, 2016); R. Selph et al., "Empathy and Life
9 (September 2008): 1311-1317, EBSCO MegaFILE, EBSCOhost (accessed May 23, 2016); Laura J. Hinkle
et al., "Factors Associated With Family Satisfaction With End-of-Life Care in the ICU," Chest 147, no. 1
(January 2015): 82-93, EBSCO MegaFILE, EBSCOhost (accessed May 23, 2016). These studies mostly
discuss the family’s satisfaction with care and how empathy contributes to that satisfaction.
show that empathy is a good thing when making EOL decisions. Empathy from the team helps them see the family (i.e., neighbor) truly, honestly, and holistically. Neighbor love should be cultivated at the EOL simply because the neighbor is worthy of being seen in this way, being honored and respected, but empathy can also help these cases come to a resolution by loving the family how they want to be loved.

Empathy solves a unique contemporary problem in these EOL cases. Given the growing intercultural reality, empathy is required for people to feel and understand the experience of others. Ethical worldviews can be completely dissimilar, and in a world where our neighbor is not guaranteed to be a close version of ourselves, empathy, driven by love, is required to cultivate neighbor love. In the brief history of love, empathy, and sentimentalism that follows, I will show how empathy is needed to love the neighbor on his or her own terms and why emotions are foundational for moral claims and decisions at the EOL. Early theologians and philosophers spoke of loving the neighbor as another version of the self and importance of love in morality. Enlightenment and nineteenth century thinkers continued to stress the importance of emotions in morality such as love, but loving the neighbor was less about loving our neighbors as other versions of ourselves; the neighbor might have different needs and emotional states, to use contemporary terms, than one’s own. Finally, in the contemporary period, psychology and philosophy have shown us that we cannot assume that we know what our neighbor is thinking or feeling. In addition to the increasing interaction between cultures from different parts of the globe, the concept of “ethical strangers” is related to how the social sciences have shown we cannot assume that we know what our neighbor is thinking or feeling. Because of the discoveries in the social sciences, we cannot say we know the
feelings and thoughts of another, thus an ethical stranger could be anyone. It is here that empathy becomes necessary, especially in trying to resolve a difficult EOL case between parties with different ethical worldviews.

Why Don’t Medical Teams Start with Empathy?

In terms of finding an answer to this question, I have not completed interviews with physicians, nurses, nursing assistants, and other staff. I have my experience as a chaplain working in a teaching hospital on which to draw. My practice as a chaplain has been to start with empathy—empathy for the patients, families, and staff that takes care of them. There are other members of the medical team that likely start with empathy, of course, but I can only speak to my own intentions as a chaplain.

I assume medical staff are practicing what they are taught to do. Based on my experience with medical staff in teaching hospitals, I don’t believe it is common place that medical training—whether it is physician, nursing, or various therapists—includes education in empathy and the interpersonal elements of working in healthcare as part of required curricula. Medical staff are taught about physiology, biochemistry, pharmacology, hospital policy and procedure, and technology. Physician James Plumb (quoting a medical professional) states it the following way:

As Inui writes: “And how are we fairing as medical educators in preparing future physicians for professional roles in our complicated world? I would conclude that the “formative arc” of education today is strong on the acquisition of technical knowledge and weak-to-negative on the acquisition of values and moral formation. While preparing successfully to pass tests of knowledge, our students measurably move from being open-minded and curious to test-driven and minimalistic, from openhearted and idealistic to self-centered and well defended, from altruistic to cynical.”45

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Neither do I mean to say medical staff are all cynical and bereft of empathy, nor that medical educators lack an understanding of empathy’s importance. This would be overstating the current state of things. A counter-example comes from Stanford University’s Center for Compassion and Altruism Research and Education (CCARE). In relationship with Stanford’s School of Medicine,

CCARE investigates methods for cultivating compassion and promoting altruism within individuals and society through rigorous research, scientific collaborations, and academic conferences. In addition, CCARE provides a compassion cultivation program and teacher training as well as educational public events and programs.46

Stanford offers training programs for professionals to learn how to practice compassion, empathy, and altruism. A simple online search of “empathy and medical education” reveals that medical practitioners and educators understand empathy’s importance. People are aware of empathy’s important role in medical practice.

However, I think there is a preference for the mechanical and technical in medical training, even though people enter the profession because they have a passion for caring for the sick and understand empathy’s importance. That is not to say the mechanical and technical training are not extremely important. Obviously, technical and mechanical training are important. People come to their nurse, physician, nurse practitioner, and physician assistant for help in times of need and expect their medical professional to know the mechanics of the body. When staff are faced with difficult end of life situations

August 2, 2016.) James Plumb, M.D., M.P.H, is a professor of family and community medicine at Jefferson Medical College. Plumb provides a footnote for his quote with a link to an interview on the American Association of Medical College (AAMC) newsroom web page. The interview is no longer available on the AAMC web page.

where there is disagreement—situations in which family are terrified, angry, or hopeless—there might be a tendency to fall back on technical training, regardless of the presence or lack of empathy training in medical school. The thought process of a medical staff member might go something like this: “If the family simply understood more about the specifics of the injury and the likelihood that the brain will heal, then they will make the more sensible decision.” To enter into and care for the family in their distress is scary and difficult to do even for those trained to provide therapeutic listening and support. As a chaplain, I have had a hard time dealing with family’s distress depending on the flow of the workday, how I feel at a particular point with my own life, and the specifics of the case. However, to be human is to experience this type of distress. Medical staff are trained and have a professional role, but they must also embody their role to be human and to be present to the family’s pain. Even though technical training is important, embodying their role to be human is foremost. The more one tamps down one’s emotions the more one is operating outside of oneself and are not being human with the family that is in distress.47 As we will eventually see in the final chapter, to counterbalance the

47 Daniel Siegel’s understanding of the mind supports this claim. There are three main elements to his definition of the mind. 1) Experiences—both intra- and interpersonal—shape the internal structures of the brain. 2) “A core aspect of the human mind is an embodied relational process that regulates the flow of energy and information within the brain and between brains. 3) The mind is the result of the relationship between “internal neurophysiologic processes and relational experiences,” thus the mind emerges out of the interaction of these two dynamics. Attachment theory is the lens through which he interprets how our relational experiences shape our brain, thus the mind. The central thrust of Siegel’s use of attachment is that one’s early relationship with one’s caregivers shapes both one’s interpersonal experiences in adulthood and the development of the pathways and structure of one’s brain. The development of attachment is, therefore, a significant part of the mind. Based the patterns of communication and emotional sharing one can develop secure or insecure attachment patterns. Emotions are the central dynamic of attachment and the formation of the mind for Siegel, and they “represent dynamic processes created within the socially influenced, value-appraising process of the brain.” Emotions are, therefore, the building blocks of the brain’s neurophysiology and the relationships with one’s caregivers. Secure attachment reflects an ability to integrate or hold together the complexities of one’s experiences with little accompanying stress, respond to new and novel stimuli with flexibility, and an awareness non-conscious and conscious emotion. Siegel, Developing Mind, 3-7, 93, 148.
technical medical training requires guidelines that overemphasize empathy. For now, we will continue our history of how emotions have played a role in western thought and why we need empathy.

Loving My Neighbor Is Loving Myself

Aristotle (384-322 B.C.E.) and Thomas Aquinas (1225-1274 C.E.) begin to make a case for the role of love and friendship in relationship to morality. I will highlight portions of their respective paradigms for two reasons. First, Aristotle and Aquinas have a particular way of constructing neighbor love. Along similar lines to Mark 12:30-31, “Thou shalt love the Lord thy God…thou shalt love thy neighbor as thyself,” they argue for loving the neighbor because the neighbor is another self. We love, honor, and respect the neighbor because they are another version of us. The two do not agree on whom we should love and consider a friend, but they both justify loving others because the other is another self. Second, when discussing the relationship between friendship and love, Aristotle and Aquinas highlight the role that emotions play in our relationship with our neighbor. Aristotle notes three kinds of friendships and lands on mutual love as the most virtuous form of friendship. Aquinas pushes this further and argues that mercy and love

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48 I will not discuss Plato here, though his thinking was equally as influential. In my interpretation, Plato focused much less on relationships and the emotions of community than Aristotle did. Though I cannot provide a detailed description of Plato’s thinking, my reading of Plato’s forms gives rise to this interpretation. The Forms are the ideal and purest form of a thing. For example, one can see a beautiful object and call it beautiful, but the beautiful object is a mere reflection of True Beauty. However, simply because Plato focused more on abstractions and the Forms and Aristotle on techne, does not mean one should see the comparison as black and white. There are two examples that offer a counter point to my interpretation. One, Aristotle was equally as abstract in his discussions of The Good. Two, part of Plato’s most famous work, The Republic, explores the issue of self-interest versus altruism through the character Glaucon. Glaucon suggests, via the myth of the Ring of Gyges, we are only nice to others because we benefit from it or are worried about what others will think of us. Plato, The Republic, ed. Andrea Tschemplik (Lanham, MD: Rowman & Littlefield Publishers, 2005), II. 359b ff.
are the foundational virtues for our lives and how we relate to our neighbor. Later on in history, David Hume (1711-1776) and Arthur Schopenhauer (1788-1860), will continue to emphasize the role emotions play in relationship to one’s neighbor through approbation and compassion respectively.

Aristotle

Aristotle’s interpretation of friendship is our entry point into his philosophy. One cannot ignore the context in which he writes and the classical Greek philosophies he inherited. Aristotle was a member of the elite class, was a tutor for Alexander the Great, and his philosophy reflects a hierarchical society. Nonetheless, his reflections on friendship are important for our understanding of neighbor love in the early history of philosophy.\(^49\)

In books VIII and IX of the *Nicomachean Ethics*, Aristotle discusses the nature of friendship. Immediately he defines friendship and its importance for individuals in society.

> For without friends no one would choose to live, though he had all other goods. … Those in the prime of life it stimulates to noble actions—‘two going together’ [Iliad X. 224]—for with friends men are more able to both think and act. … Friendship seems too to hold states together, and lawgivers to care more for it than for justice … and the truest form of justice is thought to be a friendly quality.\(^50\)

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First, friendship is one of the goods in life, even in the presence of great wealth and power. One needs to understand the distinction here in Aristotle between the *good* and the “other goods” of which he speaks in this quote. The other goods are material goods one can acquire in life and not a reference to the highest good, which is contemplative wisdom.  

Second, he notes how humans are better able to think and act when they are in the company of friends. He elaborates this second point when he talks about love and the different kinds of friendship, but here he is clear that friendship stimulates and inspires one to a noble and virtuous life.

Further specifying the nature of friendship, Aristotle claims there are three types of friendships based on three objects of love. The question is posed in the form of how people love and what they love: “Do [humans] love, then, the good, or what is good for them?” Concluding that all humans love what seems good to themselves, there are three grounds on which people love: the love of lifeless objects to which the term “friendship” is not applied, the love or goodwill wished to other humans that is not reciprocated, and

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51 Ibid., X 1177a 1-20. The first sentence of the *Nicomachean Ethics* touches on the *good*: “every art and every discipline, and similarly every action and rational choice, is thought to aim at some good; and so the good has been aptly described as that at which everything aims.” The first statement assumes Aristotle’s metaphysical biology, which is that nature has created humans, as distinct from animals, with a purpose or *telos.* See Alasdair MacIntyre, *After Virtue* (Notre Dame, IN: University of Notre Dame Press, 2007), 148. There is also a distinction between good and highest good in Aristotle. An action is judged virtuous depending how close it is to the divine activity or the highest good. All humans pursue the same pleasure for all things have by nature something divine and the highest good in them. Something is good for Aristotle when it is most complete (we pursue a good only for its own sake, like happiness) and self-sufficient (makes a life choice worthy and lacking nothing all on its own). Happiness is the thing most of all worth choosing, and there are two kinds of happiness: one that is simply human (practical virtue/happiness) and complete happiness (divine contemplation). The latter form of happiness helps direct the former for Aristotle. See John E. Hare, *God and Morality: A Philosophical History* (Oxford: Wiley-Blackwell, 2009), 50

52 Important for Aristotle, but tangential for the current discussion, is how friendship relates to justice. Friendship is what binds the city-state together and is a reflection of justice—not that friendship is the paragon of justice, but that justice has characteristics similar to true friendship. Friendship is, therefore, essential to the good life for the individual and the city-state.
then true love where there is a mutual exchange of feelings between people. The highest form of love is one of mutuality where there is a choice to equally exchange feelings between people. This is not a version of contemporary altruism by any means, but it does demonstrate that love is at the root of friendship for Aristotle. True love, a mutual love, involves a choice to love, for Aristotle. People can have feelings of love for anything, even a lifeless object, for example, but deciding to love another stems from someone’s character.53

Corresponding to the three main kinds of love are three forms of friendship: mutual, utility, and pleasure. That latter two, in Aristotle’s eyes, occur when people pursue a relationship for what is useful (utility) or pleasant (pleasure) for them.54 Only the first form of friendship is true friendship for Aristotle. For the first form of friendship, Aristotle uses the term good or virtuous. Good and virtuous people find themselves in the first category because they are good in and of themselves and wish good for the other person as well. True friendships, as friendships between good and virtuous people, are enduring. They are not based on a temporary quality (utility or pleasure) but on a permanent quality of goodness and virtue, and for Aristotle, good is a constant and static

53 Aristotle, Nicomachean Ethics, VIII 1157b 25-35. “Now it looks as if love were a feeling, friendship a state of character; for love may be felt just as much towards lifeless things, but mutual love involves choice and choice springs from a state of character. And men wish well to those whom they love, for their sake, not as a result of feeling but as a result of state of character. And in loving a friend men love what is good for themselves; for the good man in becoming a friend becomes a good to his friend. Each, then, both loves what is good for himself and makes an equal return in goodwill and pleasantness.” Again, Love in and of itself is a feeling for Aristotle, but mutual love between two good people springs from a state of character and is a choice. Love is the root of true friendship; everyone experiences love, but only a decision to love mutually results in true love and true friendship. Given that true friendship and true love are based on equality coming from the good, choice and true friendship must be based on choice, since a pure feeling cannot result in a person being good.

54 Ibid., VIII 1156a 1-20. Friendships for the sake of pleasure or utility contain a portion of true friendship, since there is inevitably pleasure and/or usefulness in even true friendships, but these can never be the focus of the friendships.
quality. Aristotle goes into many different distinctions and relationships between the various kinds of friendship, but the main thread is that true friendship is something that is “of the good,” and it is only when both parties in the friendship are virtuous and good can there be true friendship.

For Aristotle, one is related to one’s virtuous friend as oneself, or put another way, one’s friend is another self. One wishes for oneself to live and be preserved, experience what is good, live with oneself in pleasure, contemplate the good, grieve and rejoice, and to have harmonious opinions. After all, people love and have friendship for what is good for them. Since one wishes these good things for oneself, and the friend is another self, one wishes these things for one’s friend as well. It seems he is saying that one ought to love the self above others, and this is correct, but he places an important qualification on the love of the self: a good man ought to love the self. Evil men, per Aristotle, will love themselves more and will only “assign to themselves the greater share of wealth as though they are the best of all things.” A good man, however, will be a lover of the self and will also be a lover of others: “for he will both himself profit by doing noble acts and will benefit his fellows.” There is a branching out beyond the self in Aristotle. Fellows here include the immediate family (though Aristotle talks about greater regard for the father) and friends, with the latter understood broadly. The love of the self finds its truest expression in the love of others outside of the self.

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55 Ibid.

56 Ibid., 1166a 10-25.

57 Ibid., 1168b 15-25

58 Ibid., 1169a 10-15

For a moment, let us look past Aristotle’s claim that mutual love and friendship can occur only between two virtuous people—people being defined as men, educated, and able to live a leisurely life. I understand the error in this, but I want to briefly point out how emotions impact morality for Aristotle. Aristotle stresses the importance of correct love in forming relationships between people and for the sake of the city. The virtuous life depends on the right kind of love and friendship. Though Aristotle’s claims do not directly state that love impacts how people make moral claims, he does claim that love impacts the moral life. Love and friendship impact the virtuous life and the life of the city. In terms of neighbor love, Aristotle clearly argues that the neighbor is another self, and what one wants for oneself one also wants the same for one’s neighbor. When we love our neighbor, we love them as we love ourselves. However, given the cultural landscape I laid out in the introduction, can we say the neighbor is another version of the self? No. Aristotle only takes us so far in his claim that love is part of the mutual exchange of love between friends. Our neighbor—the family’s encounter with the medical team—is not another self and needs to be loved in a unique way, a love that sees the neighbor honestly, truly, and holistically even when there is disagreement on what should be done in difficult EOL cases. Aquinas will take us a bit closer to this goal in the way that he stresses both the inter-subjective nature of love and the importance of loving someone even if they do not share the same view of the good. Even though he will still claim the neighbor is another version of ourselves, the claim that we have a shared experience with the neighbor takes us closer to seeing the neighbor as unique. Even though we will not agree with how the neighbor defines and pursues the good, we still ought to love them.
Aquinas

For our purposes, Aquinas’ views on charity and mercy are the most fruitful for our discussion. Aquinas’ *Summa Contra Gentiles* will be considered where appropriate, but the majority of the focus will be on his *Summa Theologica II-II*, questions 23-33. As Aquinas moves through the internal (joy, love, and mercy) and external (beneficence, alms deeds, and fraternal connection) qualities of charity, mercy is one of the internal qualities where we find support for the ways in which emotions impact moral claims in relationship to one’s neighbor, as well as how the neighbor is another version of the self.

First, we will focus on mercy. Mercy for Aquinas is a person’s compassion or suffering heart at the sight of another’s suffering: “I answer that, as Augustine says (De Civ. Dei ix, 5), mercy is heartfelt sympathy for another’s distress, impelling us to succor him if we can. For mercy takes its name misericordia from denoting a man’s compassionate heart (miserum cor) for another’s unhappiness.” More importantly,

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60 I will pass over many thinkers after Aquinas. Martin Luther, for example, stressed loving the neighbor as oneself, but, using contemporary terms, focused on looking past the needs of the self to the needs of the other. Part of Luther’s ethics focus on love, natural law, and reason. Forsaking the neighbor was a vile and odious act for Luther. Instead, people should act for the sake of the neighbor and look beyond their own needs and wants. When Luther speaks of loving one’s neighbor, he refers to one’s work in the world: our neighbor is here in the world with us working daily to support him or herself. This world is one of God’s kingdoms, maintained through laws that restrain one’s selfish tendencies so that God’s worldly kingdom may run peacefully and serve the common good. One loves by following the natural law of loving one’s neighbor as oneself. Opposing natural law, though, is the love of the self-expressing itself in a variety of ways—only caring for one’s own needs, for example. The Decalogue and the commandments therein act as a summary of this natural law. The first commandment is, therefore, foundational for Luther for only in turning away from one’s needs, one’s idols, can one truly serve the neighbor. One’s work in the world must rise out of one’s trust and faith in God, for only in this way will one have no other God’s—no other things in one’s life to trust. See Martin Luther, “Large Catechism,” Book of Concord, eds. and trans. Robert Kolb and Timothy J. Wengert (Minneapolis, MN: Fortress Press, 2000); William H. Lazareth, Christians in Society: Luther, the Bible, and Social Ethics (Minneapolis, MN: Fortress Press, 2001); and Timothy Wengert, Gleichmut, Gewissen, Glaube, and Gemeinshaft: Luther’s Ethical Practice (unpublished paper, August 2006).

however, is the inter-subjective connection Aquinas notes in expressions of mercy towards another. The primary reason one takes pity or has mercy on another is because of a defect in the self. Defect here must be understood in terms of Aquinas’ understanding of happiness and unhappiness. The Latin defectus is similar to the current modern English definition: “a failing, a failure, a lack, disappearance, a weakness.”\(^{62}\) In context of discussing mercy, Aquinas understands a defect to be something that is left wanting, thus in some translations of the Summa Theologiae one sees “want” and in others one sees “defect.” One can understand defect or want as one seeing unhappiness or suffering in another that resonates or connects with unhappiness of suffering in the self. The resonance between the self and another occur because one’s friend is another self. When one loves another in true friendship, or another is the object of charity, one looks upon that other person as the self and will grieve when the other grieves and rejoice when the other rejoices.\(^{63}\)

Second, we will look at Aquinas and charity. Like Aristotle, Aquinas suggests that seeing the neighbor as another self creates love for the other, though, unlike Aristotle, Aquinas ties neighbor love to sin, grace, and a strong sense of the imago dei in all people. A brief note about Aquinas’ use of the word charity is in order. The word

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\(^{62}\) Oxford Latin Dictionary, s.v. “defectus.”

\(^{63}\) Aquinas, Summa Theologica, Part II-II, Kindle Locations 4958-4960: “I answer that, Since pity is grief for another's distress, as stated above (A. 1), from the very fact that a person takes pity on anyone, it follows that another's distress grieves him. And since sorrow or grief is about one's own ills, one grieves or sorrows for another’s distress, in so far as one looks upon another's distress as one's own.”
translated as “charity” is the Latin *caritas*. *Caritas* does not refer to modern English notions of charity as giving to the poor or those in need. More properly, *caritas*, is understood as “love,” the Latin equivalent of the Greek word *agape*. “Charity,” therefore, refers to the act of love or a loving interpersonal dynamic between people the source of which is God.

In question twenty-five Aquinas analyzes the relationship between the self and others by considering whether charity stops at God or extends to the neighbor. The belief one should direct their charity to the neighbor in addition to God is quickly affirmed; charity unites us to God, thus charity toward the neighbor is also charity directed to God.64 Aquinas goes on to state one ought to love sinners and one’s neighbor, but one also ought to love the self. In article six, countering a belief that one should only love and associate with those who are virtuous,65 Aquinas cites Augustine and claims one ought to consider every person one’s neighbor, sinners do not lose their humanity in sinning, and so one should love sinners and enemies. Simultaneously Aquinas asks if one should love oneself out of charity. Contrary to the claims that people are labeled blameworthy for loving themselves, he cites both the Hebrew (Leviticus 19:18) and Christian (Mark 12:11) scriptures that one should love the neighbor as the self.66 Having already

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64 Aquinas, *Summa Theologiae, Part II-II*, Kindle Locations 3915-3917: “Now the aspect under which our neighbor is to be loved, is God, since what we ought to love in our neighbor is that he may be in God. Hence it is clear that it is specifically the same act whereby we love God, and whereby we love our neighbor. Consequently the habit of charity extends not only to the love of God, but also to the love of our neighbor.”

65 Aquinas cites various biblical texts (Psalm 118:113, Exodus 22:18, Psalm 9: 18) and Aristotle (Nicomachean Ethics VIII) as the voice of the objections in regards to directing charity toward sinners.

66 Aquinas, *Summa Theologiae, Part II-II*, Kindle Locations 3984-3987: “Hence, just as unity is the principle of union, so the love with which a man loves himself is the form and root of friendship. For if we have friendship with others it is because we do unto them as we do unto ourselves, hence we read in Ethic. ix, 4, 8, that “the origin of friendly relations with others lies in our relations to ourselves. Thus too with regard to principles we have something greater than science, namely understanding.”
concluded that one loves sinners and neighbors out of charity, and because we both find our highest good in God, and we must love our own highest goods and others, it follows that one must love the self out of charity as well; the self and the other are to be loved equally. As Aristotle argued, we have a true friendship because we act toward that friend as we act toward ourselves, thus for Aquinas love of the self is the “root and origin of friendship.”

How does the love of self and neighbor as charity relate to Aquinas’ understanding of virtue? For Aquinas, action is based in intention, which is highly subjective. Wrapped up in intention are both the will and the intellect—the former moving one to act or not and the latter deciding what the action will look like in pursuit of the good. In order to pursue the good, one depends on one’s powers (intellect, will, and natural appetites) to guide one to a particular end, in this case a posture of charity and mercy. Continuing with virtues, Aquinas defines a virtue as “a certain perfection of a power. Now a thing’s perfection is considered chiefly in regard to its end. But the end of power is act.” Charity is one of the virtues for Aquinas; therefore, charity results in the perfection in regard to one’s end, which is ultimately God (as first cause and the end).

67 Ibid.

68 John Finnis, "Aquinas' Moral, Political, and Legal Philosophy," The Stanford Encyclopedia of Philosophy (Fall 2008 Edition), Edward N. Zalta (ed.) https://plato.stanford.edu/archives/fall2008/entries/aquinas-moral-political/: “It is, in other words, not an item of behavior considered not in its observable physicality as such, but rather one’s behavior as one’s objective (or the most proximate of one’s objectives), that is, as one envisages it, adopts it by choice, and causes it by one’s effort to do so.” Intention is the center of Aquinas’ understanding of action, and intention is tied to the will and intellect. What one chooses to do is also what one intends. It is not possible to so neatly separate choices and intentions, for each choice has intentions attached to it. When one decides to act—whether for an immediate goal or for a larger goal—one intends to act in such the way one decided to act. Choice and intention are wrapped up together. Actions are, therefore, highly subjective as one’s intention is subjective. The most objective account of human action is provided by the account that is most subjective.”
In fact, charity is the principal virtue, there can be no genuine virtue without charity, and charity is that which results in the perfection of one’s end (i.e., the good as God). Loving God is the perfection of one’s end, and in acts of charity toward the neighbor we also act with charity toward God. Given it is the root and foundation of virtue, charity is what shapes the other virtues—creates dispositions and habits in the person in order to cultivate the moral and intellectual virtues. Charity gives shape to the intending, choosing, and acting that have their ends in happiness and the good, both penultimate and ultimate well. The posture of love toward others is an example of charity, and this love is directed toward those who are virtuous and un-virtuous because one sees their common humanity. With a posture of love for others as fellow humans, one will intend, through the will and the intellect, the good for oneself and the good for the other.

69 Aquinas, *Summa Theologiae, Part II-II*, Kindle Locations 3406-3527. A detailed discussion of the way in which charity operates in the virtues is too long for the current discussion; one should merely note the prominence given to charity. There are natural virtues, human virtues, and spiritual virtues. Charity looks to the ultimate good (God) without looking for any gain, thus charity is above the moral and intellectual virtues. The other virtues are focused on proximate and natural good, whereas charity directs itself to the ultimate good. See also Carlos Ruta, “QUOD EST IN VITA, VITA EST: The Theology of Charity in Mister Eckhart,” in *Aspects of Charity: Concern for one’s neighbor in medieval vita religiosa*, ed. Gert Melville (*Lit Verlag Dr. W. Hopf Berlin: 2011*), 140-141.

70 Aquinas asks the following in question 25: does charity extend to all neighbors or only virtuous neighbors? In question twenty five, article six, countering a belief that one should only love and associate with those who are virtuous, Aquinas cites Augustine and claims one considers every person one’s neighbor, sinners do not lose their humanity in sinning, and so one should love sinners and enemies: “On the contrary, Augustine says (De Doctr. Christ. i, 30) that, “when it is said: ‘Thou shalt love thy neighbor,’ it is evident that we ought to look upon every man as our neighbor.” Now sinners do not cease to be men, for sin does not destroy nature. Therefore we ought to love sinners out of charity.” Aquinas, *Summa Theologica, Part II-II*, Kindle Locations 4023-4025.
Summary

From Aristotle and Aquinas, we can begin to see how the emotions relate to making moral claims, and how loving the neighbor was understood as loving another version of ourselves. First, Aristotle claims that emotion and state of love create good dispositions and habits in people if the love is the right sort of love. Though I agree with Aristotle when he acknowledges the role that love and friendship play in creating a good society, he does not go far enough in claiming the necessity of relationships between people; they are a good thing and contribute to the good, but they are not absolutely and ultimately necessary. He also does not go far enough in extending love and friendship to all people. Regardless of one’s station in life or if one’s love for someone is not reciprocated (e.g., the latter is one of Aristotle’s types of friendship described above), we ought to love him or her and empathize with him or her.

Second, Aquinas states that love can serve as the foundation of relationship with our neighbor and love is the foundation of all other virtues in life. Similar to my critique of Aristotle, Aquinas does not take his neighbor love far enough in terms of the necessity of the interpersonal relationship. Though I agree that we love God when we love our neighbor, and we can experience the joys and distress of our neighbor as our own, we are not determined by our social relationships for Aquinas.

What we can see in Aristotle and Aquinas is that we connect with the suffering and experiences of our neighbor because they are another version of ourselves; this is why we love them. We love them because the needs and hopes of the neighbor are a version of our needs and hopes. However, if neighbors are to be loved honestly, holistically, and truly as their own person, then loving them because they are another
version of us does not work. In the EOL case in chapter four, we will see a variety of love in how the medical team and family relate to each other. We will also learn how empathy is necessary when our neighbor is not assumed to be another version of ourselves.

**Sentimentalism and Beginning to Love the Neighbor as Neighbor**

In the development of emotions, empathy, and their impact on moral claims, the eighteenth and nineteenth centuries are crucial. David Hume and Arthur Schopenhauer will be our focus from these centuries. Their thinking is important for two reasons. First, David Hume comes onto the scene and continues the arguments of his mentor Francis Hutcheson (1694-1746 C.E.) that the passions (i.e., emotions) are the foundation of how humans decide whether an action or person is right/good or wrong/bad. Arthur Schopenhauer is not grouped in the same philosophical school as Hume. However, he makes the case for compassion as the foundation of and catalyst for our actions towards our neighbor. In EOL cases, Hume and Schopenhauer’s claims are important for understanding how a family’s emotions influence the decisions they make about their loved one’s care plan. Second, in these centuries we begin to see a new kind of distinction between self and other. Hume and Schopenhauer will no longer say we love our neighbor because they are another self; our neighbor is worthy of love as a human being, and the self and the object—be that a person or thing—are more differentiated than they were in Aristotle and Aquinas. The growing distinction between another and myself is part of the gap that empathy will play in the EOL of life. This is not to say that any of the emotional dynamics named so far—love, friendship, compassion, mercy, and benevolence—are not robust enough to fill the space between another and myself but that
empathy helps us to more fully understand the thoughts and emotions of others. Through empathy we are able to love the neighbor as they want to be loved.

David Hume

David Hume and Immanuel Kant (1724-1804) represent the two main versions of Enlightenment ethics: basing obligation to the other respectively in an emotional response to specific circumstances and basing this response in rational, *a priori* principles.\(^7\) As a sentimentalist, David Hume is in the former camp. Sentimentalists make the case that ethics and morality are based in our emotions rather than in reason. Hume makes some room for reason in making ethical decisions. Reason plays a role in gathering and determining the facts of a situation, and once we have the facts before us, reason has played its part and we must depend on our emotional reaction to the facts—either approbation or disapprobation. Morality cannot only rely on reason and the facts of a situation. Deciding whether something is right or wrong is closer to how we decide whether something is beautiful; when we describe something as beautiful we rely on a sense of approbation or disapprobation towards a particular thing/case/situation of beauty. Our gut sense about the object of beauty is the reason we describe something as

\(^7\) Immanuel Kant places special importance on the a priori or “pure” part of moral philosophy. In Kant’s normative ethics, Kant draws heavily on observations and ideas about human nature. But both in his normative works and in his foundational work, the Groundwork for the Metaphysics of Morals, Kant makes explicit that the supreme moral principle itself must be discovered a priori by the individual, through a method of pure moral philosophy. By “pure” or “a priori” moral philosophy, Kant has in mind a philosophy grounded exclusively on principles that are inherent in and revealed through the operations of an individual’s reason. Ethics cannot be grounded in the phenomenal world or dependent on an external source of authority, but must come from the pure noumenal, autonomous, and rational self. Immanuel Kant, *Groundwork for the Metaphysics of Morals*, eds. Mary Gregor and Jens Timmerman (Cambridge: Cambridge University Press, 2012), 4:444; and *Critique of Practical Reason*, eds. Mary Gregor and Andrews Reath (Cambridge: Cambridge University Press, 1997), 5:61.
beautiful. A judgment about beauty is not achieved via a process of taking measurements or relying on a list of facts about what counts as beautiful, per Hume.\textsuperscript{72}

From this, in \textit{Enquiry Concerning the Principles of Morals}, Hume explores “that complication of mental qualities, which form that, in common life, we call Personal Merit: we shall consider every attribute of the mind, which renders a man an object either of esteem and affection [i.e., approbation], or of hatred and contempt [i.e., disapprobation].”\textsuperscript{73} One of these qualities that “renders a man an object of esteem [is] benevolence towards one’s neighbor, tender sympathy with others, and a generous concern for our kind and species.”\textsuperscript{74} Benevolence—as sympathy and concern for one’s neighbor—is tied to a sentiment of approbation. Benevolence is approbation within oneself towards those who embody it and it works as a catalyst within the self for compassionate action.

As we look toward our difficult EOL ethics case and the need for empathy, Hume has provided us with more of a direct connection between emotions and making moral claims, as well as the normative claim that we, as humans, ought to be benevolent. Given the role that emotions play in making moral claims, the process of making decisions in clinical ethics should include not only discussion of the role that emotions play in clinical ethical decisions, but also discussion of empathizing with the emotions of the family. Emotions of the family members in our case impact how they make moral claims about

\textsuperscript{72}One could critique Hume on this. Cultural and class concepts of beauty play a role in how our gut responds to certain images, shapes, and color patterns. Therefore, one could say that beauty is achieved in part by assessing and gathering the facts.


\textsuperscript{74} Ibid., 177-178.
their loved one in the hospital. Empathizing with the family would fall under Hume’s understanding of benevolence: “A generous concern for [one’s] kind and species.” This is a highly admirable quality, but Hume’s claim needs to be pushed further. Difficult EOL ethics cases require greater nuance to the interpersonal encounter: how a caregiver can have a generous concern for, to use Hume’s words, the specific distress and emotions of someone in need. Hume speaks in generalities and there needs to be more differentiation between the self and the one for whom one expresses “a generous concern.” Hume’s benevolence is helpful in getting us a little closer to loving the neighbor in a unique and honest way that honors the beautiful distinctness of the neighbor, but we simply need to push benevolence further to get there.

Arthur Schopenhauer

In order to continue our journey to loving the neighbor in a specific way that tends to their needs in a unique, honest, and holistic way, I will now turn to an often-overlooked moral philosopher: Arthur Schopenhauer. Schopenhauer was not satisfied with Kant’s ethics, particularly the *Groundwork for the Metaphysics of Morals.* Schopenhauer did not think *a priori* ethics made any sense for developing a foundation of ethics. In fact, Kantian ethics pull any sort of foundation, to use Schopenhauer’s words, out from under one’s feet:

By discarding any empirical basis of morals he rejects all inner, and even more definitely all outer, experience. He therefore establishes his moral principle—and to this I wish to draw attention—not on any demonstrable fact of consciousness. … Human consciousness, as well as the whole external world, together with all
the experience and facts therein, *are swept from under our feet*. We having nothing on which to stand.75

According to Schopenhauer, human consciousness and human phenomena need to play a role in ethics. If one removes all elements of human experience, consciousness, thinking, and feeling, then one's proposal for ethical theory lacks any validity. After all, one is doing moral reflection to form the moral life of people, so how does it make sense to excise lived reality from ethical theory?

Schopenhauer wants ethics to explain and trace the varied behavior of humans. Here he takes head on the issue of self-love and other-love, framing it as egoism and ill-will versus loving-kindness and justice. Loving kindness and justice stem from a complete lack of egoistic motives, and they are “the criterion of an action of moral worth.”76 Compassion is one form of loving kindness is where all the criterion of moral worth are fulfilled, for it is in acts of compassion that one is focused completely on “the weal and woe of another . . . [and] requires that I am in some way identified with him.”77 Schopenhauer, however, avoids over-identification with another and a loss of the self in compassion: “. . . at every moment we remain clearly conscious that he is the sufferer, not we; and it is precisely in his person, not ours, that we feel the suffering.”78 But what does this add to the conversation on empathy and neighbor love? In empathy, it is important to maintain a distinction between the feelings in the self and the other’s

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76 Ibid., 140.
77 Ibid., 147
78 Ibid.
feelings. Schopenhauer stresses this distinction—a distinction that touches on loving the neighbor as they want to be loved in their own unique and holistic way. He has taken Hume’s benevolence and added differentiation between the self and the other.

Summary

There are some very clear and helpful threads in Schopenhauer and Hume’s thinking that point to how neighbor love helps us to love the neighbor as they want to be loved. In line with Hume’s locating of morality in the sentiments, benevolence, and approbation, Schopenhauer critiques reason and a priori methods as the foundation of ethics and stresses the importance of compassion and other-love as the ground of the moral life. One can see this in his emphasis on compassion and connecting with the suffering of other humans. We also see a crucial distinction taking shape in their thinking: the distinction between the suffering of another and our own suffering. For Schopenhauer in particular, we are identified with the suffering of others, but are at the same time it is the suffering of others and not our own suffering. Hume does not make as strong a statement as Schopenhauer. He does, however, draw a subtle line between the subject and the object of approbation or disapprobation. Compared to the my-neighbor-is-another-me of Aristotle and Aquinas, Hume and Schopenhauer’s distinctions between self and other demonstrate the recognition that there are differences between the self and the neighbor. The needs and hopes of our neighbor may not be the same as our own. Hume and Schopenhauer also make the case for emotion’s role in making moral claims. It is our feelings of approbation and disapprobation towards something that impacts whether we think something is right/good or wrong/bad. It is in our compassion—when we are focused on the suffering of others in acts of loving kindness—that we find ethics.
Feelings are part of how we make moral claims and act morally.

Specifically in difficult EOL ethics cases, when family members and loved ones are experiencing a whirlwind of emotions around their critically ill loved one, feelings will play a large part in how a family comes to a decision about what should be done. This claim may sound too general and obvious, but I am simply trying to build a case for the role that empathy needs to play in these difficult EOL cases. The degree to which emotions impact making moral claims will be different for each person involved in the case. However, if the medical team wants to practice neighbor love and empathy, they need to take account of the specific emotional states of mind, needs, and hopes of the family members.

**Empathy: Loving the Neighbor as Neighbor**

Where does empathy come into play? The concept of empathy entered intellectual discourse in 1909 via Edward Tichner’s concept of *einfühlung*, grew in and out of favor, and has found renewed interest in a variety of disciplines such as theology, psychology, and philosophy. The rise of empathy and conversation around emotions and morality is important for the same two reasons I gave at the beginning of the previous two sections in this chapter: the role of emotions in morality and the way neighbor love gets constructed. First, compared to our previous thinkers, the role of emotions in morality is elaborated and deepened through the richness of Martin Hoffman’s psychology, Martha Nussbaum’s philosophy, and Wolfhart Pannenberg’s theology. Especially in the former two, there is a move beyond the simple assertion that emotions impact moral claims to the ways in

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79 Stueber, "Empathy" (see chp.1, n. 11).
which emotion impact community relationships and how we experience others’ emotions. Second, related to the entrance of empathy on the scene, there is the realization that it is difficult to understand the mental and emotional world of another.\textsuperscript{80} We cannot assume—like Aristotle and Aquinas, and to a lesser extent, Hume and Schopenhauer—that the other person is another version of me, and therefore it is easy to understand their world. Given the importance that emotions play in moral claims and that we cannot assume we understand the experience of others, empathy is necessary.

The contributions of Aristotle, Aquinas, Hume, and Schopenhauer in terms of love, compassion, friendship, and benevolence are important in helping EOL cases with divergent worldviews come to a resolution. Each in their own way demonstrates the ways in which our emotions have an effect on what we think is right and wrong. Healthcare workers also tend to be in their profession because they care deeply about their patients and embody compassion and love when they care for the sick. However, in spite of this deep care, there are times when the care team does not understand what the family is going through. This is why empathy is required, especially in difficult EOL situations. Not only can empathy help the medical team understand the family, but also it may help the medical team introduce more affectivity into their care. Hoffman, Nussbaum, and Pannenberg will demonstrate the continued importance of emotions for shaping moral claims and how empathy is necessary to cultivate love of neighbor as they want to be loved in these EOL cases. I will briefly introduce each of them here with an eye to

chapter five where each of them get more complete treatment in dialogue with my case study. My intent is not to give preference to psychology, theology, or philosophy. I want to place them in dialogue with each other in a way that all three of them will help to illuminate empathy’s role in helping difficult EOL ethics cases reach a resolution.

Psychology

Though there are many thinkers on which I could focus for psychology—such as Daniel Baston, Heinz Kohut, or Carl Rogers—I want to focus on the thought of Martin Hoffman and his work in empathy and moral development. In terms of the need for empathy, Hoffman makes the case for responding to the distress of another as their distress and not our distress; that is, we cannot love the neighbor completely if we love them as another version of ourselves. In terms of my thesis, his arguments demonstrate how empathy fosters neighbor love and pushes one not only to love another as thyself but as the other him- or herself wants to be loved, as well as how empathy occurs in the dialogue of care between and within the staff, families, and patients at the hospital.

His book *Empathy and Moral Development: Implications for Caring and Justice* was preceded by a key debate in moral developmental theory: the Kohlberg-Gilligan controversy. Lawrence Kohlberg is one of the seminal figures in moral psychology.

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81 Daniel Baston, “How Social an Animal: The Human Capacity for Caring,” *American Psychologist* 45, no. 3 (1990): 336-346. Heinz Kohut wrote extensively about empathy in the latter half of the twentieth century: “Empathy is not just a useful way by which we have access to the inner life of man [sic]—the idea itself of an inner life of man, and thus of a psychology of complex mental states, is unthinkable without our ability to know via vicarious introspection—my definition of empathy—what the inner life of man is, what we ourselves and what others think and feel,” quoted in Hummel, *Kohut and Empathy*, 67.

82 Seyla Benhabib, *Situating the Self: Gender, Community, and Postmodernism in Contemporary Ethics* (London: Routledge, 1992). Benhabib frames the controversy as the difference between the
Kohlberg understands moral development as proceeding through a series of stages: pre-conventional, conventional, and post-conventional. At the same time as Kohlberg was developing his theories, Carol Gilligan in *Mapping the Moral Domain* stressed that the caring capacity is equally as important as Kohlberg’s definition of post-conventional. After the debate between universal justice orientations and care orientation in moral development occurring in the 1980s, Hoffman develops his theory of moral development that includes empathy, care, and justice.

Hoffman published his theory in 2001. He tends to the dialectic between care of self and others in the development process in more affective ways than Kohlberg and begins to shed light on how children eventually develop moral imagination. Empathic

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83 William Crain, *Theories of Development: Concepts and Applications*, 4th ed. (Upper Saddle River, NJ: Prentice Hall, 2000), 155-163; and Lawrence Kohlberg, “The Claim to Moral Adequacy of a Highest Stage of Moral Judgment,” in *Moral Psychology: Historical and Contemporary Readings*, eds. Thomas Nadelhoffer et al. (Malden, MA: Wiley-Blackwell, 2010), 41-48. Kohlberg divides these even further into sub-stages (italics). In the pre-conventional stage, the child is responsive to cultural labels of good and bad but experiences them in physical terms or hedonistic ways. The punishment-obedience sub-stage means the child focuses on the physical consequences are determinative of good or bad actions. In the instrumental-relativist sub-stage personal needs and satisfaction determines the goodness of an action. The conventional stage maintains the cultural (family and social) customs and conforms to those customs. The good boy-nice girl sub-stage behavior is that which pleases others and maintains order, which is followed by *law and order* when good behavior consists of doing one’s duty and obeying laws. In the final stage, post-conventional, there is a push to determine values and principles beyond the groups holding those values. With the *social-contract* sub-stage the rights are defined in terms of individual rights agreed upon by the whole society. The *universal-ethical Principal* sub-stage aligns with self-chosen ethical principles growing out of one’s conscience with the character of universality and consistency.

84 Carol Gilligan et al., *Mapping the Moral Domain: A Contribution of Women’s Thinking to Psychology and Education* (Cambridge, MA: Harvard University Press, 1990). Kohlberg ignored non-male and non-Caucasian moral thinking. Gilligan’s affectivity and focus on care is a challenge to Kohlberg’s greater focus on reason and determining values and principles that transcend the groups holding those values. Gilligan wants to reconsider the development of adolescents and youth along the same lines she focused on women’s development in her early work. She feels that care orientations in moral development have been neglected.
distress and its development is Hoffman’s central concept. Empathy for Hoffman is the “involvement of psychological processes that make a person have feelings that are more congruent with another’s situation than one’s own.”\textsuperscript{85} Empathic distress, therefore, involves psychological processes where another’s distress stirs up distress in us, but we respond to and care for the other’s distress in a way that is congruent with the other’s situation and not our own. Empathy is a central part of developing this ability to respond to the distress of another. He elaborates on this distress and draws conclusions about caring, community, and justice. Empathic distress goes through a series of stages where he draws on object-relations theory. Tracing empathic distress from preverbal forms through sophisticated attention to subtle emotions allows Hoffman to show how empathy contributes to prosocial action. Prosocial action relates to moral internalization for Hoffman, though he never states this explicitly. Moral internalization occurs when one feels obligated to abide by one’s principles even when nobody is around, regardless of external reward or punishment. Moral internalization, \textit{qua} prosocial moral motive, is the result of combining the process of empathic arousal with one’s principles. One constructs one’s principles from a variety of places: caregivers, culture, and the social context. The overall prosocial moral structure (i.e., prosocial action) consists of one’s internalized principles (caring and justice principles), behavioral norms, rules, a sense of right and wrong, and images of one’s acts that have helped or hurt others.\textsuperscript{86}


\textsuperscript{86} Hoffman, \textit{Empathy and Moral Development}, 134.
Hoffman’s theory of empathy teaches us how people struggle, despite the best intentions, to experience another’s feelings and respond to their distress with prosocial action. He outlines how this experience is possible, but he cautions that we cannot assume our thoughts and feelings are an accurate reflection of another’s situation. We may love them as ourselves as the golden rule and the gospel of Mark instruct us to do, but it is difficult to move beyond our feelings and thoughts and love them as they want to be loved. In addition to simply stressing the importance of empathy, Hoffman’s thought will help us enrich empathy’s role in EOL consults through his principles of caring and justice, as well as his detailed construction of how we develop our ability to empathize, all of which will be elaborated in chapter five after the case study. Now, we turn to philosophy and situate Martha Nussbaum in her discipline.

Philosophy

In direct and indirect ways, philosophers have reflected on empathy and neighbor love in the twentieth and twenty-first centuries. As one example, in *Upheavals of Thought: The Intelligence of Emotions* Martha Nussbaum develops a cognitive theory of emotions and compassion. Nussbaum continues the argument that our emotions not only play a central role in how we make decisions about what is right and wrong (i.e., Hume) but also deepen this claim; emotions and compassion have intrapersonal and...

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87 I am going to neglect the line of thinking associated with David Caputo and deconstruction in his book *Against Ethics: Contributions to a Poetics of Obligation with Constant Reference to Deconstruction* (Bloomington, IN: Indiana University Press, 1993). It is not that I think that postmodernist ethics have nothing to offer my discussion. While I am providing normative guidelines for communities, normativity always needs to remain open and flexible for the ways in which it supports injustice and contributes to a rigid and static worldview.
interpersonal implications related to the formation of community. Interpreting community in this way also constructively updates Aristotle’s understanding of friendship as “something that holds states together” and “stimulates to noble actions.”\(^{88}\) While both argue for the role that interpersonal relationships play in civic life, Aristotle thought that the best friendships were between two virtuous people. Nussbaum will argue we ought to expand our understanding of community and relationship beyond class and cultural boundaries. In terms of my thesis, her arguments affirm that empathy in ethics consults fosters neighbor love; not only does empathy foster neighbor love but empathy is required and pushes one not only to love another as oneself but as the other him- or herself wants to be loved.

Nussbaum favors the concept of compassion over empathy. Compassion for Nussbaum has three components: the suffering of another must be judged severe and not trivial, we decide that the person does not deserve the suffering, and we see ourselves in the goals, values, and beliefs of the person suffering. This last element might seem selfish, but she frames it as related to vulnerability. One sees the other person as vulnerable and in need and reaches out with compassion because one knows one’s own neediness and vulnerability. She defines compassion as “a painful emotion occasioned by the awareness of another person’s undeserved suffering.”\(^{89}\) Empathy falls short of this in her interpretation, and relates only to the imaginative reconstruction in the self of another’s good, bad, or neutral experience; one does this all the while maintaining the

\(^{88}\) Aristotle, *Nicomachean Ethics*, VIII. 1155a 1-25.

distinction between the self and the other. Given this reduced definition of empathy, she
acknowledges its contribution to compassion, but prefers the concept of compassion to
empathy. Her definition of empathy is limiting. My interpretation and practice of
empathy includes a response to the distress of another through care. That is to say, my
definition of empathy is closer to how she defines compassion.

First, Nussbaum highlights the development of emotion. The development of
emotion relates to the struggle between the good-bad and shame-joy dynamic within the
self and the history of emotion in one’s life in connection to one’s caregivers.90 The
good-bad and shame-joy struggle refer to the ways in which people experience the world
as they grow and develop. Is the world a trustworthy place (good) or is it not to be trusted
(bad)? Does one feel a sense of shame or joy around their identity and their aspirations?
Second, the expansion of empathy, emotion, and compassion impacts the public sphere in
terms of the ways it contributes to building a community. Simply put, empathy and
compassion cultivate relationship and relationships help build community. For a western
liberal democracy, the dynamics of empathy (and compassion for Nussbaum) and

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90 These struggles and joys are what form morality, as we saw with the sentimentalists in the early
modern period. Jesse Prinz, already mentioned in the introduction, is a contemporary sentimentalist and
updates Hume’s theory in Emotional Construction of Morals (ch.1, n. 22). Per Prinz, because the basis of
moral philosophy lies in the sentiments and emotions, moral facts require the response of disapprobation or
approbation. As a critique of the categorical imperative, there is no universal law separate from human
experiences that one can call moral (Right does not exist separate from one’s response). These two
presuppositions lead Prinz to make three claims about the relationship between emotions and moral
judgments: emotions co-occur with moral judgments, emotions influence moral judgments, and emotions
are necessary for moral judgments. Though Prinz clearly favors the passions side of the reason-passion
debate carried forward from the Enlightenment period, he mentions very little about intersubjectivity and
the role of community in the moral reasoning process. He focuses his arguments on how the moral
decision-making process happens within individual bodies, brains, and minds. This lack of focus on
intersubjectivity and community are a deficit in his theory; the very argument he makes against the ability
of reason and rationality to independently guide someone through the moral decision making process could
be leveled against him for not giving credence to the communal nature of such decisions.
interpersonal relationships contribute to a flourishing society. In order for our emotional life to fully develop and for communities to flourish, empathy is necessary to bridge the gap between people so that people can truly care for each other and help each other flourish.

Theology

Hoffman highlighted how empathy helps us respond to the distress of our neighbor through the lens of the neighbor and not our own, and Nussbaum argued that emotions impact the development of our entire worldview and explained how empathy (i.e., compassion) can create a flourishing society. We now move to theology. There are many great theologians in the twentieth century: Karl Barth, Paul Tillich, Margaret Farley, Jürgen Moltmann, and Emilie Townes, to name a few. Many of these authors have focused on justice, ethics, and neighbor love in their writings. I will be focusing on the thought of one theologian in particular: Wolfhart Pannenberg. He moves the discussion into an area only briefly explored in the introduction, that is, how I think about God’s presence and action in the midst of empathy. He elucidates and provides a theological perspective on empathy that occurs in the dialogue of care between and within the staff, families, and patients at the hospital where we can think of God as present, moving people to love others as they want to be loved in the midst of diverse ethical worldviews.

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91 Benhabib states it in the following way: “Individuals do not have to view themselves as encumbered selves. It is not necessary for them to define themselves independently either of the ends they cherish or of the constitutive attachments, which make them what they are. In entering practical discourses individuals are not entering the original position [of John Rawls]. They are not being asked to define themselves in ways that are counterfactual to there every day identities, and individuals do not stand behind a veil of ignorance.” Benhabib, *Situating the Self*, 73.
When thinking theologically about empathy, it is important to be in dialogue with the human sciences. Wolfhart Pannenberg’s methodology reflects this approach, especially in his *Anthropology in Theological Perspective*. Pannenberg develops his anthropology through the concepts of human becoming, exocentricity, centrality, and basic trust of social relationships. Social relationships and the accompanying emotions are central to the interpretation of the *imago dei* for Pannenberg. The core of his anthropology addresses loving oneself, loving the neighbor, and loving God as part of being human and the *imago dei*; this is grounded in the premise that “the existence of human individuals is determined by social relations.”

I will briefly summarize how he arrives at this claim and expand on it later. He begins with a “methodological abstraction” in order to clearly articulate “the main structural features of the human form of existence with its centrality and exocentricity.” This is how God the creator created humans. Centrality is the inability of humans to step outside of themselves and reflect on their feelings, thoughts, and actions; people remain focused only on themselves. Exocentricity is the ability to be open to the experiences of others and to step outside of oneself and one’s experience. These two concepts are at the heart of how people relate to, and thus empathize with each other. It is in moments of exocentricity that we are able to love our neighbor honestly, truly, and as a unique person. I will argue that centrality illuminates the struggle for empathy and exocentricity illuminates the possibility of empathy in EOL situations. Pannenberg then turns his attention more explicitly to a consideration of centrality and exocentricity in light of the

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93 Ibid.
“social context of human behavior.” The social context and its relationships is a place where people experience God and their full personhood. He particularly wonders, “is the social world perhaps the place where [humans] exocentric destiny is achieved and therefore also the place where their identity as subjects and persons is established?”

Pannenberg boldly pushes forward to make the case that “the I, or ego, does not simply stand as an independent entity over against the Thou . . . rather, the ego proves to be dependent on its social context for the determination of its identity.”

God created humans to be in relationship and one’s identity is only fully realized in relationship with others.

In, under, and through this social context—for us the family, the medical team, and the hospital—we can think of God as present calling us to greater empathy with those in distress. Pannenberg’s ideas will help illuminate why it is that people struggle to empathize and why empathy is a natural part of being human, our struggle with centrality and exocentricity. It is the dynamic of centrality and exocentricity within all of us that hinders us and allows us to be open to the needs and distress of another and cloud that distress—love our neighbor as they want to be loved and not love them as ourselves.

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94 Ibid.

95 Ibid., 164.

Looking Ahead

Hoffman, Nussbaum, and Pannenberg develop their paradigms as part of a long history of thinking on empathy and emotions. Hoffman provides insight into the ways in which people care for one another during times of distress, Nussbaum highlights how emotion is part of the fabric of our society and how it can contribute to human flourishing, and Pannenberg both stresses that God created us in such a way that we are determined by our social relationships and that we experience God’s love through these relationships. Though all three share a great deal with Aristotle, Aquinas, Hume, and Schopenhauer, these three will be the focus from this point forward.

These contemporary thinkers have continued arguments from the past on the importance of emotion, and added new flavors with the ways in which they support the need for empathy. First, the emotions and the affective life provide a foundation for how we respond to the distress of others and how we develop our worldview as a place of trust or mistrust. Second, emotions and empathy are not only part of how we develop a worldview, but they are also part of how we develop relationship and build community. Third, loving our neighbor in such a way that honors their unique and distinct personhood is how I define loving the neighbor as they want to be loved. We cannot assume the other is another version of ourselves; not only is it important to understand others as distinct from ourselves, but also empathy is required to bridge this divide. Fourth, we can think of empathy and loving the neighbor as they want to be loved as the presence of God. From his theological vantage point, Pannenberg states that we are created by God and created in such a way that we are determined by our social relationships. Not only are we determined by these relationships, but the trust, love, and care we experience in these
relationships is God working through and within creation. Further, because we are determined by these relationships God also calls us to this life of empathy. As we are empathized with so to we must empathize with others.

Hoffman’s, Nussbaum’s, and Pannenberg’s insights into empathy and neighbor love will be the heart of the practical moral reasoning move. In the practical moral reasoning move, I will be interpreting these insights and then defining empathy so as to construct normative guidelines for hospitals in difficult EOL ethics situations that overemphasize empathy. As the reader can imagine, this is because of what I interpret to be a lack of empathy in clinical ethics and EOL care.

Before arriving at that move, we first need to make a couple of stops: methodology and the descriptive move. The methodology proposed in the next chapter will act as a template for interpreting the rich paradigms of our three aforementioned thinkers. The methodology may add another layer onto an already dense group of theorists, but it is necessary that we take a journey through method because it is how I will be interpreting the thinkers in the practical moral reasoning move. I want the reader to be aware of my methodology. There is indeed a method to my madness, at least this time. If the reader takes nothing else away from the following chapter on methodology, the reader should heed the section titled “intercultural practical moral reasoning” (IPMR). My methodological musings on practical moral reasoning are the heart of the template I will use in chapters five through seven aptly named the intercultural practical moral reasoning move chapters.
CHAPTER THREE
METHODOLOGY: REVISED FUNDAMENTAL PRACTICAL THEOLOGY

My methodology, revised fundamental practical theology, is made up of Don Browning’s fundamental practical theology tempered with Emmanuel Lartey’s intercultural pastoral theology. The structure of Browning’s fundamental practical theology is four-fold: descriptive theology, historical theology, systematic theology, and strategic theology with practical wisdom influencing each part of the process. Within this structure, there is a strong emphasis on theological ethics in the middle two sections. Browning’s focus on ethics and his movement from description, to reflection, and lastly to strategy is well suited for my purposes of exploring empathy and an ethic of neighbor love in order to provide normative guidelines of practice for communities. Lartey’s focus, as I hinted at in the introduction, is on intercultural pastoral theology. He takes into account the global context in which theologians do their work and how, in the midst of this global context, purveyors of care need to account for the Other and listen to the needs of the Other. Browning’s practical moral reasoning is sometimes detached from lived reality, and Lartey’s attention to the Other will help connect Browning’s practical moral reasoning to a lived reality such as the case study of the following chapter.

Practical Theology

There are many methodologies from which one could choose when analyzing the ways in which empathy cultivates neighbor love in EOL ethics consults. Why did I
choose practical theology? EOL ethics consults and clinical ethics are inherently practical: the medical team and family work through a decision making process, there is attention to the day to day observations of the patient’s condition, and the lifestyle and quality of life implications of particular plans of care are considered. As a chaplain concerned with empathy’s role in EOL ethics consults, I find that practical theology provides a framework to explore this. Practical theology focuses on a rich description of practices, relationships, beliefs, and values. We will see this in the descriptive move of chapter four’s composite case about an EOL situation in a hospital.

Given that practical theology provides good scaffolding, what must practical theology accomplish in this dissertation? In answering this question, we will begin to understand some of my revisions to Don Browning’s practical theology. First, practical theology must begin with the practice of people and communities; practices and the lives of people must be a starting place for theological reflection. Not only does there need to be a framework that favors practices, but there needs to be a rich description of practice—in my case, an EOL ethics consult or patient story. Narrative detail of people’s lives is important and any methodology that does not attend to narrative detail is not adequate. The description of practices is not the place to include sociological, philosophical, or theological interpretations of what one is describing because these can place a pre-existing framework on the narrative of a community. Second, practical theologies must incorporate the divine reality along with the social sciences. I adhere to an interdisciplinary model of the revised critical correlational method. 97 I will say more

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97 Historically in the United States there has been a division in practical theology between correlational and transformative methodologies. The former, to which I adhere, sees the dialogue between theology and the social sciences as a mutual dialogue. The latter views the dialogue as one of asymmetrical unity with theology having ultimate influence. For a good summary see Richard Osmer, Practical
about this method below in the IPMR move. For now it is important to note that in correlational methodology, when approaching a question such as “how does empathy play a role in EOL ethics consults?” one turns to the social sciences and theology for understanding the issue or question and treats these disciplines as equals. I will incorporate the questions and answers of the social sciences and theology equally as I explore this question. My Lutheran theology provides some insight into what I mean by “the divine reality.” Lutheran Eucharistic theology focuses on the real presence of God in the elements of bread and wine. Neither are the bread and wine transformed into the body and blood of Christ, nor is there a mere spiritual presence with the bread and wine. The bread and wine remain bread and wine, and they are the body and blood. In all of my practical theological or social scientific musings, I understand God as presence. I see the social sciences and theology as description, interpretation, and exploration of God’s world. In all of these descriptions, interpretations, and explorations God is present. The experiences and interpretations of those experiences are not transformed into the divine nor are they merely materialist. They are inherently sacred and God is present because God is part of, connected to, and reflected in creation. Third, normativity has a place in

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98 My theological claim comes from many sources but primarily from my interpretation of natural law supported by Pannenberg. Parenthetical citations refer to the volume and page number of Pannenberg’s systematic theology. First, Thomas Aquinas is the father, so to speak, of natural theology. Natural law is part of the divine providence since it is given by God. There is an internal law of the universe, and this eternal law is what rationally orders creation and the world. It is this the turn a law that rationally orders creation that is natural law. Humans participate in this eternal law by which God rationally orders the universe. Because of humankind’s participation in the eternal law, natural law is part of practical rational thinking. Given this, humans are both bound by natural law and natural law can be known by all humans. Humans are bound by natural law because we participate in the eternal law that rationally orders creation and naturally directs humans’ pursuit of the good and the trajectory towards the good. Second, Pannenberg wants to rework the traditional understanding of natural law. “By nature, from creation, God, the God of the apostolic gospel (Rom 1:19-20), is known to all people” (1:107). For Pannenberg, this is a statement made about us in light of the revelation of God in Jesus Christ. He is trying to reinterpret one of the
foundational natural theology biblical texts as a combination of revelation and echoes of stoic natural law—a both/and approach; natural law is imputed to us externally and internally. Aquinas felt God was mediated by the things of the world via the senses and we are implanted innately with such knowledge; Luther and Melanchthon emphasized that there is an inborn rather than acquired knowledge of God because of their mistrust of human reason. And though Paul’s text has space for an innate and acquired (experience and rational reflection) knowledge of God, the Romans passage seems to show a preference for the innate. Given this innate knowledge, how does one explain human action and choices? Pannenberg says it in the following way: “From the life of feeling in which it is rooted there develops in the conscience a nonthematic relation to the totality of life in which subject and object—world, God, and self—are as yet undifferentiated. This type of feeling and feelings corresponds to the estatic rootage of the early individual development of the child in a symbiotic sphere which in the first weeks of life binds the child to its mother (and the world at large) without any conscious distinction from the mother. In the emotional life the symbiotic relation to the world in the early stages of individual life finds a kind of continuation. Differentiation of the at first undistinguished dimensions of God, world, and self is a product of the cognitive development of the child, of experience of the world and reflection on it, though a nonthematic self-relation is present already in the quality of feelings as desire or non-desire. … Only with the process of cognitive development and differentiation may objects of trust be distinguished, and choice becomes possible (1:112-113). Pannenberg believes that once we are able to differentiate between subject and object—world, God, and self—we can become aware of God: “Only in the process of experience, as we achieve distinct knowledge of finite things and the finitude of the self, do we attain to an express awareness of the gods and God” (1:114). In terms of Luther’s exposition of the first commandment, only with experience do we learn what true objects of trust are, i.e., what it means to have a God. The non-thematic awareness of God can lead to “false gods,” but experience thematizes the non-thematic and we can make a proper distinction. Through the non-thematic and thematic experience of creation, all people know God; this is both innate in a non-thematic way and becomes thematized because this sense is ultimately “the religious experience of God by means of a sense of the working and being of God in creation” (1:117). Pannenberg is, therefore, afraid that natural law, because natural law was equated with the eternal triune God that orders creation rationally, will limit God and denies freedom to the gospel message and the gospel itself. Thinking of God at work in creation is crucial, but we cannot limit the workings of God to our understanding of the natural order. The essence of God for Pannenberg is Trinity, and the Trinity is love, a love resonating in the relationship of the son, father, and Holy Spirit. Thus, when it comes to natural law and God’s will for the world, Pannenberg sees this as love. God’s will and essence are love. Love is what spontaneously breaks open the world to creative potentialities and new possibilities. The natural law of the universe for Pannenberg is love, and not a rationally ordered creation in which humans participate based on their pursuit of the good. One should pursue the good through the spontaneous fruits of the spirit, the spontaneity with which God enlivens creation (3:80-95). God’s enlivening, so to speak, of creation takes place via a process of dual causation. I am positing the existence of God as the energy and/or substance of our universe on both micro- and macroscopic levels. Using a theory of bottom-up and top-down causation, one can think of God as enlivening the universe with love. God is active on the particle level up to the whole person and community in such a way that breaks open the world to the possibilities of love (2:115-116, 193-197). The reverse is also true. God is part of larger systems that cascade from the top down to immerse people and communities in love. Enlivening creation is the dual causation process that pushes people to love the neighbor. See Nancey Murphy and Warren S. Brown, Did My Neurons Make Me Do It?: Philosophical and Neurobiological Perspectives on Moral Responsibility and Free Will (New York, NY: Oxford University Press, 2007); Wolfhart Pannenberg, Systematic Theology, trans. Geoffrey Bromiley, 3 vols. (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1991-1997); and Mark Murphy, “The Natural Law Tradition in Ethics,” The Stanford Encyclopedia of Philosophy (Winter 2011 Edition), Edward N. Zalta (ed.), http://plato.stanford.edu/archives/win2011/entries/natural-law-ethics/.
practical theology. Practical theologies cannot stop at description and interpretation. These moves must point to what should be or ought to be the case in a given context. In this dissertation, I will not stop at a description of an EOL case and my interpretation of empathy’s role in that case. I have already stated that empathy should be part of EOL consults, and I will push this further and provide normative guidelines for making empathy a regular practice in EOL consults.

The methodology in this chapter addresses these three accomplishments, so to speak, for practical theology. I will parse out my methodology in the following way. First, I will summarize Larney’s intercultural model that will soften, in my interpretation, the rationalism of Browning’s model. I present Larney first so that the reader will carry his focus on the Other into my revisions of Browning’s model that I call “revised fundamental practical theology.” Second, I will describe this revised model. My revised model will carry Larney’s focus on the Other and will have descriptive, intercultural practical moral reasoning, and strategic moves. The reader should focus her or his energy on the intercultural practical moral reasoning move, because it is with this move that I will interpret Hoffman, Nussbaum, and Pannenberg in chapter five.

**Larney’s Intercultural Model**

Larney draws on the philosophy of Emmanuel Levinas to bring attention to the Other and adds his own interpretation of context. For Larney contexts are always a melding of experience and inherited philosophies. The latter speaks to how people are molded and shaped by the worldview, social norms, and relationship patterns of place into which they are born. The former speaks to how experience can reframe and alter the norms of a given context. Larney adds a focus on the voice and experience of the Other to
Browning’s model. In focusing on the Other, we can let the Other’s feelings and thoughts stand on their own—in my words, love them as they want to be loved by walking alongside them. With these thoughts in mind I will explain Larney’s intercultural paradigm as he describes it in *Pastoral Theology in an Intercultural World*.

**Pastoral Theology as Contextual Theology**

At the outset, Larney claims, “Contextual analysis can be understood as a way of discerning and seeking to hear what God may be saying out of the different exigencies of the human condition in different contexts.”99 The accent is on hearing or listening to another voice or context and not speaking at or to that context so as to silence it. Though he describes what pastoral theology is in Western and non-Western contexts, various contexts of pastoral theology that are non-Western are explored to highlight what God might be saying in different contexts.100 Cultural, political, economic, and religious factors are considered in individual, communal, contemporary, and historical ways as well as how the former factors interact in diverse ways through the latter.

According to Larney, there are three different processes at work as one explores pastoral theology in different contexts: globalization, internationalization, and indigenization. These terms represent a continuum moving from very little to greater acknowledgement of the value of non-Western pastoral theologies. Globalization is an economic term, but theological globalization occurs when models and practices of

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99 Larney, *Pastoral Theology*, 42.

100 The Western and non-Western is a dichotomy practical theology, and all other fields of religious and non-religious inquiry, can do without. Defining various practical theologies as non-Western always defines them in relation to a Western worldview instead, as Larney seeks to accomplish, letting them speak on their own terms. I would prefer Anglo- and European American to Western.
Western pastoral theology are “imported” into other countries with little or no change in their function.\footnote{Lartey, \textit{Pastoral Theology}, 44.} Internationalization takes places when Western and non-Western theologies are in conversation with each other while pastors and theologians try to develop a pastoral theology that is more authentic for a particular context. There is equal regard for both types of pastoral theology as creative approaches are sought for the non-Western context.\footnote{Ibid., 46.} Indigenization, as the last item in the continuum, attends to the non-Western context to the greatest degree. Western theological and social scientific paradigms are jettisoned in favor of local practices focused on healing for individuals and communities. As contextual pastoral theology is sought, theologians need to be aware of the Western influence (globalization and internationalization) and at the same time “to press forward to touch those beliefs and practices that originate within the culture they work.”\footnote{Ibid., 47.} Briefly—though Lartey elaborates in detail on Asian, African, Western, and the Latin American contexts—some of the practices and beliefs in non-Western contexts to which one needs to attend are as follows: Asian understandings of community, the self, and goodness (i.e., \textit{hiya}, \textit{jen}, \textit{li}); African spiritual ontology and relationality; and Latin American colonization by and reinterpretations of Protestant and Roman Catholic theology.\footnote{Ibid., 55, 63, 66.} The local and the global interact in any context, and as pastoral theology is practiced in any context, it is embedded in and requires responses based on the political, religious, and cultural context.
Highlighting different cultural contexts of pastoral practice does not preclude making claims about common human experience. Human experience, no matter what context in which it takes place, has some commonalities and can speak across cultures.\textsuperscript{105} There is a balance in Lartey’s model between the otherness of another culture and the common human experience: “However, the best way to do [contextual pastoral theology] is to listen deeply, and with empathy and interpathy\textsuperscript{106}, to the experiences of others from distinctly different contexts without seeking to subsume them into their own.”\textsuperscript{107} As we listen to the Other in their otherness, there is an intersubjective connection in our common humanity across different cultures. It is to the concept of otherness to which we now turn—a way to hold onto our common humanity in encounters with another but to honor and let another culture speak at the same time.

Attention to context will be in the background as we move through the case study and the three thinkers in the following two chapters. Lartey’s focus on context pushes the medical team to attend to the context of the family, whatever it may be. What sort of worldview is operative for the family? What is the story of their family up to this point? When the medical team asks these sorts of questions of themselves, it will help them empathize with the family.

\textsuperscript{105} Ibid., 71.

\textsuperscript{106} Lartey provides the following definition of interpathy: “David Augsburger coined the term \textit{interpathy} to refer to ‘an intentional cognitive envisioning and affective experiencing of another’s thoughts and feelings, even though the thoughts rise from another process of knowing, the values grow from another frame of moral reasoning, and the feelings spring from another basis of assumptions.’ (Pastoral Counseling Across Cultures, Philadelphia: The Westminster Press, 1986, p. 29). This ‘other’ comes from another culture, has a different worldview, and operates often with a different epistemology.” Ibid., 152. I do not think it is necessary to come up with a different word than empathy when describing deep listening in intercultural encounters.

\textsuperscript{107} Ibid., 71.
Pastoral Theology at Work in the World

Within the various contexts there are different models of pastoral theology at work: classical-clerical, clinical-pastoral, and communal-contextual. To these three Lartey adds a fourth newly emergent model: intercultural. Similar to the communal-contextual model, the intercultural model expands the community to the global community. In the global intercultural community, there are many voices speaking and needing to be heard. More important, however, is resisting totalizing pastoral theology models and favoring plurality, fragmentation, and pluriformity. This approach involves listening to and speaking from many different voices; it rejects both complete relativism and utter absolutism. It is in the intercultural model and its pension for plurality that Lartey finds a place to focus on the Other.

Lartey draws on Emmanuel Levinas to develop a philosophy of relationship in the encounter with the Other. Levinas uses the terms Self and Other to define his paradigm. Per Levinas, rather than trying desperately to know the Other like one knows the Self, one should accept that one cannot and should not know the other. In fact, one desires to protect the Other from the appropriation of the Self. Some sense of cultural distance and epistemological humility are important in encounters with others. Lartey quotes Levinas:

The Other is in no way another myself participating with me in common existence. The relationship with the other is not idyllic and harmonious relationship of communion or sympathy through which we put ourselves in the

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108 Lartey provides a good summary of each of these models, but for a more complete summary, one should look at David Patton, *Pastoral Care in Context: An Introduction to Pastoral Care* (Knoxville: Westminster David Knox, 1993).


110 Ibid., 134.
other’s place; we recognize the other as resembling us, but exterior to us; the relationship with the other is a relationship of Mystery.\textsuperscript{111}

Lartey does not elaborate on the “resemblance,” but resemblances could be things like recognizing the other as human, learning about cultural similarities or life experiences, or maybe sharing a spiritual or religious tradition. Even though the Other resembles the self, it is still an encounter of mystery. Encountering the mystery of the Other puts the Self’s freedom and power into question, but it is the limiting of one’s freedom that provides for experiences of truth and what Levinas calls ethics. Ethics begins in an open dialogue with the other as one limits the Self and opens to one’s obligation to the Other. Obligations are entertained because one is not trying to subsume the other into the self.\textsuperscript{112} In dialogue grounded in ethics—ethics defined as obligation and openness to the Other—one experiences truth. Experiencing truth as a dialogue with the other acts against notions of truth discovered in isolation from others.

The medical team and family enter these dialogues of truth discovery—difficult dialogues when people do not agree on what should be done. The medical team has and feels an obligation to the family and their loved one. I would add an obligation of openness to the Other. As a chaplain, for me it is important that the family is not subsumed into the medical team and the family is allowed to stand on their own. The medical team, including the chaplain, must seek to hear the values and beliefs of the

\textsuperscript{111} Ibid.

\textsuperscript{112} This model seems to require a strong sense of self as well. Letting the Other be Other is not merely about overly egoistic models of aggression directed at the Other. Without a strong sense of self, a strong sense of the ego, one will not be able to treat another as Other for one will be too weak. There is just as much danger as one becoming the Other as imposing the Self on the Other, both of which could happen due to a lack of ego strength.
family without molding those values and beliefs in the image of the medical team. As we move into my revisions to Browning’s paradigm, Larney’s focus on the Other will impact not only how I revise his overall paradigm but also how I shape each of my moves.

Revised Fundamental Practical Theology

Theoretical Framework

Before we get to the specifics of my descriptive, IPMR, and strategic moves, we need to frame Browning’s model and his reliance on practical moral reasoning. Three central ideas drive Browning’s championing of practical moral reason: hermeneutics and the overall dynamic of *phronesis* (practical moral reasoning); the outer envelope of the visional dimension; and the inner core of the obligational and tendency-need dimensions. First, hermeneutics constitutes the overall dynamic of the process, as *phronesis* entails reinterpretation(s) of practice; I will say more about this in the section below. Second, composing the outer envelope and the inner core, his process of practical moral reason interprets the “fund of inherited narratives and practices. . . . Mediates between our theories of the pre-moral good . . . [and] provides implicit or explicit theories.

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113 Aristotle, *Nicomachean Ethics*, VI 7: “Prudence [phronesis] on the other hand is concerned with the affairs of men, and with things that can be the object of deliberation. For we say that to deliberate well is the most characteristic function of the prudent man; but no one deliberaates about things that cannot vary nor yet about variable things that are not a means to some end, and that end a good attainable by action; and a good deliberator in general is a man who can arrive by calculation at the best of the goods attainable by man. [7] Nor is Prudence a knowledge of general principles only: it must also take account of particular facts, since it is concerned with action, and action deals with particular things. . . . And Prudence is concerned with action, so one requires both forms of it, or indeed knowledge of particular facts even more than knowledge of general principles. Though here too there must be some supreme directing faculty.”

114 Browning, *Fundamental Practical Theology*, 10.
and hierarchies about the pre-moral goods of life that must be morally organized.”\textsuperscript{115} The outer envelope comprised of the visional dimension speaks to the core values of various cultures and communities—the principles that define life and what are the goods of life. The inner core of the obligational and tendency need dimension looks at how a community decides what they are obligated to do in light of their principles and definitions of the good. I will parse out the envelope and core in greater detail below. The overall dynamic, outer envelope, and inner core can be seen as concentric circles moving toward the inner core of practical reason. I will move through these in that order, but the latter two will be elaborated in my IPMR.

**Overall Dynamic: Hermeneutics**

The overall dynamic of Browning’s *phronesis* relates to hermeneutics. There are two main features to Browning’s hermeneutical paradigm: his use of Hans-Georg Gadamer’s method and his revisions to this with revised correlational method of interpretation (inherited from Paul Tillich and David Tracy). The revised critical correlational method is part of his practical moral reasoning. As Browning applies moral reasoning to each step of his practical theology paradigm, hermeneutics is at work within each phase of the reasoning process and within each step of his practical paradigms.

Hermeneutics is a process of interpretation. There are, however, many hermeneutical models espousing different processes of interpretation. Per Browning, hermeneutics is a conversation, and it is the idea of hermeneutics as conversation that is

\textsuperscript{115} Ibid., 10, 105-107.
embedded in each level of the practical moral reasoning process.\textsuperscript{116} The Enlightenment stressed the improvement of society through an increase in objective knowledge, which was applied to the human experience in order to achieve understanding. Hans-Georg Gadamer’s philosophy questioned this model and emphasized the importance of experience in making philosophical propositions or truth claims. All disciplines are structured as a dialogue between our commitments (pre-understandings developed through experience) and the process of understanding any kind of human action.\textsuperscript{117} Pre-understandings or commitments are, in fact, an important part of the process of understanding, as one can only understand something in relation to oneself. The self includes the experiences and beliefs one brings to the task of understanding and interpretation. The conversation takes place by taking our pre-understandings to the task of trying to understand any human action. The human action or experience then “speaks to” and changes our pre-understandings. Understanding as a conversation has moral implications for Browning and Gadamer:

> The hermeneutic process aimed at understanding any kind of human action—a classic text, work of art, letter, sermon, or political act—is like a moral conversation, when the word moral is understood in the broadest sense. . . . Understanding is a moral conversation shaped throughout by practical concerns about application that emerge from our current situation.\textsuperscript{118}


\textsuperscript{117} Browning, \textit{Fundamental Practical Theology}, 36-39. Gadamer would call this effective history: the events of the past shape the present worldview. One could apply this to individuals and communities. The events of an individual’s past shape her or his present consciousness just as the history of a community impacts the individual and community’s actions.

\textsuperscript{118} Ibid., 39.
Browning is acknowledging that the process of answering the primary question is a hermeneutical process. Practical moral reasoning involves allowing one’s moral commitments to speak to, but not rigidly determine, the process of interpretation and understanding. Experience and pre-commitments shape the moral reasoning process as much as one’s understanding of theory does.

One can see how Browning begins to develop his moral hermeneutical paradigm—never allowing either human experience or philosophical theories to completely control the process of moral understanding. In light of his understanding of Gadamer, Browning’s hermeneutics includes a revised correlational method of theology. A revised correlational method creates a conversation between Christian theology and experience, never allowing there to be a pure uninterrupted human event or theological statement.\(^\text{119}\) Christian thought and experience provide the answers and questions for each other. Browning’s model is a reshaping of Paul Tillich’s correlational method and David Tracy’s critical correlational method.\(^\text{120}\) Broadly speaking, Tillich’s model states that the church’s answers must correlate with the questions arising out of individual and communal experiences. Tracy grants that Christians bring the primary question and other understandings to the Christian classics. In this respect Tracy is following Tillich. Tracy sees a richer correlation taking place, however. There is a critical correlation and conversation between the questions and answers of the Christian classics and the questions and answers of human experience and culture. Theology, in the paradigms of

\(^\text{119}\) Browning, Religious Ethics, 50.

Tillich and Tracy refers to the history of theological writings and biblical texts. Finally, Browning revises this by making practice (not texts) the fundamental starting point of theology. If we place the revised critical correlational approach in a moral hermeneutical process, then one would say the primary question that arises out of practice guides the moral questions and answers of Christian thought that are in conversation with the moral questions and answers of culture and human experience. For example, in a difficult EOL ethics case, Tillich’s method would provide theological answers to the questions of the medical team and family; Tracy’s method would include a conversation between the theological questions and answers that address difficult EOL cases, and the questions and answers about EOL from the experiences of medical team and family; and Browning’s method would say that the questions and answers of theology, the medical team, and the family are not two separate camps divided between theology and the experiences of the medical team and family. Theology’s role in difficult EOL ethics cases is intertwined with the experiences and practices of the medical team and family, as well as providing insight from the history of theology and biblical texts.

Intercultural Practical Moral Reasoning and Empathy

One may be wondering how all of this relates to our case and empathy. I will describe Browning’s revised correlational approach and its dependence on hermeneutics to guide each step of the practical moral reasoning process tempered with Lartey’s pastoral theology from earlier, all the while pointing to the case in the next chapter. Browning’s complex method and way of interpreting theology lay the foundation for his praxis-theory-praxis thinking and his use of practical reason. The hermeneutical process and revised correlational method explained above are the overall dynamic of practical
moral reason. What follows relates to the outer envelope (the visional/metaphorical level) and the inner core (obligational and tendency need levels) of my practical reason move. The concepts of the outer envelope and inner core need more explanation. The outer envelope relates to the metaphors that arise out of a community’s worldview that shape what they think to be right. The inner core needs this outer envelope to surround it, so to speak, to provide a framework for how obligations as well as human tendencies/needs are defined.

Browning has two more levels to his moral reasoning (environmental-social/ego development and rule-role) but gives them minimal treatment in either of his works under consideration. In the concluding chapters of my dissertation, I will address the outer envelope and inner core in the context of providing guidance for communities facing ethical dilemmas.

Visional/Metaphorical Dimension

Narrativist approaches to ethics lead to Browning’s development of the visional dimension of his practical moral paradigm. The types of reasoning and rationality espousing universal principles, such as Kant’s categorical imperative, are rejected. In narrative ethics, the stories and narratives shaping a community’s or individual’s life and values receive pride of place. Out of the narrative tradition in ethics, there arises a visional/metaphorical dimension. When trying to decide what should be done in a particular case, as in our EOL case in the following chapter, the values and beliefs articulated within the paradigmatic stories of our lives shape how we make decisions.
The visional and metaphorical level is the outer envelope of practical reason and is driven by the question: how do religious-cultural and metaphors support and cohere with moral intuitions and what people think to be morally right?\textsuperscript{121} I will direct this question at Hoffman, Nussbaum, and Pannenberg; the visional/metaphorical level will reflect on how their respective religious-cultural metaphors shape their understanding of neighbor love and empathy. The insights gleaned from this interpretive level will help shape elements of my guidelines that argue for the necessity of empathy from the medical team at the EOL. The religious and cultural metaphors of our thinkers, and many members of the medical team I imagine, cohere with an intuition that empathy in EOL situations is right.

We think from a foundation of metaphors, and these metaphors have a moral quality to them as they impact thought processes and one’s actions.\textsuperscript{122} The metaphors we use to represent the ultimate context of experience function to orient us toward that context. While we explore the metaphors of Hoffman, Nussbaum, and Pannenberg, Lartey’s stress on preserving the otherness of the Other and listening to the Other will help us to question the Other’s presence within their respective paradigms. No matter what religious and/or cultural tradition percolates within and around the Other, the Other can carry different ultimate metaphors.

\textsuperscript{121} Browning, \textit{Religious Ethics}, 62.

\textsuperscript{122} Browning, \textit{Fundamental Practical Theology}, 105.
Obligational Dimension

For Browning, the next two levels represent the inner core of practical moral reason. This inner core arises out of two main threads of ethical thinking in the history of Western ethics. First, in teleological ethics one is obligated to follow a rule that produces at least as much good over evil as any alternative. Good is defined in a non-moral (or possibly pre-moral) way such as food, shelter, transportation, human potentialities, or intimacy. There are two main threads within teleological ethics: ethical egoist and utilitarian (act and rule). Ethical egoists are concerned about the most good for the self. Utilitarians are concerned about the community, and can be divided into those who focus on performing the act that leads to the most good or on following the rule that does. The second main strand in western ethics is deontological ethics. Per this model, an act is morally right because of its nature independent of a drive toward the most good or happiness. Teleological approaches, in Kant’s paradigm, are too enmeshed with human wants and desires to be trustworthy. Teleological and deontological ethics are the two main threads on which Browning draws to develop his second movement in practical moral reasoning.

The teleological and deontological threads relate to the obligational level by helping to define how the visional metaphors become obligations. An obligation can be coupled with any number of visional metaphors, and in this sense the obligational and the visional dimensions are in a conversation. For example, Jesus’ dual love commands are examples of moral obligations—visional metaphors given moral substance. In Jesus’ dual

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123 Browning, Religious Ethics, 24-27 and Fundamental Practical Theology, 99-100. Here Browning develops his understanding of two main threads in the history of Western ethics.
love commands, Browning sees a version of Kant’s categorical imperative: all involved in the wrestling with the primary question ought not to make claims on someone else that they are unwilling for someone else to make of them.\textsuperscript{124} However, obligations do not automatically oblige. According to Browning, individuals move through a moral development process with the highest stage taking on a deontological character when one adheres to universal ethical principles. An individual needs to arrive at what he or she thinks to be moral, and this is evidenced in different ways depending on the level of moral development.

We will look at how Hoffman, Pannenberg, and Nussbaum define maxims in terms of empathy and neighbor love—what their visional metaphors look like when given moral substance in the form of a maxim. In whatever way the authors frame their obligations to the neighbor, in our difficult EOL case it is important for the medical team to focus these obligations in such a way that coalesces around the needs and concerns of the family’s obligations to their loved one. One will see how the obligations of the family differ from the medical team because of their beliefs about what their loved one would want and what they believe constitutes the end of life.

\textsuperscript{124} Browning, \textit{Fundamental Practical Theology}, 197 and \textit{Religious Ethics}, 65. Browning takes the Golden Rule and a Kantian interpretation of that rule to be the central obligation. He then applies his interpretation of the obligational level to a case study with which he has been working, which seems to contradict the argument Browning tries to make for practice informing theory. The proper use for the obligational level would be to discover how someone defines his or her obligations, which he does with the case study as well, but he seems to indicate his Kantian Jesus should take lead.
Tendency-Need Dimension

When reflecting on an obligation to others or oneself, one ought to think about the physical and emotional needs of the people involved in the deliberation about the primary question. How is one to follow the command to love the neighbor as the self in light of one’s own needs and tendencies as well as the needs and tendencies of another?

We get our information on human tendencies and needs from intuitive experience, religious and cultural traditions, and human sciences. The human sciences of anthropology, sociology, and psychology provide insights into what the pre-moral goods (unreflective responses and needs of people) are for humans. Features of animal and human behavior need consideration as the primary question is digested. Browning terms these pre-moral goods, which relate to humans’ basic biological needs. Some of his examples are food, intimacy, shelter, and others necessary for human life. Basic creaturely needs are also negotiated within communities and groups of kin, something that has been observed by primatologists.

Deep listening to the Other and treating them as Other creates space for their tendencies and needs to be made known. Creating this space is central for loving the neighbor as they want to be loved in a true, honest, and holistic way. Especially in difficult EOL ethics cases, the medical team needs to be focused on the thoughts and feelings of the family; the family members are the Other in this case.

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125 Browning, Religious Ethics, 69.

126 Browning, Fundamental Practical Theology, 103.
Browning’s approach to tendency-need is disembodied. He reflects on Niebuhr’s paradigms for our relationship with God and how God has created us. Are these categories with which the Other wrestles? Complete openness to discerning human needs would require a shedding of, as much as possible, one’s pre-developed paradigms about what ought to be the case in a situation. By letting Niebuhr’s theology set up parameters for human tendencies and needs, Browning seems to advocate for using Niebuhr to define the Other’s needs and tendencies. A true intercultural paradigm at the tendency-need level would heed the Other to a greater degree instead of defining the issue from the perspective of the self. In the categories from the introduction, the needs of the self eclipse the needs of the Other when one loves the neighbor as *thyself*, but the needs of the Other have space to blossom when the neighbor is loved as they want to be loved.

Descriptive Move

With Browning’s theoretical framework outlined above, I will briefly describe my revisions to his model and my three moves. Browning’s model is designed to address crises, questions, and tensions within a community. Descriptive theology is the first response to this situation. When a community asks a question about a practice, they take time to reflect on their practices and they may even describe their current practices to fully understand the questions they are asking. What will guide the descriptive process that forms Browning’s model is the focus on a primary question. In this dissertation, the primary question is as follows: how can the medical team embody neighbor love and empathize with the family in the midst of divergent ethical worldviews when trying to

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127 Ibid., 161-164.
answer the question “what should we do in this situation?” I have already provided my answer to this question: empathy occurs in the dialogue of care between and within people and communities in which we can think of God as present moving people to love others as they want to be loved. However, we need to build up to this conclusion.

My descriptive move will follow a composite end of life case in the intensive care unit. In the descriptive move, Browning includes five levels of practical moral reasoning with its accompanying hermeneutics because he wants to emphasize that pure objective description is not possible; description must always acknowledge the interpretive moves of the describer and the describer’s own history. The levels of reasoning were discussed above: visional/metaphorical, obligational, tendency-need, social-environmental, and rule-role.

I disagree with including the levels of practical moral reasoning in the descriptive move. First, the descriptive move, as I noted above, is not the place to include philosophical and sociological interpretations. These cloud the narrative of a particular community and space needs to be spent on providing rich detail. If “an inquiry [is to be] practical throughout,” as Browning desires, then attention to more narrative detail is important. Second, I think one can acknowledge one’s own interpretive lens in the descriptive process without moving through five levels of practical moral reasoning. In

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128 Don Browning, *Fundamental Practical Theology*, 77-109. In the descriptive theological process, Browning’s model attends to the rich dialogue between hermeneutics and the social sciences via Hans Georg Gadamer and practical moral reasoning via narrative ethics and rationalism (Kant and Mill). When developing his hermeneutics, in addition to Gadamer, Browning draws on Paul Ricoeur and Robert Bellah with the goal of deconstructing the notion of scientific objectivity when gathering data in social science research. The researchers and the subjects of research are part of historically situated and effective histories, which must factor into the research process.

129 Ibid., 57.
describing the end of life case, I will walk the reader through a brief family history and the patient’s clinical picture in the hospital; the psychosocial dynamics within the family, within the medical team, and between the family and the medical team; and the ethics committee consult process while the patient was in the hospital. I will acknowledge my own interpretive lens prior to providing narrative detail of the case.

Intercultural Practical Moral Reasoning Move

The five levels of practical moral reasoning will serve as the lens for my conceptual analysis of empathy’s role in an ethic of neighbor love. Browning sets up the five levels listed above as an interpretive paradigm—to interpret the experiences of a community and the theoretical and theological frameworks that drive a community’s practices. My version of this will be to use the first three levels—visional/metaphorical, obligatory, and tendency/need—as an interpretive framework for Hoffman, Nussbaum, and Pannenberg: what are the ultimate metaphors these authors use to frame their arguments, what do they say are our obligations to each other and to ourselves, and how do they define peoples’ tendencies and needs? This move could also be a place where we interpret the visional metaphors, obligations, and tendencies and needs of the various players in the chapter four case study. However, I am using Browning’s method to interpret the role of empathy in difficult EOL cases. Because I have a specific goal in mind, even a goal that arises out of concrete situation of practice, I will use the interpretive levels to interpret empathy instead of the worldview, actions, and needs of the various players in the case.
Strategic Move

Here we have arrived at the third move in my paradigm. According to Browning, after describing and reflecting on practical moral reason, a community will arrive at new meanings and understandings of the particular practice that brought about the question in the first place. These new meanings and understandings arise out of the primary question and drive praxis in light of the descriptive and practical moral reasoning moves. There are four questions that drive the strategic move: how do we understand this concrete situation in which we must act, what should be our praxis in this concrete situation, how do we critically defend the norms of our practice in this concrete situation? Four, what means, strategies, and rhetoric should we use to communicate to our community, in this case the hospital? As I address these questions in light of our primary questions on empathy, neighbor love, and diverse ethical worldviews, I will focus first on normative guidelines for empathy as a sacred ethic aimed at the members of hospital ethics committees, those invested in clinical ethics, and direct care providers in healthcare contexts. The fourth question, in particular, will aid in determining how to bring these guidelines to life in a hospital.

Looking Ahead

We have now seen how I will proceed to interpret the case of an ICU patient, sift through the three interdisciplinary partners on empathy, and construct my normative guidelines for hospital to practice empathy in difficult EOL ethics situations. Browning’s revised practical theology, with the addition of Lartey, served as a good foundation from

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130 Ibid., 55-56.
which to build my revised fundamental practical theology. The first move, the descriptive move, will follow in the next chapter and describe an ICU brain injury case in rich narrative detail.

The second move, IPMR, will follow in chapters five and six. Using intercultural practical moral reasoning as a foil, again, my interdisciplinary analysis will include Martin Hoffman’s psychology of empathy and working toward justice, Martha Nussbaum’s philosophy of emotion and compassion in public life, and Wolfhart Pannenberg’s theological anthropology. Hoffman’s rich understanding of moral development wrestles with the role that empathy plays in creating caring relationships and strong principles of justice within people; he also treats compassion fatigue and the limits of empathy. Nussbaum dissects the role of empathy in compassion and how compassion cultivates more loving and healthy public life; she also notes the limits of empathy in that one can become, to use my own words, overly sentimental when trying to help one’s neighbor. Pannenberg’s anthropology incorporates the *imago dei* and, in my interpretation, the presence of God in caring relationships.

The third and final move, the strategic move, will close the dissertation and provide hospital with normative guidelines. The normative guidelines may sound vague and detached from the concrete details of the day-to-day work at a patient’s bedside, so I will also provide some guidance on how to bring these guidelines to life based on my experience working on medical teams.
PART TWO

REVISED FUNDAMENTAL PRACTICAL THEOLOGY
CHAPTER FOUR
DESCRIPTIVE MOVE: COMPOSITE CASE

Introduction

We arrive at the first of our three moves. The descriptive move grounds the intercultural practical moral reasoning and strategic moves and ties them to a specific situation. I have elected to do a composite case study. Again, I will focus on narrative detail in my descriptive move. Narrative provides us with more intersubjective depth and detail in the descriptive process: we will learn more about the relationships between the various people in the case study, we will shed light on the internal struggle within each of the people, and we will not get bogged down in thick interpretive work, at least not until the next chapter.

The following case is an example of an end of life ethics case from my seven years working as an inter-faith staff chaplain in a variety of clinical settings: trauma hospitals, hospice, and long-term acute care. This particular case takes place at a trauma hospital. The danger of a composite case study is in its constructed character. People and cultures can become molded and divided to fit the specific point one is trying to make. One can also mold groups and individuals to fit into one’s idea of a specific

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131 Thanks to Sarah Storrs, a trauma surgeon, and Jena Wirt, a critical care physician, for reading and offering helpful comments on the prognostic and physiological elements of the case. I worked with both of these physicians at a trauma hospital and both of them stated that this case study reflected their experiences with difficult end of life cases in an urban trauma center. I also want to thank my chaplain colleagues Margo Richardson, Sarah Lindberg, Steve Grove, and Ann Romanczuk.
culture, as well as put them into ideological boxes. In this case study, for example, the risk would be both putting the family and medical team into specific cultural and ethical boxes. Not only does a single composite case fail to represent the ethos of a particular culture, but it also bypasses the ethical nuance of a particular family or medical team in a specific context. After all, loving one’s neighbor is about people loving each other and caring for each other, not composite and artificially constructed people artificially responding to and caring for another.

In light of these concerns, my composite case strives to do the very thing against which I caution. I want the family and the medical team to fit into particular ethical worldview boxes. I want to demonstrate how there are diverse ethical worldviews within communities, and in order to do so, the medical team and family will act as placeholders for the combination of a variety of values and practices. I do this knowing that, even though the family and medical team are composite in nature, they arise out of my clinical experience. I do this understanding its limitations. For example, the medical team will represent contemporary western medicine as I have experienced it. No one healthcare team or medical staff person will espouse all the values that the team does in the case study, nor will one patient and family adhere to all the values of the family.

When deciding between a composite and a real case, a composite case study does more work, so to speak. It illustrates my larger point of empathy’s importance in difficult EOL cases more than any one particular real case could do. Another strategy would have been to refer to instances of em(a)pathy in my hospital experience as I moved through my interpretive work—em(a)pathy not as apathy, per se, but cases where there was either a
conscious or unconscious lack of empathy. I decided to lump all of these instances into one composite case. End of life ethics cases in hospitals are just one example of this.

If I do not use an actual case study or data on case studies, how am I sure there are ethical disagreements and cultural trends with the characteristics I will describe? Isn’t this simply anecdotal evidence from one person’s perspective and someone who is constructing a straw person to prove his point? The short answer is no. First, all hospitals in the Twin Cities metro area have ethics committees, and all of these committees get consulted throughout the year to deal with ethical disagreements in a patient’s care. These consults are the result of the medical team and family’s inability to agree on what should be done. Beyond ethics committee consultations, there are frequent disagreements between medical teams and surrogate decision makers (i.e., anyone not designated as a health care agent).132 Second, whether or not hospitals deal with end of life situations exactly as I describe this case does not matter; the larger point I am making is that empathy is effective for cultivating neighbor love and loving the other as they want to be loved when there are ethical disagreements.

Cases such as these are often stressful for the family and the medical staff because of the tension around the dissimilar ethical worldviews. Both the family and the medical staff care deeply about the patient and are concerned with his or her well-being. Both the family and the medical staff have the best interests of the patient in mind. As I indicated in my discussion of clinical ethics, attempts to resolve these cases often work through the

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132 Douglas B. White et al., “Prevalence of and Factors Related to Discordance About Prognosis Between Physicians and Surrogate Decision Makers of Critically Ill Patients,” JAMA 315, no. 19 (2016): 2086-2094. White does not discuss ethical disagreements explicitly. In his study of two hundred twenty-nine surrogate decision makers and one hundred and seventy-four patients, there was discordance about prognosis between physician and surrogate in 122 of 229 cases.
three topics in combination with certain principles of medical ethics. These principles often fall short in cases like the one summarized below, however. The failure is not because end of life deliberations lack affect or love-of-neighbor. The difficulty is that the family and medical team may not agree on the prognosis or what a quality of life would be for the patient.

What about the experience of the family? There needs to be empathy. Both the feelings of the family about the trauma they have gone through and their ethics about such end of life decisions are central when deciding what should be done. Again, empathy is a practice that can help bridge the divide in ethical disagreements so that all involved can compassionately arrive at a resolution as to what to do in a particular situation. In this case, I claim the medical team must empathize with the family.

**Case: Brain Injury in the ICU**

David is a forty-year-old man in the intensive care unit (ICU) with a brain injury in a minimally conscious state. David will need a tracheostomy in order to continue breathing on the ventilator, a percutaneous endoscopic gastrostomy tube (PEG tube) to continue getting nutrition, and eventually to be transferred to a skilled nursing facility with a permanent tracheostomy where he will be completely dependent on the staff for his cares. What does the medical team, David, and David’s family think should be done?

**Before the ICU**

When David was walking across the street one evening with his family, a car struck him and threw him twenty feet and he hit his head on the asphalt. The driver of the car sped away, but his family called 911. Nobody else in his family was physically injured when the car hit David. They were crying and screaming in the street in utter
disbelief and shock over what happened. David’s wife fell to her knees and was shaking with tears. One of the family members had the wherewithal to call the paramedics, and other family members helped the wife off the street and to the curb for her safety. David was pulled to the curb and family tried to revive him until the paramedics arrived.

David initially appeared somewhat alert: he was moaning and clearly in pain. However, he soon became unresponsive, and when the paramedics arrived just a few minutes later they started CPR. After about twenty minutes of CPR they got a sustainable heart rhythm back, but because of the loss of consciousness and concern about the change in mentation, the paramedics intubated David en route to the hospital. In the state of chaos, the family was able to make it to the emergency room and was escorted to the waiting area while the ER staff stabilized him. They were told that the physicians would give them an update in the waiting room when David was stable enough.

Upon arrival to the trauma room at the hospital, the emergency room (ER) staff stabilized David and fully assessed him for other injuries. Besides the head trauma, there were four rib fractures, bilateral femur fractures, and a few lacerations and scrapes that were not concerning. After he was stabilized, David was immediately taken to get a computed tomography (CT) scan of his head to check for brain bleeding. The CT scan revealed a large diffuse subarachnoid hemorrhage in the temporal lobe with twelve millimeters of mid-line shift. This, combined with the twenty minutes of CPR that left David’s brain without adequate oxygen, led some of the care team to believe David was suffering from a non-survivable head bleed—non-survivable in the sense that he would likely never be able to verbally interact with his family or friends and would likely need a
skilled nursing facility to take care of him. This was the best-case scenario in their minds after seeing the CT scan.

The doctors were also concerned that David would eventually herniate. Herniation occurs when the brain swells from damage to such an extent that it pushes down through the base of the skull and damages the brain stem, where the key automatic responses are controlled (e.g., heart beat and breathing). David was taken to the ICU for further monitoring of his brain bleed and injuries.

After the CT scan, the physicians were able to update the family. Karna was David’s wife. They had been married for twenty years and had one son named Steve and two daughters named Ann and Sarah. Karna worked at home by taking care of the children. They had their oldest, Ann (21), who was away at college, and then Steve (18) and Sarah (16), who were both present at the hospital. The family heard the words “large brain bleed” and “without oxygen to the brain,” and felt overwhelmed and panicky. “He is dying,” they thought to themselves, and the description the care team gave of “critical but stable” did not make any sense to them. “Stable” stood out to them, but how could someone be critical and stable at the same time?

The physicians also said that David may not survive his injuries, and that the family should think about what David would want in this situation. The wife thought, “Survive how? Will his heart stop beating? I thought they said his heart was okay since they got it back beating, and he is connected to the breathing machine, so he should be okay, right? As long as he is breathing and his heart is beating, we will feel okay. That is what David would want.” Steve interpreted the update as it was a matter of time before the brain bleed got worse or that he would simply never wake up. The physicians
explained the treatment protocol for brain bleeds: they would continue to monitor his vitals, his intercranial pressure (ICP), tend to the other injuries as possible, and would have to wait a few weeks to see how the lack of oxygen impacted his brain and cognition.

Week One

There was not much change in his condition the first few days. David was in the ICU on the ventilator hooked up to telemetry and his ICP was somewhat stable. Near the end of the first week his ICP went up and the surgeons had to put in a ventricular drain to keep his ICP in the acceptable range. The need for a drain indicated his brain was continuing to swell, and the physicians were getting concerned about herniation. The whole family was distressed from the addition of the drain. Seeing David in the ICU was hard enough—the slow hiss of the ventilator, the IVs for hydration, the suction container for his lungs full of bloody mucus, and the facial swelling—and now they added a drain that had bloody fluid coming from his head. Karna and Sarah were taking it the hardest.

Since the drain was distressing to the family, David’s nurse asked the chaplain to come and see Karna to offer further support. During the day, Karna was at the hospital with David’s parents and needed support. The chaplain had visited them initially when David was first admitted to the ICU, but another visit was appropriate at this time due to the added distress of the drain. Chaplains will often offer support when a patient or family’s distress level changes.

During the second visit, the chaplain learned that while both David and Karna had grown up in Christian homes, their religious beliefs were more permeable while maintaining identification with their childhood religious traditions. Karna said both felt comfortable incorporating elements of many religious traditions into their current belief
system. Karna requested prayer with the chaplain. After the visit the chaplain consulted with the social worker and noted that David’s parents had also been in the visit with Karna. The social worker had learned that since David and Karna had Ann in their last year of college, David’s parents helped them take care of Ann for the first year so the two of them could graduate. They were in the hospital because of their love for and support of David and his family.

At the end of the first week, neurology came to do another clinical exam at the bedside to check for David’s level of brain activity. The primary team had consulted neurology from the outset, but neither Karna nor any of her other family members had been present. The family had heard the results of these exams when the interdisciplinary team briefly stopped by the room each day. The results of the most recent exam were not good and showed very little activity besides David’s brain stem (the part that controls the automatic body functions like heartbeat and breathing) and he did not have pupil or corneal reflexes.\(^{133}\) The neurologists agreed with what the primary care team had told the family, which was that the outlook was not good for David, but they also added that they ultimately did not know what the outcome would be. It was unlikely that he would wake up and know who they were, or that he would be able to survive off the ventilator, but they couldn’t say for sure. Each time the family heard this it felt like new information. “How can this be happening?!? Why are you saying these things? It has only been one week,” were some of the phrases the family expressed to the neurologists and primary

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\(^{133}\) G. Bryan Young, “Neurologic Prognosis after Cardiac Arrest,” *New England Journal of Medicine* 361, no. 6 (2009): 605-611. The absence of pupil or corneal reflexes on day three, per Dr. Bryan Young, means that the patient will likely be in a minimally conscious state and/or totally dependent for the rest of their life.
care team. The term “non-survivable” was also odd for the family to keep hearing. Karna and Sarah especially didn’t understand how David would die if the ventilator and other treatments were helping to keep his heart beating; for them, non-survivable would be the cessation of a heart rhythm, otherwise David would be clearly surviving.

The first week was overwhelming for the family as they went through the initial trauma and crisis on the day of the accident, the shock of seeing David in the ICU, and the difficult prognosis they kept hearing of “non-survivable head bleed.” Nurses and physicians gave them updates on David’s situation day-to-day as well as larger predictions related to prognosis. David’s prognosis had not changed very much and the family was wondering what to do at this point. The medical team was also wondering what the plan of care would look like in the coming week. Many of them wondered if the family understood the patient’s poor prognosis. After all, some of them thought, if this was a non-survivable head bleed, then there would be a point when the extensive care he was getting would not make sense. David would not live a meaningful life, there were wasted resources going to his care, and they were simply doing things to him and not for him.

Weeks Two and Three

The second week continued mostly along the same lines as the first, except for the family care conference at the end of the week. There were no major changes in David’s condition and the neurology team continued to do daily bedside exams to look for changes in their prognosis. The surgeons were able to remove the ventricular drain midway through the second week. In addition to the daily bedside quick updates, the ICU team wanted to have the family get together with all the care teams to talk about a plan of
care for David. The surgery and neurosurgery attendings had been talking amongst themselves and were wondering why the family wanted to keep going with such aggressive and curative care when the patient was not going to have a meaningful life—in a nursing home, on the ventilator with a tracheostomy, prone to infections and bed sores, and fully dependent on the nursing home staff for cares. The neurology attending physician, however, did not completely share the views of the other attending physicians. She was near retirement and had seen people recover in ways she never thought possible. Though these patients were never fully who they were before their injuries, some were able to recognize and interact with their families and be at home. She still felt this case had a poor prognosis, but she was not so quick to claim certainty. She was also wondering what the family and patient thought a meaningful quality of life would be. She had heard a variety of opinions from patients and families on what counts as a life worth living.

In preparation for the care conference, the chaplain, social worker, and a staff member called the clinical coordinator, worked to get the conference scheduled, and reached out to all family members. The chaplain continued visits with the family in the ICU, learning about their spirituality, praying with them, and providing emotional support to Karna, Steve, Sarah, and David’s parents. The chaplain, clinical coordinator, and the social worker learned over the course of the week that Karna was someone who worked very hard at home to make sure that the children were taken care of and the house

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134 The lack of oxygen to the brain (anoxic brain injury) is a central part of the physician’s poor prognosis for David. Anoxic brain injuries (ABI) have poorer outcomes than traumatic brain injuries (TBI). The lack of oxygen to the brain is very damaging to its potential for healing, as compared to blunt trauma to the brain in the case of a TBI. See Alasdair Fitzgerald et al., “Anoxic Brain Injury: Clinical patterns and functional outcomes. A study of 93 cases,” *Brain Injury* 24, no. 11 (2010): 1311-1323.
was maintained. David worked as an environmental lawyer for a large urban law firm. David’s commitment to preserving the environment and God’s creation was something that attracted Karna to David, as well as his sharp intellect. He was always such a hard worker and never gave up on the people impacted by environmental injustice. Karna and the family hoped that David had a strong desire to live and would fight to overcome his injuries. Near the end of this week before the care conference, the family expressed to the clinical coordinator and the chaplain they were beginning to feel that some of the medical team disagreed with how the family wanted the care plan to unfold.

The care conference happened on a Friday afternoon around 2:30pm. The family hesitantly gathered in the conference room just prior to the meeting. Ann was able to come back from college for the care conference, so all of the family members were present, including David’s parents. The hospital staff in attendance included the following: social worker, clinical care coordinator, chaplain, ICU resident physician, neurosurgery resident, neurology attending, and ICU attending. The family and staff members introduced themselves, and the ICU resident started by asking the family what their understanding of David’s condition was and how they were doing. The family talked about how overwhelming everything has been for them—the sudden trauma and terrifying accident, and seeing David with IVs and a breathing tube, seemed like something from a nightmare. They just did not know what to do or think. But, they believed that David was a fighter so they hoped he would eventually respond to them in some way. They knew he had a brain bleed, that his ICP was down, and that the chance of recovery was small.
After the family had a chance to talk and express themselves, the ICU resident and neurosurgery resident started filling in the story of David’s hospital course with more detail. They talked about the size of the brain bleed and damage—not just how much was damaged, but also the location of the damage: the temporal lobe. The neurologist elaborated on why the specific area of damage was significant. Many of the personality traits and capacity for memory are located in the frontal lobe. So, not only was it hard to tell if David would end up responding to the family in any way, it was hard to know if he would have any of his personality traits or to what extent he would have memory.

The resident physicians also went over the hospital course from the beginning. They stated it was good that David’s swelling had gone down, because they were worried about the swelling continuing to grow and eventually the brain herniating, which would lead to brain death. Even though his swelling had gone down, they had not seen any changes in his response level over the course of two weeks. Given that his neurological exam had not changed (the neurologist confirmed this), they did not expect him to become more responsive than he was at the present time. He would continue to be in a minimally conscious state. The team asked the family what they thought David would want. Karna’s answer at this time was the same one she had when David first arrived at the hospital. She felt he would want to keep fighting.

The family asked questions about his minimally conscious state, what that meant for his survival, how long it takes the brain to heal from an injury, and what the next steps were. The family’s affect was varied as they asked these questions. Karna’s face was concerned and nervous as she waited to hear the physicians explain what she assumed was bad news; when she was not asking a question she was wringing her hands under the
Steve and Ann were withdrawn and appeared numb—resigned, in their minds, to the inevitable bad news of their father being stuck as a “vegetable” for the rest of his life. Sarah was next to her mom with her arm around her providing comfort, and was tearful over the lack of hope in the medical staff’s voice and communication. The neurosurgeon and the neurologist explained how David had a small chance of “coming out of” his minimally conscious state, and that even if he did, again, he would not be the David they knew. The best-case scenario they saw for him would be living in a nursing home dependent on others for his daily cares and unable to respond to his environment, except through facial expressions if he was in pain. However, the neurologist added that it was ultimately impossible to know what would happen for David, though the scenario they described was the most likely outcome.

In answer to the family’s question about what the next steps were in the ICU, the medical staff started talking about plan of care from this point forward. There were essentially two options for the family. They would not need to decide between these two options right away, but the time would be coming, if nothing changed in David’s condition, when the family would need to decide. One, given the extent of his brain damage, the medical staff would recommend moving David to comfort care, which meant removing life sustaining treatment. They reminded the family they had told them this was a non-survivable brain injury. The ventilator would come out, the IVs would be taken away (except access for pain medication), lab draws would stop, pain and anxiety medication would be given, and David’s care would focus totally on his comfort until he died. The family was silent and overwhelmed at hearing this. Ann got up and left the room. The chaplain and social worker asked the family how this was for them to hear all
of this. Karna and David’s parents started crying and they said, “We just can’t believe it. We don’t know… David wouldn’t want us to stop trying to help him. He is such a resilient person and is a fighter.” They also could not imagine simply not feeding him or giving him water when he needed it, even if he was in a minimally conscious state. The non-survivable part of their recommendation also did not make any sense. How could this be non-survivable if he was currently alive, heart beating, machine breathing for him, and other vital signs stable? Hearing this option was overwhelming and the family did not want to pursue it.

The team explained that they knew this was a lot to hear right then and they had one more option to talk about. The second option was to elect to do a tracheostomy and PEG tube. They did not recommend this, but it was one of the options they could pursue. David would need to go to a long-term acute care hospital and then to a skilled nursing facility where he would likely remain. Given he would have a tracheostomy, he would be prone to infections and likely bounce back and forth from the nursing home to the hospital. The process of eventually getting to a skilled nursing facility would take two months. In order to pursue this path, the ICU team would continue to follow the current plan of care, try to resuscitate him if he suffered a cardiac arrest, and eventually get him stable enough to be transferred. Though this was also hard for them to imagine, the family wanted to pursue this plan of care. David was alive and survived the accident, and they wanted to do everything they could for him. The medical team repeated the information about his recovery potential and what his life would be like, but the family was committed to doing what they could despite the recommendation of the medical team.
After the care conference the medical team had a separate meeting amongst themselves to debrief about the family meeting. The ICU and neurosurgery physicians were irritated with the family’s insistence on continuing to provide aggressive care for the patient, knowing he would never be the same person the family knew and cared about. The patient was simply laying in the bed—only a whisper compared to the environmental lawyer the family described to them briefly during rounds one day. This was not living in their mind—sitting in a hospital or nursing home bed, not doing anything. The chaplain and social worker offered up how hard it was for the family to be making these kinds of decisions after only two weeks of adjusting to the traumatic event, though it was hard to say if the family would make a different choice a few months from now after they had time to adjust. The physicians said they knew how hard it was, but that it was a choice the family had to make right then; nobody would be able to adjust to such a hard choice, but it was what they were facing in life. “They can’t just run away from their grief and delay the inevitable,” the ICU resident said.

The neurologist and clinical care coordinator were not as opposed to what the family wanted to do at that time. While they did not ultimately agree with the family’s plan because it would cause David distress from the pain, continued infections from the ventilator, and possibly existential suffering from laying in bed all day, they were more accepting of the plan for their own reasons. The neurologist, as previously noted, had cared for many different patients in her career and had seen some patients recover more than she ever thought they would. The clinical care coordinator found herself trying to understand the situation from the family’s perspective. She could not do this completely, but she wondered what it would be like for her, or any of the members of the medical
team for that matter, to have their loved one in that situation and have to make those choices.

Weeks Four and Five: Ethics Consult and Discharge

There were not many changes in the fourth week of David’s ICU stay—changes in his condition, the team’s prognosis, or the family’s plan of care. The medical team continued their updates with the family when they rounded, and every now and then would remind them of the poor prognosis and their recommendations. The family heard them but did not change what they wanted to do; they also felt more distance between themselves and the medical team. Knowledge of the case spread amongst the ICU residents, nurses, and other staff. It became known as the case where the family was in denial or “weren’t quite getting it.” Staff wondered why the family was deciding to keep going when the patient’s condition was so grim. Karna and the children had been keeping family and friends up to date in terms of David’s condition on a Caring Bridge web page, but now family and friends were hearing more and more about how the medical team wanted the family to make different choices. There were, in a sense, two vaguely defined sides in the case that disagreed on what was best for David. The chaplain, social worker, and, in some ways, the neurologist and clinical care coordinator tried to occupy a middle ground.

Towards the end of the fourth week, the staff and family were still in the same place, even after another mini-family care conference that went over the severity of David’s prognosis. The ICU attending decided to consult the ethics committee about having a formal consult. He felt this would help the family see how serious the medical staff felt about David’s prognosis and help the family feel better about moving to an end
of life care plan. Many of the medical staff were getting very frustrated with the plan of care and the family, and an ethics consult seemed to be the only course of action left to take. The team informed the family that the next meeting would involve an ethics consult. At first, Karna and David’s parents were taken aback. Was this simply to coerce them into agreeing with the team or to actually come up with an agreed upon plan of care? An ethics consult sounded very intense, but the medical staff explained it was because of the disagreement over the plan of care, and this made some sense to the family. The ethics consultant contacted the family on the phone to explain more about the consult and to pick a time to meet. The consultant explained this was not a high pressure meeting; it was to further explore the medical indications, David’s and the family’s preferences, quality of life issues, and any other contextual features (legal, religious, cultural, etc.) in order to reach a consensus about the plan of care. The ethics consultant would not be pressuring the family to make a particular choice.

Prior to the ethics consult, the chaplain and social worker continued to provide spiritual and emotional support to the family. The chaplain discovered that Karna and David had met in college in their second year of school in one of the extra-curricular religious student groups that met on Fridays. This was an inter-faith group. Their shared passion for the law, religion, and their intellect were some of the things that drew them together, along with their shared sense of humor. After they graduated college, they made the decision that Karna would stay home with Ann and David would continue on to law school. Throughout all of this, and as their children had grown up, their marriage had gone through some tense times, but they were overall lovingly committed to each other.
The social worker spent some time talking to the children. He learned that, of the three children, Ann was the most distant from her father. He remembered her walking out of the first family care conference and wondered if this history of distance was part of the dis-ease she felt in the meeting. Ann remembered the most about the early years of law school and David’s late hours of study, interning, and eventually work. When he was home, he was present to her and demonstrated his care and love for her. This pattern of feeling distant and close to her dad continued throughout her growing up. But she was now in her third year of college, and she had experienced more of the distance—distance in miles, time, and shared interest. Ann wanted to make a living in theatre and this was frustrating for her father.

Steve and Sarah had different experiences of their parents. They were born later and did not remember their parents working hard while David was in law school and interning. They were born three and five years after Ann, respectively, so by that time David had a job and both parents seemed less stressed overall. While there were times when they felt distance from their father and mother, they could not put words to it and these feelings were not the dominant part of their narrative with their parents. In terms of sibling relations, Sarah knew that Steve was closer to Ann than she was. However, as the youngest, she was clearly “daddy’s girl,” as people sometimes called it.

The chaplain also learned that David did not approve of Ann’s move away from religion. While their parents had raised them in their religious tradition, Ann did not identify with this tradition or some of the ideological commitments it required: sacred texts as paradigmatic for life, the reality of God’s relationship with the world, and God’s role in human life. These commitments seemed silly and irrational to her. After all, she
had never experienced anything that she would equate with God. She felt that people should love each other, but that did not require anything close to religious commitments. Steve and Sarah, on the other hand, were still part of and valued their religious community. Sarah was still in high school and Steve was about ready to go to college. They found hope and meaning in participating in a religious community. When Ann had moved away to go to college, home life had changed. Steve was closer to Ann than Sarah. They were both interested in the theater and performance, and had been in productions together. He missed this shared interest and the intimacy it led to with Ann. Sarah, though she found purpose in participating in a religious community, admired Ann’s ability to find purpose outside of a religious community.

The ethics consult happened on a Friday afternoon, like the last major family care conference. The consultant led the meeting this time. The ICU and neurology teams from the medical staff, the core members of David’s family (Karna, his parents, and the children), and the chaplain were all present for the meeting. Given that David’s condition had not changed very much, save for a few fluctuations in his vitals, the family and medical team quickly gave their account of what was happening medically for David. The core of the ethics consult revolved around the patient/family preferences for David’s care and the quality of life David would have.

In terms of patient and family preferences, the chaplain thought it pertinent that the family express what they told him early on in David’s hospitalization. When the physicians had told the family they were worried about herniation, Karna didn’t understand how David would die if the ventilator and other treatments were helping to keep his heart beating; for them, non-survivable would be the cessation of a heart rhythm,
otherwise David would be clearly surviving. In this case, even though David would be in a nursing home with a tracheostomy, they felt he would still be surviving and alive. Religiously, this was a belief of theirs: cessation of cardiac rhythm was the death of an individual. Religious adherence was an important value for the family.

The physicians and others present did not agree with this definition of an individual being alive or dead. A person, though physiologically sustained, is not necessarily alive in this condition of minimal responsiveness. One of the physicians described this as “alive, but not living and thriving the way in which someone might find joy.” The clinical coordinator had stressed for the team to imagine themselves as the family, so the physicians asked the family to try and imagine what David would want, imagine how life would be for him. Ann, and to some degree Steve, understood the point of the physician. Ann thought the distinction her mom was making in terms of what makes a person alive was a little odd, but wanted her mom to be the final voice in what happened for her dad.

This discussion naturally moved on to quality of life, and again, the family and medical team could not come to an agreement. Though living in a nursing home was not ideal and not something David would necessarily choose, Karna and David’s parents felt he would be willing to endure it if he knew it is what Karna and the family wanted. He was always a strong person and a fighter, so he would be strong and be okay with a nursing home, even after the medical team re-explained how he would be prone to infections, bedsores, and general myopathy. The one place the family and medical team agreed was on David’s code status. The medical team thought David should be NO CODE; the team did not want to do cardiopulmonary resuscitation (CPR) if David’s heart
stopped. Given the amount of life support he was already receiving, if all of this could not prevent a cardiac arrest, then his arrest would be an indication of his body dying. On top of this, CPR would damage his body and decrease the likelihood of a meaningful recovery even more. Up to this point he had been full code, but the family agreed that they would seriously consider changing this down the road. Karna and the children seemed to understand the perspective of the medical team in this situation. David would have further injury and lower quality of life if he had another cardiac arrest. The family was not ready to make this decision right then, but they were open to it later down the road.

The ethics consult ended with the following care plan for David: David would leave the ICU, get a tracheostomy in order to continue breathing on the ventilator, get a PEG tube to continue getting nutrition, and would eventually be transferred to a skilled nursing facility with a permanent tracheostomy. Unless his brain injury dramatically healed, he would remain in the nursing home for the rest of his life. David was discharged from the hospital after four weeks. Two months later the hospital held hospital-wide “care and compassion rounds” to address the distress of the medical providers in providing the type of care they did for David. The attending physicians were still unsettled by having to provide medical treatment that allowed David to go to a skilled nursing facility. It was pointless and futile in their eyes, and they were still upset.

**Case Study and Empathy**

The goal of this case study is to provide an example of a disagreement in ethical worldview around a particular situation: making medical decisions in the face of a poor medical prognosis. I believe that empathy can play a role in creating neighbor love in this
situation.\textsuperscript{135} Empathy occurs in the dialogue of care between and within people and communities in which God is truly present, moving people to love others as they want to be loved in the midst of diverse ethical worldviews.

There were many places in this case where medical staff and family had different moral worldviews and could not agree on a general plan of care. It is not that this case lacked neighbor love of any sort or there was no similarity whatsoever in their worldviews, but that there was disagreement about “what should we do?” in a particular case. The family was okay with David being in a skilled nursing facility; the medical team disagreed and was so distressed by this that some of them were still unsettled two months after David left the hospital. There were also more specific disagreements in worldview. First, they disagreed on how to define living or being alive. The family thought that the cessation of heartbeat meant David was dead and no longer alive, and the medical staff thought that the extensive brain damage meant David was no longer able to live. Second, the family did not want to make David “do not resuscitate” (i.e., if his heart stops do not attempt to resuscitate him) until they had thought about it more; the medical staff wanted to make David DNR right away. Third, the family thought that David was a fighter and would be able to tolerate a less-than-ideal life in a minimally conscious state; the medical staff felt this was not an acceptable quality of life, and the treatment to get David to that point was non-beneficial. Fourth, the family had religious reasons for

\textsuperscript{135} One could make the argument that the medical team’s anger and dis-ease is actually neighbor love. If they did not care about the patient, then they would not be angry. Neighbor love does not have to be warm fuzzy butterflies where everyone gets along and feels happy. Their anger could be part of not wanting David to go through such suffering, and this sentiment stems from care and love for the patient, so the argument might go. However, even though the presence of anger may indicate the presence of love, neighbor love as I have defined it is about making space for the needs, cares, concerns, and worldview of the Other and not raging against it from one’s position of authority and power. Those in power must empathize with those who are suffering and respond with compassion.
justifying some of the care plan decisions; if the medical staff had any religious beliefs, they did not bring them up with the family.

These are just some of the examples of the ways in which ethical worldviews differed between the family and medical staff. There were also glimpses of understanding, empathy, and mystery—that-did-not-claim-all-the-answers between the family and the medical team—times when those with more authority and power in the situation attempted to enter the experience of those who were suffering. The clinical coordinator and the neurologist whispered of a different way to approach the family and a different way of trying to decide what to do in this case. It is not to say these two staff members empathized and the other members of the team did not. I am not suggesting there are only two ways of relating to the family: empathy and lack of empathy. The neurologist and clinical coordinator demonstrated humility and an interest in taking the family’s perspective. The neurologist claimed mystery; she was open to the unknown of being wrong about David’s prognosis, and while she disagreed with their decisions, she understood why they were making the choices they made. The clinical coordinator in her own subtle ways tried to get the various members of the medical team to imagine themselves in the place of the family—what the family was feeling, thinking, and going through as they tried to make these very difficult decisions.

Taking the perspective of those with whom one disagrees cultivates neighbor love, and empathy is one way to begin to take the perspective of another. What follows will use the thinking of Martin Hoffman, Martha Nussbaum, and Wolfhart Pannenberg to provide a rich interdisciplinary understanding of empathy grounded in the case study of this chapter.
CHAPTER FIVE
INTERCULTURAL PRACTICAL MORAL REASONING MOVE

Introduction

We have arrived at the intercultural practical moral reasoning move (IPMR). The case study of David’s ICU experience is a few paces behind us and will help ground the interpretation of empathy that follows in this chapter. As we enter this interdisciplinary conversation, I want to repeat my thesis: *Cultivating empathy in ethics consults fosters neighbor love; not only does empathy foster neighbor love but it is required in difficult EOL cases from the medical team. It nurtures a love that coalesces around the thoughts, feelings, relationships, and beliefs of the family—loving the family as they want to be loved.* Cultivating empathy, in my interpretation, occurs in a specific way. *Empathy occurs in the dialogue of care between and within people in which we can think of God as present, moving people to love others as they want to be loved in the midst of diverse ethical worldviews.* I will use IPMR as a guide through Hoffman’s empathy and moral development, Nussbaum’s philosophy of emotion, and Pannenberg’s anthropology. If the reader remembers from chapter three, IPMR consists of three main levels of interpretation: visional/metaphorical, obligational, and tendency-need. Each of these interpretive lenses will help define empathy and how it plays a role in helping the medical team and family deciding what they should do in difficult end of life ethics cases.
Visional/Metaphorical Level

Recall that for Browning, out of the narrative tradition in ethics, there arises a visional/metaphorical dimension. The question, “how do religious-cultural and individual metaphors support and cohere with our moral intuitions and what we think to be morally right?” drives the visional and metaphorical level of IPMR. What are the religious-philosophical-cultural metaphors that help us understand how Hoffman’s empathy and prosocial action, how Pannenberg’s affective life and culture, and how Nussbaum’s philosophy of emotion all play a role in understanding how empathy cultivates neighbor love and nurtures a love that coalesces around the thoughts, feelings, and beliefs of the family? Answering this question will help us understand how the medical team can love the family as they want to be loved. The visions of our three authors cover a wide territory but coalesce around the idea that people need to be open to the needs of its members in distress. This is morally right. Through the concepts of care, compassion, vulnerability, and openness to the world we will begin to see a vision for communities in which people are open to the needs of others beyond themselves who are in distress—a vision for how empathy can cultivate neighbor love and how God is present in the distress of others.

Hoffman’s Moral Development

I want to focus on the vision of care Hoffman lays out in his work and how this will help us understand empathy. Care is a goal towards which Hoffman wants people to strive; a caring society is Hoffman’s ultimate vision for society and how I interpret what he would define is morally right. This vision fits well with our case study that takes place
in the context of a hospital, a place that, ideally, wants to care for all people who are suffering and in need of help.

Care is made up of empathy and prosocial action for Hoffman. As previously stated, empathy for Hoffman is the “involvement of psychological processes that make a person have feelings that are more congruent with another’s situation than one’s own.”\(^{136}\) Care is stepping out of oneself as much as possible and having feelings that are more like those of someone else in distress. Without going into the long history of empathy, he defines this history as consisting of two camps: empathy as cognitive appraisal of another’s mental state and empathy as affective response to another person.\(^{137}\) He focuses on the latter, as we can see from the above definition “…a person have feelings that are more congruent.” Focusing on affective components of empathy is important for how empathy will play a role in responding to someone’s distress and igniting one’s passion for justice and caring (in the next section). The cognitive component and the affective component of empathy are not mutually exclusive, as both require elements of the other to be truly effective, but Hoffman chooses to focus on the affective elements. I agree with Hoffman’s focus even while I recognize a place for cognitive appraisal within the affective response components of empathy. Affective empathy is also more important for situations like our composite ICU case. It is not enough to understand someone’s distress and situation. Cognitive appraisals alone do not move people to truly enter the situation of another; this can lead to a detached objectivity that does not take the subjectivity of the distressed Other seriously.


\(^{137}\) Ibid., 29-30.
Hoffman is not merely interested in defining empathy but wants to explore how this contributes to prosocial action, the second element of care. Prosocial action issues from one’s internalized principles (caring and justice principles), behavioral norms, rules, a sense of right and wrong, and how one interprets how they have helped or hurts others. In my simple definition, prosocial action is the ability of an individual to care for those in need, and empathy plays a crucial role in this ability of an individual to care for those in need. An important piece of the prosocial moral structure is empathic distress. Empathic distress involves responding to the feelings of distress aroused in the self because of another’s distress. Empathic distress is associated with helping: “There are countless studies showing that when people witness others in distress, they typically respond empathically or with an overt helpful act.”

Here we can see the foundation of how Hoffman will describe the dialogue of care. He elaborates further on this distress and draws conclusions about caring, community, and justice. Empathic distress goes through a series of stages drawing mostly on object-relations theory. Tracing empathic distress from preverbal forms through sophisticated attention to subtle emotions allows Hoffman to show how empathy contributes to prosocial action.

Caring, therefore, arises from empathic distress and its role in one’s prosocial moral structure. Hoffman continues to play with the concept of caring throughout his work—caring out of guilt, care and anger, and care and principles. He also acknowledges the mixed and sometimes conflicted reasons people care for those in distress; reasons for caring for someone are not always completely altruistic and may be out of feelings of guilt, distress within the self, and anger towards the object (i.e., person or system) that

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138 Ibid., 31.
harmed the victim in distress.\textsuperscript{139} These are good reasons to care for someone in distress, but they are not completely about the needs of the distressed individual.

Distressed individuals of David’s family are our Others in the case study. He acknowledges that the empathic distress and caring for those in need cannot be completely about the distress of the Other—to love them as they want to be loved. At the visional level, Hoffman’s concept of care resonates well with the stress on the Other. By illuminating the ways in which one’s own motives or struggles drive how one responds to distress, in an indirect way, Hoffman’s understanding of care makes more space for the voice and needs of the Other in the caregiving relationship. The Other’s voice, in Hoffman, may get silenced and colonized to some extent, but on a visional level, Hoffman acknowledges how the mixed motives of the self can impact how one responds to people in need. Despite the mixed motives that are inevitable as one provides care, when David’s family is in distress and reeling from the traumatic events, how could the medical team have looked beyond their goals for David’s care and reflected on how the family envisioned David’s care? I will address these questions later in chapter seven.

Martha Nussbaum’s Philosophy of Emotion

Nussbaum’s vision of what is morally right focuses on compassion and public life. A large of part this vision for public life includes compassion (empathy) for our loved ones and people we do not even know.\textsuperscript{140} These two features lead to an expansion of our circles of care. Such an expansion is healthy for a society and promotes

\textsuperscript{139} Ibid., 93-94, 176ff.

\textsuperscript{140} One sees the other person as vulnerable and in need and reaches out with compassion because one knows one’s own neediness and vulnerability. See Nussbaum, \textit{Upheavals of Thought}, 315-319.
flourishing. Grounded in the dialogue of care that occurs between child and caregivers, friends and friends, the intimacy developed in these relationships reaches out to the community and creates an empathic public framework. The expansion of empathy impacts the public sphere in terms of building a community. In our medical case from the ICU, heeding Nussbaum’s concepts of interpersonal depth and expansion of empathy can create a loving community between the medical team and family.

The dialogue of care between caregivers in communities is where the seeds for empathy and expansion are planted. There are many communities, and Nussbaum notes how the process of moral development depends on the society in which it occurs. Different societies cultivate different contexts for emotional development based on the physical conditions, religious/metaphysical beliefs, language, and social practices and norms. 141 How one understands love, care, and friendship depends on the context in which the loving, caring, and friendship take place. For a western liberal democracy, the dynamics of empathy (i.e., compassion for Nussbaum) and interpersonal relationships contribute to a flourishing society. She characterizes this in terms of Sophoclean tragedy:

“Tragedy asks us … to acknowledge that life’s miseries strike deep, to the very heart of human agency itself. And yet we are to insist they do not remove humanity, the capacity for goodness remains when all else has been removed.” 142 When a society stresses the importance of empathy and compassion, citizens are able to empathize with the joys and the sorrows of human life and experience. Rather than creating a bunch of pathologically narcissistic megalomaniacs, compassion opens societies up as a whole to vulnerability.

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141 Ibid., 140-157.
142 Ibid. 409.
Vulnerability and compassion are the glue that hold society together and allow other people to flourish. Vulnerability requires familiarity with one’s inner feeling states and having these states heard and accepted by another; then one is able to share one’s vulnerability with others.

However, compassion, per Nussbaum, must be coupled with an ethical theory. We cannot all walk around empathizing with each other’s sorrows and expect the world’s problems to be healed. An empathic and compassionate society coupled with an ethical theory leads to the blossoming of moral imagination—the ability to imagine the sufferings and joys of others and respond to them in order to facilitate healing and repair. Nussbaum supplies a moral theory to do just that, which we will explore in the obligational level of IPMR.

Pannenberg’s Anthropology

There are many threads about what is morally right in Pannenberg’s thought, but I will focus on his ultimate vision of being human and what this means for being in relationship with each other. After all, clinical ethics encounters at the EOL are between people, and I am concerned with how empathy functions between the family members and the medical team. Overall, Pannenberg is a dialogical theologian in the sense he engages the disciplines of biology, philosophy, and psychology as he develops his anthropology. His anthropology is rooted in the idea of human becoming. Humans are always in a process of becoming the image of God. He builds this argument by beginning with a discussion of humanity from the perspective of biology and psychology and then constructs an overall vision of being human as “openness to the world.” Our openness—Pannenberg’s ideas on self-transcendence, egoism and the self, and social relationships—
impacts how we are able to empathize with each other, how we love our neighbor as they want to be loved. In difficult and stressful EOL cases like the composite case study, there can be a tendency in the medical team to be caught up in their own interpretation of the situation. Openness to the family and patient can help both parties figure out what they should do for David.

Let us start at the beginning and build to Pannenberg’s understanding of openness. Prior to his argument on our openness to the world, he makes a claim about human uniqueness. Like many contemporary theorists in other disciplines, he argues that humans are different than animals in their ability to reflect on their instinctual reactions and exhibit some sort of control over themselves and their environment. He quotes Max Scheler’s ideas, “Human perception does not function primarily as releaser of reactions that are imprinted in an innate behavioral schemata. What is characteristic of human beings is, rather, that they can dwell on the contents of ideas and intuitions.”

Claiming humans are able to dwell on the contents of their ideas gets Pannenberg to his claim about the image of God and human nature. Since humans are able to step outside their natural (i.e., biological) inclinations as distinct from animals and exhibit reflexive behavior, humans are not dependent on their environment. Humans are, therefore, “open to the world and not dependent on their environment.”

I think Pannenberg’s distinction between humans and animals is simplistic and binary. There is a great deal of contemporary research around animal behavior, and I

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144 Ibid., 34.
doubt the primatologist Frans De Waal, for example, would not agree with Pannenberg’s simplistic distinction.\textsuperscript{145} Primates demonstrate helping and caregiving behaviors that seem to be more than instinctual responses to their environment. Even though Pannenberg’s distinction between humans and animals is too simplistic, we can still accept his concepts of being open to the world and bound by the world as indicative of human nature.

Openness to the world instead of bound by the world allows Pannenberg to claim that humans are in a process of becoming human, and it is in this process of becoming where one finds the image of God. One can speak of becoming in the absence of being bound; one can speak of becoming human as different from being bound by nature. Humans are able to reflect on the content of their ideas and become “more than” or “other than” their environment in their quest for becoming human. This quest begins from birth as humans only posses potentialities at first. Such a quest, nonetheless, is not totally of one’s own volition: “And the harmonious working of all these factors is guaranteed solely by the fact that in all of them God himself, the origin and goal of our destiny to communion with him, is influencing us.”\textsuperscript{146} The divine created intention is not solely within humans or solely external to humans.\textsuperscript{147} The image of God, for Pannenberg, is the goal of human life, the goal of becoming, and it is a goal with which humans and God are involved. As humans, we are grounded in God and touched by grace.


\textsuperscript{146} Pannenberg, \textit{Anthropology}, 53 and 58.

\textsuperscript{147} Ibid., 60.
Pannenberg continues to develop his understanding of the human being as the “becoming image of God” in terms of centrality and exocentricity. Humans are in the process of becoming and characterized by both centrality and exocentricity. Centrality and exocentricity are particularly related to his understanding of human nature, but he will continue to elaborate on nature when he touches on the concepts of the ego, self, and how relationships and needs define the former two categories. In my interpretation of Pannenberg, centrality is having a center within the self; the center of one’s motivations, desires, and volition is characterized by a lack of openness to the world. Humans are centric but have an ability to achieve exocentricity through self-reflection. He acknowledges there are different understandings of human reflexivity or self-transcendence, but in its essence it relates to the distinction between subject and object. Openness to the world does not mean, that one is only open to a divine reality beyond the world but is also open to the reality of this world as well. Exocentricity is characterized by a “presence to the other as the other. … Grasping of an object as an object distinct from the self one becomes aware of its otherness.”

148 In late Antiquity, one finds another seminal figure in Augustine of Hippo who speaks of how people are focused on themselves. Here I want to note his writing in Of the Morals of the Catholic Church. We have a tendency, per Augustine, not only to turn to our own private good instead of to God—turn to incorrect objects of love instead of turning to God in love. Cupiditas (greed), is defeated by and depends on caritas (grace), for humans’ moral strivings will always ultimately fail. True virtue, however, is the perfect love of God form which the love of the neighbor and love of self flows: “we can think of no surer step towards the love of God than the love of man to man. … Now you love yourself suitably when you love God better than yourself For you do not love him as yourself, unless you try to draw him to that good which you are pursuing.” Augustine, “Of the Morals of the Catholic Church: Chapters XV, XXIV, 434, XXVI, and XXVII,” in Christian Social Teachings, George W. Forell, ed. (Minneapolis, MN: Fortress Press, 2013), 50-51.

149 Pannenberg, Anthropology, 37.

150 Ibid, 63.

151 Ibid., 66-67. Pannenberg comes back to this in the final part of his Anthropology on page 525: “[The time-spanning present] is an expression of the specifically human being—present to the other as other,
an object, then one understands oneself as separate form or a perceiver of the object, and
going further, one can then reflect on an “object” reaching beyond the possibility of all
objects of perception to an absolute Other.\footnote{Ibid., 68. Pannenberg’s argument that exocentricity ultimately points to reflection on an object
beyond all objects of perception. An absolute Other in Pannenberg resonates with the ontological argument
for God’s existence. In Anselm’s (1033-1109) \textit{Proslogion}, he makes the argument that God is “something-
than-which-nothing-greater-can-be-thought.”}

Empathy and the Visional/Metaphorical Level

We have and can cultivate a God-given capacity to empathize with each other.

Part of chaplaincy work is openness to the variety of people and beliefs encountered in a
clinical setting. As a chaplain, I make every attempt to begin my encounters with patients
and families with empathy and openness. Openness to the world and exocentricity are
part of the human capacity to empathize with another—empathize with another as a
distinct subject from the self with his or her own feelings, needs, and concerns. This type
of empathy—type of love and care—are an example of loving the neighbor as they want
to be loved. The other is distinct from the self; the other is not to be loved as \textit{thyself} but
as an Other distinct from the self. Pannenberg pushes us to open ourselves up to the other
and embody exocentricity; listen to the other and do not be bound by centrality. We can
also see this line of thinking in Hoffman and Nussbaum. Hoffman’s vision of care
included having feelings that are more congruent with another’s feelings than with one’s
own, and caring actions that respond to the needs of the other’s state of emotional
distress. Nussbaum too wants us to strive for openness towards each other—an openness
that recognizes that life’s tragedies and joys strike deep within us and are part of each of

an expression \textit{of the exocentricity} of the human mode of life and thus an expression of the presence of the
spirit who is at work in the interrelationships of things.”
us. We must be open to the vicissitudes in our own lives and in others’ lives. We will now dive a little deeper into the obligations to our neighbors inherent each of their respective frameworks.

**Obligational Level**

What kinds of obligations do we have to our neighbor? When we think about the role that empathy plays in cultivating neighbor love and the beliefs and vision that shape our worldview, our vision of the world has obligations that go along with it—maxims that shape how we relate to others and what motivates us to relate in a particular way. It is not necessarily a movement from the visional to the obligational, however. A maxim can be coupled with any number of visional metaphors, and in this sense the obligational and the visional are in a conversation. This conversation is so tightly knit that it can be hard to tell the difference between these two interpretive lenses. For example, Hoffman’s vision of care or Pannenberg’s concept of openness to the world both shape and are shaped by how they each understand our obligations to our neighbor. Given the intertwined nature of these two levels, what will follow will continue to elaborate on how empathy can cultivate neighbor love and how we need to look beyond the needs of ourselves to the needs of others from the visional level. However, it will have a normative edge to it. We *should* or *ought to* empathize with our neighbor and we *should* or *ought to* look beyond ourselves to the needs of others. Empathy is *required and nurtures a love that coalesces around the thoughts, feelings, and beliefs of the family*. We can think of the obligational edge in these statements as God’s presence in the needs and distress of our neighbors calling us to empathize and love them as they want to be loved in the visceral moments of EOL decision-making.
Hoffman’s Moral Development

Hoffman’s obligations are clearly stated in his discussion of his caring and justice principles. Understanding empathy through Hoffman’s obligations of caring and justice adds depth to the psychological motivations of responding to empathic distress. In order to understand the relationship between caring and justice, we first need to know how Hoffman understands the interaction and bonding of empathy and moral principles. For Hoffman, people come to distressed situations with moral principles, which influence the ways they respond to empathic distress. When we see someone in distress, we may feel immediately called to care for them because their distress and their identity resonate with our principles. There are also distressed people with whom it is hard to empathize, either because empathizing seems too draining or we do not identify with their distress. Our principles, however, can transform the victim into a representation of a larger category of injustice thus catalyzing our empathic distress and an ability to perform a prosocial act.\textsuperscript{153} In our EOL case, the principle of caring can push the medical team to empathize with the family in their difficult situation.

Caring and justice are Hoffman’s moral principles. Caring is concern for the well-being of others—their need for food, shelter, avoidance of pain, and self-respect—and helping those in need or distress. Justice includes the following: fairness when there are competing claims, people be treated in a manner consistent with their rights, and people (in general) get their due in treatment.\textsuperscript{154} Given his definition of “caring,” we can clearly

\textsuperscript{153} Hoffman, \textit{Empathy and Moral Development}, 221. Hoffman is careful to acknowledge there is no universally agreed upon moral principle, thus Kant’s categorical imperative is not realistic.

\textsuperscript{154} Ibid., 222-223.
see how the principle of caring drives empathy and empathic distress for Hoffman. We must help and care for others who are in distress/need. For those with whom we have a hard time empathizing, we may respond to them with prosocial actions because we adhere to the caring principle that drives us to reimagine or reinterpret the distress of the person/people. For Hoffman, it is right and good to care for those in need or in distress.\footnote{Though this is important for Hoffman, some of his biases come out simply in the amount of space he dedicates to the caring principle: a mere page and a half compared to the ten pages he uses to write about empathy and the principle of justice.}

Empathy also connects with the principle of justice. Hoffman briefly discusses punitive justice, but we will leave this aside since he focuses mostly on distributive justice and empathy. Simply put, distributive justice relates to the ways in which a society’s resources are distributed among its people. For Hoffman, distribution can be divided into three general areas: productivity (more work equals more pay), need (receive resources regardless of productivity), and equality (everyone gets the same amount). He sees empathy as more active in the latter two categories, but empathy overall can move one to take another’s situation into consideration when deciding about distribution of resources.\footnote{Ibid., 230ff.} Empathy constrains self-interest in real life contexts. Therefore, empathy contributes to an equal distribution of resources. Drawing on John Rawl’s concept of the veil of ignorance, only empathy can provide the motive and rationale for creating institutions and a society where resources are equally distributed.\footnote{Rawl’s veil of ignorance is a philosophy game on which he draws to argue for a equal distribution of resources. If individuals were asked to create society from the beginning, and they stood behind a veil of ignorance in regards to what their life would be like in this new society, an individual} Empathy makes the participants in a game like Rawl’s choose equal distribution.
Empathy and the principles of caring and justice work together to create prosocial action, action that is helpful to the persons in distress. These principles help us to love the neighbor as they want to be loved. Principles can, in Hoffman’s words, de-center the caregivers from being consumed by the distress of the situation and help the caregiver to understand the breadth of the needs of the distressed person. When one encounters someone in distress, both one’s cognitive and affective principles as well as one’s empathic distress are activated.158 Hoffman sees the principles of caring and justice as helping to neutralize over arousal or catalyze under-arousal in one’s empathic distress.159 If one is experiencing empathic over-arousal, the cognitive components of one’s principles can help one detach, so to speak, oneself from the actual distress of the distressed person and provide more helpful care; getting consumed by another’s distress does not allow for prosocial action because one is overwhelmed while trying to provide care. If one is experiencing empathic under-arousal, then drawing on one’s moral principles as they relate to the situation can intensify one’s empathic distress and catalyze prosocial action.

What of the Other in Hoffman’s obligations of care and justice? If the medical team is to love the family as they want to be loved, whose definition of care and justice

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158 John C. Gibbs, Moral Development and Reality: Beyond the Theories of Kohlberg, Hoffman, and Haidt, 3rd ed. (New York, NY: Oxford University Press, 2014), 12-13, 131. Here Gibbs critiques Hoffman’s lack of emphasis on the cognitive elements of empathy. However, at least in Hoffman’s work under consideration, he does emphasize the importance of the affective and the cognitive in empathy.

159 Hoffman, Moral Development, 239. The medical team cannot and should not sustain an empathic focus every moment they are caring for sick people and their families. This would lead to burnout and empathic over-arousal. There is a long-standing struggle to achieve the appropriate balance between empathizing and emotional distance. See Gibbs, Moral Development and Reality, 116.
does the family and medical team follow? Tying empathy and justice directly to Rawls’ veil of ignorance, for example, gives Hoffman’s obligation of justice a univocal voice of individualistic western moral philosophy and psychology. Rawls’ veil of ignorance isolates individuals behind a veil as an individual makes decisions about society. Hoffman attempts to address this issue in one of his final chapters on “the universality and culture issue.” Citing the biological substrate in the brain’s limbic system, the seat of emotional experience, he makes the universal argument that responding to others in distress is part of our brains.\footnote{Ibid., 274.} Hoffman thinks the biological and cognitive mechanisms allow for universal empathy: people sense their own bodies, sense their own emotions, and can represent themselves and others. These primitive arousal methods are universal based on facial recognition and central nervous system responses. Humans do share neurophysiological features with each other, but that hardly provides evidence for constructing principles of caring and justice based solely on more individualistic paradigms. These principles can look very different in different cultures and different, even down to different families in the same community. For difficult EOL cases, individualistic conceptions of care and justice are not helpful. Each member of the medical team should not stand behind the veil of ignorance and ask what only he or she would want for David. Humans do not construct their life detached from their friends, family, or other relationships. The medical team needs to be in relationship with the family and empathize with them as a way to figure out what should be done.
Martha Nussbaum’s Philosophy of Emotion

Because her obligations were discussed in the visional level and will be in the following level on human tendencies and needs, I will not spend much time in this level for Nussbaum. Nussbaum’s normative claims resonate with much of what I said in the introduction about neighbor love as it applies to EOL cases. The obligations and norms in Nussbaum’s work are woven throughout her work; that is to say, her normative theory is not explicitly argued for in a linear fashion. For Nussbaum, a theory of emotion must have an adequate normative moral theory to support the role emotions play in morality. In the case of empathy and EOL, we cannot make a case for the importance of empathizing with the family without a normative theory about empathy and emotions.

The most direct statement of human obligations comes in her introduction:

In particular, I assume that an adequate [normative] view should make room for mutual respect and reciprocity; that it should treat people as ends rather than as means, and as agents rather than simply as passive recipients of benefit; that it should include an adequate measure of concern for the needs of others, including those who live at a distance; and it should make room for attachments to particular people, and for seeing them as qualitatively distinct from one another.\(^{161}\)

Her summary of her flexible normative theory gets expressed in different ways throughout her reflections, in particular her emphasis on our common humanity.

Motivated by the values of compassion and love that teach us to care for and honor every person simply because they are human, we are obligated to honor each other’s common humanity. Compassion may sometimes cause humans to favor their kin, but the value of compassion also pushes us to consider distant others that we do not know because of their

\(^{161}\) Nussbaum, *Upheavals of Thought*, 12.
common humanity. Love too carries this value, and Augustine’s theology is an inspiration for her: “In loving God, Augustine emphasizes, one loves each and every human being—not only the good parts but also the flaws and faults, and not only as stepping stones to one’s own artwork but in themselves.”

Compassion and love see each and every person as having value, agency, importance, and worth—worthy of being cared for not because they are a means to some other end but simply because they are human.

Pannenberg’s Anthropology

Like Nussbaum, Pannenberg does not explicitly state specific obligations, but we can infer obligations from his theology. These are obligations born out of how Pannenberg understands the imago dei. Within his anthropology and understanding of the image of God, it is clear that humans are to honor and respect the dignity and worth of each person, which comes from his concept of exocentricity and openness to the world; we are to care for people in distress, which comes from how he sees human anthropology working toward a unification of despair and grace; and we are to provide comfort and care for each other as we seek unity in the midst of despair, which comes from his use of George Mead and Erik Erikson’s thought to argue that caregivers mediate divine love. I will include my interpretation from the visional/metaphorical section, some material from his systematic theology, and introduce new concepts that will be fleshed out more in the following interpretive level of IPMR on human tendencies and needs.

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162 Ibid., 371.
163 Ibid., 549.
First, I will focus on Pannenberg’s understanding of exocentricity and openness to the world that directly speaks to an obligation to respect and honor the worth of each person. Again, exocentricity is contrasted and with centricity. As biological creatures, humans have drives and basic needs just like other creatures in God’s creation. However, these forces in creation do not determine humans because humans are able to step outside of themselves and reflect on the nature and purpose of those drives and basic needs. This is why Pannenberg refers to this process as exo-centric; it is a way of becoming external or on-the-outside-of-oneself. Centricity is the opposite of this and is a focus on the self that exhibits an inability to step outside of the self. The exocentricity of humans allows them to be open to the world—open to the world and not bound within the self, which allows one to participate more fully in the process of becoming. Openness relates to the process of becoming through the mechanism of stepping outside of oneself. One can analyze, anticipate, question, and refocus their bodily energy in ways that tend to the needs and concerns of others. It is in the exocentricity and openness where one finds part of Pannenberg’s locus of the divine.

Because of one’s exocentricity, one can be open to the voices and experiences of the other. Because one is able to step outside of oneself one can, ideally, experience a certain level of empathy and care for another regardless if their values or beliefs in an EOL situation differ. As a spiritual caregiver in a hospital, for example, one is able to hear the needs and concerns of the other as separate and different from oneself. Pannenberg understands this exocentricity and openness as part of being created in the image of God. God created the world and humans and called it good, therefore, this
component of the image of God is part of the way in which God wants us to care for God’s creation. This obligation is built into the fabric of creation.

Second, the way in which Pannenberg sheds light on human misery and love pushes us to care for people that are in distress. Ultimately for Pannenberg, since God created the world, humans are determined by and get their meaning from God. God creates the universe and God, therefore, determines humans. For Pannenberg, being determined by God means that God’s redeeming grace (through the incarnation) focuses on redeeming the misery and sin in humanity. God created the world and redeems the world out of God’s love because of human despair and sin. Pannenberg prefers the word misery instead of sin. It more accurately captures the experience of humanity’s brokenness, separation from God, and experience of evil as humanity awaits the consummation of God’s kingdom for Pannenberg. We are far from God: “the term misery sums up our detachment from God, our autonomy, and all the resultant consequences much better than the traditional word of sin.”

Unity is a response to the separation, isolation, and despair of God’s creation and people. Pannenberg seeks to understand human unity and wants to move beyond traditional interpretations of Paul’s simple distinction of body and soul. Pannenberg would argue that the biblical view and the early church fathers do not make any distinction in terms of human body and soul as separate entities. For Pannenberg, our unity seems to depend on the working of the Spirit as a way of unifying conscious life

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164 Wolfhart Pannenberg, Systematic Theology, 2:179.

165 Ibid., 182: “Over against Platonism, which was becoming the dominant philosophy of late antiquity by the middle of the 2nd century, the early church fathers defended our psychosomatic unity as a basic principle of Christian anthropology.”
and subjective freedom. “The being with others as others mediated by perception awareness seems to include, along with the distinction of objects from one another and from the “I” of one’s own body, the field of consciousness in which the basic relation of me and world takes its contours.” Interrelatedness of all these elements—me, the world, Others—is not the result of a person but the Holy Spirit, the divine Logos. We are all persons in unity, psychosomatic unity, because of the work of our Creator.

As the Son, in his self distinction from the Father, is united with him by the Spirit in the unity of the divine life, and as, in his creative activity, he unites what is distinct by the power of the Spirit, so the differentiating activity of human reason needs the Spirit who enables it, by mediating the imagination, to name each thing in its particularity, and in all the distinction to be aware of the unity that holds together what is different.

How does Pannenberg’s thinking on the image of God, misery, and unity relate to our obligation to care for each other? First, despair is an all-encompassing description of the experiences of crisis and illness of all creation. In the face of despair within a hospital setting, humans seek unity, comfort, peace, and a reconciliation of their fragmented crisis of health. Caregivers can, therefore, connect with and care for all peoples through the common experience of despair and the seeking of unity. Further, since love is the divine essence, and love and care are the driving force of caregiving regardless of one’s context, one’s love for creation and the people of the world drives and shapes care.

Lastly, Pannenberg draws on the concept of basic trust in Erik Erickson and George Mead’s understanding of “I and Me.” For Pannenberg, one is dependent on one’s social relations for a complete understanding of and experience of personhood. Social

166 Ibid., 193.

167 Ibid., 197.
relations and the experience of care are what contribute to human development and the process of becoming the image of God, especially in early childhood. Before he gets to Eric Erickson’s idea of basic trust, he draws on Mead’s understanding of interpersonal subjectivity. A subject and another subject are distinguished as I and me because of the process of exocentricity that I outlined above. Pannenberg and Mead both espouse the necessity of community and interpersonal relations. Given the necessity of these relations, Pannenberg draws on Erickson’s understanding of basic trust. The central caregivers in one’s life are a symbol of God’s love and the concrete medium through which one experiences God’s love. Caregivers point beyond themselves to the nature of the divine love, which is the only “symbol,” so to speak, capable of being a true holding environment for are the needs of God’s people.

At a basic level, all humans depend on social relations for their personhood and being. I want to push Pannenberg’s claim and state that we are obligated to empathize with people because we are all part of God’s creation. One’s concern for and care for God’s creation cannot be dependent on the particular framework out of which the caregiver operates and finds meaning. Especially in difficult EOL ethics situations, the medical team is obligated to empathize with the family. As a caregiver one can provide a moment of love for the needs and concerns of another as one who mediates the unconditional love of God—not ultimately as God but as one who simply cares for another.

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169 Ibid., 232-233.
Empathy and Obligational Level

Empathy not only cultivates neighbor love, but also we are obliged to empathize with our neighbors and love them as ourselves and as they want to be loved. From the visional level of IPMR we learned that empathy cultivates neighbor love, and now in the obligational level we learn about our obligation to empathize with our neighbor. First, we are obligated to care for those in distress out of the principles of care and justice. However, our care and justice must coalesce around the experience of the family. Second, we are obligated to strive for exocentricity and openness—in EOL cases, to be open to the distress of the family. As humans created in the image God, we will struggle with these two forces that work against each other but ultimately we can strive to focus on the needs of the other. Third, we have an obligation to love and have compassion for every human being as people suffer the tragedies and despair of life.

Tendency-Need

When reflecting on an obligation, one ought to think about the physical and emotional needs of the people involved. Humans have certain tendencies that need consideration when reflecting on how obligations are or are not put into action. If we recall chapter three and Browning’s understanding of tendencies and needs, the human sciences of anthropology, sociology, and psychology provide insights into what these needs and tendencies are for humans. Browning terms these pre-moral goods, which relate to human’s basic biological needs. According to the human sciences, there are many things that fall under the category of pre-moral goods, and Browning is fairly vague on what pre-moral goods look like in someone’s day-to-day life. Pre-moral goods are not easy to define. Browning does provide a list of these goods from the Catholic
theologian Louis Janssens: life, health, pleasure, joy, friendship, education, a good meal, or a good automobile. However, even this list is vague. Pre-moral goods may relate to David’s case in terms of his prognosis: how much will he be able to enjoy his life and find it meaningful given his prognosis? More specifically, will David be experiencing “a good meal,” so to speak, if he is in a minimally conscious state and in a care facility? One can get food for nutrition and bodily sustenance without enjoying the process of eating. Does food-as-sustenance count as meaningfully experiencing food if that food comes through a feeding tube? Will he experience intimacy/friendship and a meaningful way? Does having a loved one in the room with him reading to him, holding his hand, and talking to him count as friendship and intimacy? Does David have to let the medical staff and family know (i.e., communicate verbally or non-verbally) that he has found pleasure in these activities? One may benefit from intimacy without communicating that one has benefitted from intimacy. Not only is it difficult to decide what counts as a pre-moral good (understood as part of our basic biological needs), but also it is also difficult to decide what counts as experiencing these goods.

The difficulties of naming and defining pre-moral goods aside, I want to focus on human needs and tendencies as they relate to empathy and care. There are obligations we have to our neighbor, and some of the concrete details of how we live out the aforementioned obligations to our neighbor will become evident below. What we will also see is how the dialogue of care—understanding the mental and emotional states of others and responding with care in which we can think of God as present—gets lived out and is a central part of empathy. David’s family has needs related to their distress because

of David’s hospitalization. The medical team needs to empathize with the family in order to determine their needs.

Hoffman’s Moral Development

Driven by his ultimate metaphors and how he frames obligations, the core of Hoffman’s understanding of empathy comes in the tendency-need dimension of IPMR. As we saw at the beginning of the chapter, his interpretation of empathy focuses on people’s tendencies in responding to those who are in need—how people care for others who are in distress. He traces this through his developmental paradigm. These tendencies and responses are part of the dialogue of care between people and within communities that is central to cultivating empathy. In difficult EOL cases, the individual members of the medical team vary in their ability to empathize with the distressed family. Hoffman’s developmental process outlines why it is important to empathize with people in distress and some of the reasons why individuals have a hard time doing so. The way Hoffman details the development of empathy shows how we might develop the ability to

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Hoffman’s developmental pathway, like his obligations of caring and justice, is framed in a highly Anglo-European American manner. Hoffman tries to make his model apply to all times and places when he addresses the “universality and culture” issue in the last few chapters of his book. Even though he appeals to basic human tendencies and biological processes (i.e., the recognition of the face and the desire to care), I do not agree with his universality claim throughout his entire developmental paradigm. His claim may work for the early stages of development, but even those are difficult to hold onto given the diverse parenting and caregiving practices throughout the globe. This is not to say that his model is non-viable. In Anglo-European American contexts, his particular interpretation of relationship patterns resonates well. Hoffman seems to want to make his model one for all times and all places, and I do not think this is possible. For global comparisons, see Miriam K. Rosenthal and Dorit Roer-Strir, “Cultural Differences in Mothers’ Developmental Goals and Ethnotheories,” Journal of International Psychology, 36, no. 1 (2001): 20-31; and Catherine S. Tamis-LeMonda et al., “Parents’ Goals for Children: The Dynamic Coexistence of Individualism and Collectivism in Cultures and Individuals,” Social Development, 17, no. 1 (2008): 183-209.
love in such a way that coalesces around the needs of the family in these cases. There are four main stages to his developmental paradigm.

First, the newborn automatically cries when hearing the sound of another’s cry, which Hoffman refers to as the “newborn reactive cry” phase. There is little to no differentiation between the distresses of either infant. When a secondary infant hears the cry of the primary infant, the second infant’s cry is almost identical to the spontaneous cry of the first distressed infant. The cry could be reactive, imitative, or conditioned, but what one sees in such a cry is the early dynamic of empathy. The emotional state of one person causes a similar emotional state in another. Because there is no distinction between self and others, as demonstrated in the automatic cry, there is no dialogue of care of self and care for others at this point in one’s development.\footnote{Gregory Hamilton, a psychiatrist, reflects on the creation narrative in Genesis as reflecting the state of the newborn: “In this way, the Bible begins by describing an undifferentiated and unintegrated mass—the stuff out of which humankind was molded. … Object relations theory indicates we all begin in an undifferentiated state, without form. Slowly we begin to take shape and separate. N. Gregory Hamilton, \textit{Self and Others: Object Relations Theory in Practice} (Lanham, MD: Rowman and Littlefield Publishers, 2004), 271-272.}

The care from the caregiver has a profound impact on the infant. Experiencing love results in “feeling felt” and impacts how neural pathways are developed in the brain. The caregiver’s ability to recognize the emotional states of the child impacts the child’s sense of relationship with the caregiver.\footnote{Siegel, \textit{The Developing Mind}, 69-71.} “Feeling felt” leads to the development of a more secure sense of self, thus a greater chance the child will empathize with the emotions of others since it literally has felt that dynamic before.

Second, near the end of the first year there are hints of the child understanding the difference between his or her distress and another’s. Hoffman calls this “egocentric
distress.” Whimpering and watching the other, suggesting some difference, may accompany the newborn’s cry. The difficulty in distinguishing between the self and the other, however, still exists because kinesthetic sensations also pervade the infant’s response to the distress of another.¹⁷⁴ What creates the infant’s “core self and gives it coherence and continuity are the kinesthetic sensations infants receive from their muscles.”¹⁷⁵

Third, infants begin to make helpful advances toward the distressed other early in the second year of life. These advances may be in the form of touching, patting, hugging, or kissing. Hoffman refers to this as the “quasi-egocentric” phase of development. Such actions indicate the child is able to see the other person as a separate person, but children tend to “use helping strategies that they find comforting.”¹⁷⁶ Therefore, there is both understanding of difference and a lack of difference as the infant responds to the distress of the other.

The difference between the self and other continues to grow at this stage. The child physically moves and responds to the distressed other. The care of the parent in the earliest years of life continues to show forth as the child becomes less and less engrossed in its own world and begins to open itself up to another. The kissing and hugging are small acts of love directed toward the distress and hurt of another. Seeing the other as unique, the child reaches out and responds in the only way s/he knows how—asking him-or herself, “what would comfort me?” In light of this question, however, one sees how


¹⁷⁶ Ibid., 70.
the tendency to care for the other in light of the needs of the self shapes one’s actions. Though the child responds to the other, s/he is also responding to the other as if the other is the self.

The fourth and final phase for Hoffman is called “veridical empathy” and is the longest stage, lasting the rest of our adult lives. Infants recognize themselves in a mirror for the first time and begin to recognize that others have inner states of feeling.¹⁷⁷ These developments occur in the second year. For example, in the previous stage a child would soothe a distressed person using methods the child found helpful, whereas in veridical empathy, the child adjusts and uses methods the distressed finds helpful. Subjective experience goes through a series of differentiations, and the child is eventually able to differentiate its own inner feeling states from another’s. Hoffman notes that children engage in “self-focused and other-focused role taking.”¹⁷⁸ The self-other role taking occurs as the caregivers use induction during the child’s development. Induction occurs when parents highlight the other’s perspective, point out the other’s distress, and make it clear that the child’s action caused it. Highlighting the child’s role may be the way to expand their empathy to understanding how they caused the distress.¹⁷⁹

¹⁷⁷ Veridical empathy proceeds through three sub-stages. First, in the early years children begin to understand the causes, consequences, and correlates of emotions and especially feelings that can affect a person’s facial expression—not only the differences in facial expressions but that people can have different responses to the same situation. Second, in the middle years (ages six to eleven), the child makes connections between their own feelings and the feelings of others, understand the same event can cause opposed feelings, and by age nine or ten draw on another’s reaction to a situation when constructing their own feelings. Third, in adolescence, children are able to make assessments about what one would normally feel in a situation and what a specific person actually feels.

¹⁷⁸ Hoffman, Empathy and Moral Development, 73.

¹⁷⁹ Ibid.,142, 152-153.
caregiver points out how one’s actions impact others, one begins to imagine the needs of other’s and how to respond to a distressed other.

Hoffman’s developmental scheme demonstrates how one moves from a very self-focused world (not necessarily selfish) to empathy focused on another person as separate from the self. From Hoffman’s observations and survey of studies, it is clear in his work that this is a human tendency. Humans respond to distress and attempt to soothe it for a variety of reasons: love, guilt, distressed by the distress, justice, and many others. There is also a deep need to be cared for when one is in distress. This need is what catalyzes the empathic distress in the caregivers. People, in early development especially, want to feel felt and understood and have a sense of a safe and trustworthy caregiver.

The stages of newborn reactive cry and egocentric distress exhibit how a person remains largely intertwined with her or his world. It is difficult to tell the difference between distress in the self and distress in others at this point. The care at this point in development is, therefore, care of the self. On an unconscious level, the person worries mostly about their needs and less about the needs of others. One’s caregiver, however, is (hopefully) focused on the needs of the child, thus there is a strong sense of care of the other on the part of the caregiver. Having the other (i.e., caregiver) care for the self in this way is important for the mature development of empathy. The stages of quasi-egocentric and veridical empathy exhibit the point at which a person begins to respond to the other’s distress and care for him or her. Quasi-egocentric distress demonstrates how the person still responds out of the self’s needs but applies these to another person. The care of the other still means care of the self as one applies self-soothing methods to another person. In veridical empathy, one tends to the other’s distress as the other’s distress.
The caregiver’s role in this process is important. Caregivers can point out to the developing person how their actions impact others. Having one’s own needs met (the other caring for the self), meeting one’s own distress needs (caring for the self), tending to the distress of another (caring for the other) is the dialogue of care out of which the ability to empathize grows. All of these processes—having one’s own needs met, feeling cared for, and understanding another’s distress—create the emotional sensitivity and social understanding to be able to empathize with and respond to another’s distress in a supportive way.

Martha Nussbaum’s Philosophy of Emotion

A large part of Nussbaum’s work focuses on the development of emotions and the needs of people throughout their various stages in life. Nussbaum recognizes the impact emotions have on the development of the person—not merely how one expresses and processes emotions in the present, but the history of emotion in one’s life in connection to one’s caregivers. Nussbaum’s key concepts and terms that address emotions, tendencies, and needs are as follows: cultivating a map of the world and vulnerability. I will explain each of these in turn and how they relate to our tendencies and needs. The central thread in Nussbaum is that people need to experience the world as a trustworthy place—a place with people that care about them where they can share their emotions and struggles with others and hear the emotions of struggles of others in return.

First, Nussbaum’s concept of “a map of the world” is the foundation for illuminating the aforementioned central thread in her thinking. Within the process of development and our experience of emotions, she emphasizes how we, in her words, develop a map of the world as good and bad place. We all interact with the world
emotionally and in other ways, and as a result of these interactions, we develop an interpretation of the world as a place that we can trust or not trust. This is our map. To parse this out a little further, up until the later stages of development, the person goes through a drama of development—a series of struggles and joys related to developing a sense of self that is independent of the comfort of the mother’s womb and is in interaction with an unpredictable environment. Drawing on Lucretius, an Epicurean poet and philosopher who died around 50 BCE, she states that this drama of development has everything to do with an infant discovering a relationship to external objects of high importance. These objects of high importance are people and experiences in one’s life, and they are important because they are either to be trusted or feared:

But in our world, emotions are needed to provide the developing child with a map of the world. The child’s emotions are recognitions of where important good and bad things are to be found—and also of the externality of these good and bad things, therefore also of the boundaries of its own secure control.

Nussbaum uses the metaphor of a map because our experiences of the world as a trustworthy or untrustworthy place are placed on our map, so to speak, as part of our experience, memory, and history. Our maps are part of our identity; at the same time they are rooted in our past and chart a course for the future in our lives. Our maps impact how we organize our life in the present and how we make decisions about our lives in the future. In my interpretation, our maps of the world come into play during stressful and heartbreaking moments in our lives. In difficult EOL situations, it is helpful for the

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180 Martha Nussbaum, Upheavals of Thought, 183.

181 Ibid., 206. Italics mine.

182 Ibid., 140-142, and 174.
medical team to be aware of the subtle interplay of good and bad maps of the world that are at work within themselves and the family.

Second, mapping the world as a place of trust is related to the concept of vulnerability. I do not mean vulnerable in the sense of being susceptible to physical or emotional attack or harm, but in the sense of being able to share and express our emotions, beliefs, and values with the knowledge that others will respect and honor us. Again, is the world a trustworthy place (good) or is it not to be trusted (bad)? Will others respect and honor my emotions, values, and beliefs? If we cannot be vulnerable and open up to others about what we feel and think, our map of the world will contain points of mistrust, shame, and fear. Nussbaum cites Winnicott and states that we must feel held, so to speak, by our environment if we are to feel that our environment is trustworthy:

His idea is that the sense of self, and especially any inner depth or creativity in the self, require a sense of safety that is not always being reinforced by the physical holding of a caretaker. In order for this sense of safety to emerge, the child must be able to feel held even when not being physically held: she must come to feel that the environment itself holds her.\(^{183}\)

Though Nussbaum speaks of children in this quote, she touches on a deep human need across the life span. We may not trust that others will accept us for who we are and what we believe, we will be ashamed of how we feel or think, and we might be scared of particular cultures, experiences, or challenges. Being vulnerable with each other is a human need. When others share their emotions and beliefs with us, we need to honor and cherish them. When we are vulnerable with each other—when we are able to honor the emotions, beliefs, and values of others—we are better able to empathize with each other and help each other feel as though our environment is holding us.

\(^{183}\) Ibid., 208.
Nussbaum touches on the brokenness and suffering of what it means to be human. It is in the *pathos* of the vicissitudes of life where we connect with each other, learn what to value (good and bad), and are taught how to value the world and its people. Vulnerability related to the self and in the other is an important psychological insight if one is to see and embrace the other holistically as a unique individual. We are vulnerable creatures, and it is in this vulnerability where we comfort, connect, and empathize.

**Pannenberg’s Anthropology**

The earlier discussion of exocentricity and centrality demonstrates the tension in human nature around the capacity for empathy—a focus on the self or on the other can dominate one’s map of the world. I have been focusing on *intrapersonal* dynamics in Pannenberg, but *interpersonal* dynamics also impact human nature in his thinking. It is within the interpersonal dynamics that we can think of God as present calling us to love our neighbor as they want to be loved in difficult EOL cases. To tease out the ways in which interpersonal dynamics relate to human nature, Pannenberg addresses the relationship between the individual and society: individuals shape society and society shapes individuals. Pannenberg concludes, “The ‘I’ or ego, does not stand as an independent entity. … Rather, the ego proves to be dependent on its social context for the determination of its identity.”\(^{184}\) This theory of the self and society has merit, in my interpretation, because it shows the dependence of the ego on the encounter with a Thou; the ego is not a sovereign subject.\(^{185}\)

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\(^{184}\) Pannenberg, *Anthropology*, 164.

\(^{185}\) Ibid., 184. Pannenberg is not unique in discussing the I-Thou relationship in theology. For Karl Rahner, one reaches beyond ones finitude and experiences oneself as transcendent. This transcendentiality of the individual results in one, the realization that this transcendence is grounded in the world because it is only realized as mediated through the various empirical anthropologies (*a priori*); and two, that an
and other members of the medical team are not completely autonomous subjects. In EOL situations like this, there is intersubjectivity and it is within this (loving) intersubjectivity where we can think of God acting.

Pannenberg ultimately draws on G.H. Mead and William James when developing an understanding of the relationship of the individual to society. Humans are dependent on the face of another, so to speak, for their identity. For Mead, individuals understand their relationship to others through the ability to understand language and gestures of others. When one makes a gesture, one sees how the other reacts to it thus perceiving the gestures significance; one knows one’s own actions and that one’s actions are something to which the other reacts. There is, in this scenario, both an ego and a self—an ego with its own agency and a self-created by how others (i.e., the face of another) react to the original ego. Pannenberg wonders: What is the true ego or self? Am I the original acting ego or the socially constituted ego given to me by other’s reactions? William James provides his answer for him: “The momentary ‘I’ that appears in the form of each momentary unit of consciousness can exercise its synthetic function of appropriating its objects to ‘itself’ only indirectly via the ‘self.’”\(^{186}\) The self, for Pannenberg and James, is the socially mediated sense of self. There is an initial and very brief independent action of

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\(^{186}\) Ibid., 220.
the individual, but in the end the ego and the self are tied together. The ego is given vitality only in the reflecting back of itself from the face of another.

It is in the idea of a “face of another,” as I have described it, that Pannenberg sees God in the socially meditated part of human nature. The child’s ego is dependent on the caregiver in the early stages of development and develops a sense of basic trust. Humans inevitably detach from their parents and direct their sense of trust about the world in another direction. Pannenberg argues this basic need of humans to have an object of trust shows there is a “theme of God’ inseparable from the living of human life.”

Basic trust is directed to an agency that is capable of providing limitless safety and trust. There is, therefore, a religious thematic to all of life and a seeking of “God” in life.

The seeking of an agency of trust is the quest for wholeness in one’s life and it comes back, in my interpretation, to Pannenberg’s idea of human becoming. This provides a place to summarize Pannenberg’s understanding of human nature and draw in the visional and obligational levels. Humans are, on the one hand, characterized by the unique quality of openness to the world and exhibit reflexive thought patterns. Animals are, on the other hand, bound by the environment, and their actions are solely dictated by their instinctual behavior. As I said earlier, Pannenberg’s distinction here is too simplistic, but we can adopt his thinking for looking at human nature.

Exocentricity, defined as self-transcendence, is the way in which humans distinguish themselves from animals. Centricity is focus only on the self and a lack of openness to the world. Though humans may be unique in their reflexive thought patterns,

187 Ibid., 233.

188 Ibid.
centrality and exocentricity characterize their human nature. Openness to the world (exocentricity) creates a place for Pannenberg to talk about the image of God as a teleological concept, something towards which humans move. Openness to the world is ultimately being open to the absolute Other beyond the world. The quest of humans to live into the image of God, however, is also fraught with overt and excessive focus on the self in centricity. The self is not always focused on the other or God, hence the self is guilty of the sin of pride and egoism. The process of other-focus and self-focus begins early in childhood with the trusting relationship of the mother. The caregiver and a relationship of basic trust mediate the sense of self. Once the child grows up, a new source of trust is sought in an agency capable of providing a limitless sense of trust. In this seeking of an agency of trust, sometimes the needs of the self become dominant. One turns oneself into the agency of trust or puts one’s trust in a principle or agency incapable of providing limitless trust. Other times one’s trust is directed at the appropriate agency of trust.

For our purposes in difficult EOL cases, Pannenberg sheds light on the intersubjectivity of the encounter between the family, medical team, and patient. Humans become the image of God and get their identity from the socially mediated self. David is not isolated from his loved ones, and the medical team is not isolated from the family. All of the people involved in our case are connected to each other and are dependent on each other for their identity. Pannenberg urges us to see our identity and being as dependent on forces outside of ourselves: God and other people. Becoming the image of God means we open ourselves to how we part of each other, and in doing so, we learn to trust each other and care for each other.
Empathy and Tendency-Need Level

The tendency need level of IPMR is rich with resources not only for illuminating how the dialogue of care cultivates empathy and how we can think of God as present in this dialogue, but also for deepening our understanding of empathy. First, we learn how important the caregiver’s caring is in the early years of development. In these years, humans can learn that someone is there to soothe their distress. The seeds are planted for later development when humans can learn to differentiate between their own distress and the distress of another, which is what Hoffman refers to as empathic distress. These early years are also when humans develop a map of the world, what is safe/unsafe and good/bad. People develop a trust and an ability to respond to the distress of others.

Second, under the auspices of the caregiver, we can think of God’s presence as part of the dialogue of care. In seeking a symbol to hold our sense of hope, safe/unsafe, love/hate, joy/despair, and insecurity/security, there is always a God-theme to life. I will flesh this out more in the last two chapters, but for now, I will say that we can think of caregivers as the presence of God. Caregivers do not become God, but they are the sacred vessels through which we experience love and trust, the vessels through which love of neighbor is shared.

Looking Ahead

The final two chapters will be devoted to bring the insights of this chapter together into a definition of empathy that we can use to develop normative guidelines for hospitals in difficult EOL ethics cases. There are many insights into empathy to mine from the case study and our interdisciplinary thinkers. After I construct my definition of empathy, the normative guidelines will serve to operationalize the insights of this chapter.
for use in hospitals. These guidelines will heavily emphasize the importance of empathy in EOL situations. I do not think EOL cases should only be about empathy, but it is not emphasized enough and it can help these cases reach a resolution.
CHAPTER SIX
INTERCULTURAL PRACTICAL MORAL REASONING: DEFINING EMPATHY

Definition of Empathy

The final step in the IPMR move is to bring together the reflections of the previous interdisciplinary chapter. The authors' ideas on development, emotion, God's presence, and relationships provided insights into empathy which can help us to understand how practicing empathy cultivates neighbor love and facilitates resolution to difficult end of life cases. Before moving into the strategic move of IPMR, I want to make sure that the richness and depth of the last chapter are not lost. Here I will unpack my interpretation of empathy based on my experience as a hospital chaplain, the case study, and the insights from the last chapter.

Empathy is a practice that develops out of the developmental antecedents in early childhood experiences with the caregiver as a result of the dialogue of care with one's caregivers and feeling felt. In adults, this results in the ability to understand the mental and emotional states of others and a desire to respond to their distress with compassion, in which we can think of God as present calling us to love the neighbor as they want to be loved.\(^{189}\)

\(^{189}\) My definition of empathy comes primarily from the psychology of Martin Hoffman, the theology Wolfhart Pannenberg, and the philosophy of Martha Nussbaum, but there are also influences from the primatologist Frans De Waal, the psychiatrist Daniel Siegel, and the political philosopher Michael Morrell. First, my definition eschews understanding empathy as a cognitive process between caregiver and care receiver. Mid-twentieth century psychotherapy tended to understand empathy in this way. Carl Rogers and Heinz Kohut, for example, speak of empathy in the psychotherapeutic relationship, respectively, as “entering the private perceptual world of the other and becoming thoroughly at home in it … communicating your sensings of his/her inner world,” and “empathy is a mode of cognition which is specifically attuned to the perception of complex psychological phenomena.” One can see Rogers and Kohut’s focus is on understanding the feeling and mental state of the other with very little emotional resonance or congruence with the other. Carl Rogers, “Empathic: A Unappreciated Way of Being,” *Counseling Psychologist* 5, no. 2 (1975): 3. Heinz Kohut, *The Analysis of the Self* (New York: International Universities Press, 1971), 300. I side more with the social and developmental psychologists Nancy
In order to unpack this definition and bring in the interdisciplinary thinkers from the previous chapter, each of the italicized phrases will be parsed out below. Each subsection will bring in elements of the case study and the interpretations from the previous chapter. I will close the chapter with a section on the limits of empathy. It is important to know the strengths and weaknesses of empathy. It is not a magic pill that will fix all that ails difficult EOL cases.

God as Present Calling Us to Love

I am going to start with the last element in my definition of empathy. From my perspective as a chaplain, this is part of every element of my definition. I say this because for Pannenberg humans are always in the process of becoming, becoming the image of God towards which a loving God is calling them. As we develop, God is present calling us to love; as we experience a dialogue of care with others throughout life, God is present

Eisenberg and Janet Strayer who define empathy as “an emotional response that stems from another’s emotional state or condition and that is congruent with the other’s emotional state or situation.” Nancy Eisenberg and Janet Strayer, “Critical Issues in the Study of Empathy,” in Empathy and Its Development, eds. Nancy Eisenberg and Janet Strayer (Cambridge: Cambridge University Press, 1987), 5. However, even though Eisenberg and Strayer highlight that empathy is an emotional and affective congruence, I favor defining empathy as containing both emotional and cognitive elements. I think this more multifaceted definition captures everything involved in empathizing with another person. Pannenberg, Nussbaum, and Hoffman will be extensively discussed in this chapter, so I will briefly describe the others’ influence on my multifaceted definition here. Drawing on Morrell, empathy is process or dynamic between people. Empathy is not an emotion in and of itself, though emotions are experienced in the process of empathy. One should say one had an empathic interaction with another person as the result of the proper pathways for the flow of emotions to take place. Second, drawing on Siegel and neuroscience, empathy is the presence of resonance or attunement in the developmental process. Attunement or resonance is important because feeling felt is the central element of an empathic dynamic between people. For Siegel, feeling felt results in the development of neural pathways of emotional connection. Third, similar to the way that Siegel describes in his comments on the development of neural pathways, De Waal speaks of a mechanism in the brain, which grants the ability to read the emotional states of others and responding accordingly. The brain needs a place to experience emotional contagion of another. But, and leading into one of key elements of Morrell’s argument on reactive intrapersonal outcome, De Waal requires a response or action from the observer. This is a response to the felt internal empathic dynamic. See Morrell, Empathy and Democracy; Frans De Waal, Primates and Philosophers; and Daniel Siegel, The Developing Mind.
calling us to love; and as we try to understand other’s thoughts and feelings, and respond to their distress, God is present calling us to love. For Pannenberg love is God’s essence, God’s action, and the totality of God’s being. The anthropology that we explored in the visional, obligational, and tendency need levels were all part of how this loving God acts within God’s creation. The openness to the world made possible by humans exocentricity is part of this radical and reckless love that allows us to step outside of ourselves to embrace others; the need for and dependence on social relations is God’s love working in and through each other; and God’s love calls us to care for each other in times of suffering and in times of need. Love is the radical force that breaks open and breaks into the brokenness of creation and works within the tissue and sinews of God’s people and God’s world. I am focusing on a very small part of this call to love, empathy, but empathy is necessary in difficult end of life situations if we are to heed God’s call to love our neighbor.

Love is present in the visional level of Pannenberg’s thinking. I see love as present and part of his emphasis on exocentricity and openness to the world. Our ability to reflect on ourselves—as connected to each other yet distinct from each other, as we saw in Hoffman’s psychology—is one of the ways that we can think of God working within us to love our neighbor, a love that moves to penetrate and touch suffering in order to understand the nuances of that suffering. I will say more about how this is an ideal way for love to function in the following section on the limits of empathy, but this is an important part of empathy’s gift.¹⁹⁰

¹⁹⁰ Is love only present when an entity has the ability to be open to the world and exocentric, to use Pannenberg’s terms? Since Pannenberg states that animals are centric, what do we do with centric creatures that can show love? When I use Pannenberg’s distinction between humans as open to the world and animals or nonhumans ask closed off to the world in this way makes it seem like there is only Love
Love is also present in our obligations to others. Given our ability to be open to the world, there is an obligation to love others. Given the brokenness of creation and the suffering of creation that touches everyone and everything, which Pannenberg defines as despair, we are called to love each other as we suffer together. Being present with and caring for those who are suffering brings a measure of hope and grace to situations of despair and brokenness. Given that we are who we are because of our social relations and loved ones, we are called to love each other and care for each other.

Love is present in meeting the needs of others. Each of us has a need for a basic trust in the world, and this is often mediated through the caregivers in our life. Caring for another and helping them cultivate a basic trust in the world is an act of love. If someone has this trust, their map of the world is one of goodness—or at least good enough so the badness, so to speak, is met with goodness of care and love.

**The Case Study**

“God calling us to love” is not necessarily a different part or layer of David’s case. Just as I see God’s call to love in each part of the definition of empathy, I see the parts of the case explicated so far as part of the ways in which God’s love plays a role in this case. We can think of God as present in each of the lives of the family and the medical team as they developed and grew into the people that they are now in the particular moment of the ICU. We can think of God as present in the dialogue of care

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when an entity has the ability to be open to the world. I do not believe in such a rigid hierarchy. There are many types of love and humans or animals are still caring for and tending to each other’s needs even if they live a more biological life and not a biographical life, biographical in that they can think about their thinking and situate themselves in history. However, for the purposes of interpreting and defining empathy, I do think the capacity to be open to the world and exocentric is necessary. Empathy is a practice that requires complex cognitive and emotional mechanisms.
between the medical team and David, David and the family, and the family in the medical
team; care is present in each of these relationships as God pulling the medical team to
love the family as they want to be loved. We can think of God is present calling the
medical team to love in the moments where they understand the mental and emotional
state of the family; when neurologist understands the family’s desire to go to another
hospital to keep trying for recovery, when the clinical coordinator asks the members of
the team to try and imagine if they were in this family the exact situation, and when
members of the family don’t agree with the wife’s decision and still support her. These
are all examples of places we can think of God’s presence calling each of those people to
love through empathizing with those in distress in this case study. The medical team
cannot “love the family as ourselves.” The love required in this case is the love that
focuses on the other, the needs and suffering of the family.

Developmental Antecedents

We can see the developmental antecedents of empathy in all three of the thinkers
from the last chapter. We touched on these mostly in the tendency-need level of the last
chapter. Pannenberg and Nussbaum emphasize the importance of development in the
early years of life. In these early years, the relationship between the child and caregiver
cultivates a basic sense of trust in the world and the child’s sense of identity. Trust in the
goodness and/or badness of the world, to use Nussbaum’s words, depend heavily on the
dynamics between children and their early caregivers. Empathic interactions with the
caregiver will help this face become trustworthy, thus helping the child, but the face may
not always be trustworthy and can cause distress. As we will see in the closing section of
this chapter on empathy’s limits, humans can have multiple motives when empathizing
with each other that are part of complex human behaviors. Caregivers will not always embody God’s love—empathizing with their children and loving them holistically as unique beings worthy of honor and respect. Despite this potential absence of love, to be human, created in the image of God, is to experience despair and long for unity. Humans continue to seek love, care, trust, and unity. It is in this face of the caregiver that humans may experience God’s love in, through, and under the auspices of the love of the caregiver. It is in the face of the caregiver that humans can experience empathy and learn how to empathize with others.

Hoffman lays out the descriptive account of how empathy develops, and it is within this descriptive account that we can think of God’s presence. Hoffman’s development process in the tendency need level is the most concrete example of developmental antecedents. Again, there are four main stages. An important element of the first stages is the empathy of the caregivers with the child as growth occurs. These empathic interactions help the children understand their own inner feeling states and in turn begin to see others as having their own unique feeling states. Hoffman’s veridical empathy, stage four, is where the developmental process arrives at what we would call empathy—the process of seeing the other’s feelings and needs as separate from one’s own. For example, in the previous stage a child would soothe a distressed person using methods the child found helpful, whereas in veridical empathy, the child adjusts and uses methods the distressed finds helpful. The child makes connections between their own feelings and the feelings of others, understands the same event can cause opposed feelings, draws on another’s reaction to a situation when constructing their own feelings,
and are able to make assessments about what one would normally feel in a situation and what a specific person actually feels.

**The Case Study**

In the composite case study, each of the people involved have their own developmental history with their respective caregivers. This element of empathy plays a role to the extent that the developmental history of each of the people impacts how they respond to the EOL situation under consideration. However, simply because someone in the case was not able to exhibit empathy in this situation, it is not an indication of distorted or dysfunctional developmental antecedents. There are many factors at work in the case study such as professional role and identity, the emotions of being in crisis, the values and beliefs of the medical team and family, and power dynamics between medical team and family, to name a few. No person can or should empathize with others at all times. However, the developmental history of each of the participants—to what extent they experienced trust, mistrust, joy, love, and despair—does impact how they respond to others in the case. As I have said, it is the medical team’s job is to care for and to empathize with people who are suffering, but the suffering are not required to empathize with the care team.

**Dialogue of Care and Feeling Felt**

The dialogue of care and feeling felt is a core component of the developmental antecedents mentioned in the previous section. The dialogue of care refers to not only the way in which the caregiver interacts with the child, but also to the ways in which the child interacts with the caregiver, and the ways in which the child, caregiver, and social
communal relationships interact with each other. Feeling felt is important for empathy because as a child is empathized with so they may be able to empathize with others.

This element of my definition may seem like a repeat of the previous section, but the dialogue of care and how people feel felt is a specific part of the developmental process and the human experience in general. We depend on others not only for care but also for our identity: people are dependent on their context and become who they are because of their social relationships. This is part of the image of God, part of how humans are created. Feeling God’s love through the love and presence of caregivers is crucial at the beginning of life, but people need the love and presence of others throughout their life; as we grow, the caring becomes more complex as we give and receive care, but we are created to need this throughout life. Caregiver and child are the major players in the dialogue at an early age, but it is crucial not only for people to give and receive care throughout their lives, but also that people feel felt throughout life. Nussbaum reminds us of the deleterious effects that an absence of this emotional resonance has on the life of children and adults. Hoffman also reminds us of the importance of emotional resonance, and though he focuses a great deal on the early years of life, his focus is also on adulthood. The caregiving and caring relationship is important for people at every stage of their lives.

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191 David Hogue supports this claim from a theological perspective: “We are born in relationship and we are nourished by human connections throughout life. There is a very real sense in which the soul exists only in its connection with other souls.” See David Hogue, “Brain Matters: Neuroscience, Empathy, and Pastoral Theology,” The Journal of Pastoral Theology 20, no. 2 (2010): 25-55.

The Case Study

Combining our three thinkers, the dialogue of care is present in larger ways in the case study: the relationships between the family members, the family’s relationship with David, the relationships among the members of the medical team, the medical team’s relationship to David, and the relationship between the medical team and the family members. We can see how complex and difficult it can be to make a decision about what should be done for David given all the variables present in these relationships. If we reduce the above list to the core relationships, then I think we end up with the relationship of the family and the medical team, the family and David, and the medical team and David. First, the medical team is taking care of the family as they are taking care of David. Some members of the team both emotionally and physically (i.e., hospitality for the family and/or medical procedures for David) take care of the family, and other members of the team focus on the former or latter. When the medical team feels conflict in these dual relationships—when what the family wants for David goes against their conscience as medical professional—caring for the family becomes difficult. Second, as part of the family, David has taken care of his family members in various ways over the course of their history. All of the family members have their own feelings about the care (or lack thereof) that David gave them. The family has also taken care of David. Now, they are especially attuned to how they can take care of him in the midst of the crisis. Third, and mentioned a little bit in the first point, the medical team is taking care of David. This is both a personal and a professional care. Professionally, David was brought to the hospital in an emergency situation and it is their duty and obligation to
take care of David. Personally, most members of the medical team got into the practice of medicine because they want to take care of people; they want to take care of David.

These three relationships of caring demonstrate the ways that people are determined by their relationships with each other. For Pannenberg, community is part of the image of God; because we are, therefore I am. We are not autonomous individuals but a community of people caring for each other. We care for each other in the midst of brokenness and suffering in the hope that we feel the presence of Love that unites us together and casts out despair. For Nussbaum, compassion, joy, invulnerability are the words she puts to this kind of love that unites. When people experience shame, distress, and badness, as it were, it is Love that casts out despair.

Understand Mental and Emotional States of Others

This component of the definition depends in large part on the previous two components of the definition. First, we can draw on Pannenberg’s understanding of exocentricity and the image of God. Humans are created with a capacity for exocentricity, which includes the ability to reflect on the self and differentiate the self from others, and in turn to understand someone else as a separate self with separate needs and concerns. Exocentricity is characterized by a “presence to the other as the other. … Grasping of an object as an object distinct from the self, one becomes aware of its otherness.”193 If one is able to name something as an object, then one understands oneself as separate from or a perceiver of the object, and going further, one can then

reflect on an “object” reaching beyond the possibility of all objects of perception to an absolute Other.\textsuperscript{194}

Again, we can see this openness to another and a reaching beyond the self in the development of empathy. Ideally, because of the empathy they received in childhood and their own growing awareness as they matured. As adults, children will be able to understand and differentiate the mental and emotional states of others from their own. Caring for those in distress (i.e., Hoffman’s principles) requires these capacities—to see another’s need and distress as separate (e.g., exocentricity) and not focus on our own needs exclusively (i.e., centrality). Our map of the world—whether the world is place we can trust, and what the good and bad parts of the world are—depends on how well we understand other’s thoughts/feelings and how well people understand ours.

The Case Study

In our case about David, there are moments when the people involved both understand and do not understand the thoughts and feelings of each other. For our purposes, the relationship between the two main units—medical team and family—is the most important. Because the family members were the ones in the most distress, as well as the fact that the medical team members were the default professional caregivers and had the power in this situation, I will focus on the needs of the family. There are many relationships within these two units, but we do not have enough space to address all the nuances in these relationships. Hoffman’s concept of empathic distress helps illuminate the emotions that are present.

\textsuperscript{194} Ibid., 68.
Each of the family members had a variety of needs—needs stemming from their unique distress. Ann was feeling complex emotions from her strained relationship with her dad, and even though she deferred to her mom, didn’t understand why her mom would want to send her dad to a nursing home; Karna was overwhelmed, sad, and in disbelief over the suggestion of comfort care; Sarah was upset at the suggestion of comfort care and overwhelmed that her dad was in the ICU; and Steve occupied a place between being upset at the suggestion of comfort care and confused why his mom would want his dad to go to a nursing home.

There are members of the medical team who empathize with the family better than other members. The neurologist and clinical care coordinator, for example, seem to understand why the family wants to have David go to a long-term acute care hospital and continue waiting to see if he can recover more. While they do not agree with this plan of care, they are able to empathize with the family. Some of the other members of the team struggle with empathy; this is not to say that they should feel and think the same way as the members of the team who are able to empathize, I am only highlighting that there are differences. These members care deeply for David and struggle to empathize with the family because of this care; they do not want to see David condemned to a life of a minimally conscious state in a long-term care facility, making trips to the hospital for treatment of infections.

The medical team responded to the needs of the distressed family in a variety of ways. In the day-to-day care, the entire team cared for David and provided the love and hospitality the family needed. As the case wore on, however, some of the members of the team became less patient with the family. The attending ICU physician was angry with
the family, was overall distant from the family, and remained angry months after David had been discharged from the ICU; the resident ICU physician could also not understand why the family would want David to go through suffering, and eventually pulled away from the family somewhat save for daily short updates; the clinical care coordinator sided, so to speak, more with the family in that she understood the distress of the family and tried to imagine herself in the distressed situation of the family; and the neurologist’s tendencies were more nuanced as she occupied a middle ground between some of her physician colleagues and the clinical coordinator—understanding the poor prognosis but also reaching out to the family.

Understanding the emotions and mental state of the family is an important part of the medical team’s role. If the family feels the care (i.e., care in the emotional sense) that goes into taking the time and energy to understand what they are feeling, even on a basic level this dynamic leads to trust—trust of the medical team by the family and trust that they are being cared for. Being cared for, however, does not mean the family will agree with the medical team’s recommendations. If the medical team cares for the family, it also does not mean the medical team will agree with the family’s wishes. Remember that I think empathy will help the case reach a resolution, not convince one group to agree with the other. A resolution is one in which there is a care plan in place and there is mutual respect and love between the medical team and family.

There is a clear benefit to empathizing with the emotions of the family, a clear benefit that Hoffman captures in his developmental theory and in the studies that he cites. Emotionally attuning with the family also creates a basic trust that is at the core of how Nussbaum described the human condition. Basic trust in the world is how we can think of
God being present in love through the caregivers. Emotionally connecting to the family can touch on this deep in primal sense of hope and trust in the world. Emotionally connecting to the family can help them develop a map of the world, a map of the hospital that is good and sees the care that the team in the hospital gives them as good. We can see how combining the insights of our three thinkers—Hoffman’s understanding of emotions in development, Pannenberg and the cultivating of basic trust through caregivers, and Nussbaum’s understanding of how we develop a map of the world—enriches this component of empathy.

Respond to Their Distress with Compassion

We find the impetus to respond to the distress of others primarily in the obligational level of reasoning in the last chapter. Out of love, compassion, and a sense of care, each of our authors stress how we must respond to others’ distress. Such a response may come from a desire to care for those in need, it may come from one’s overarching principles, or it may be a combination of both. In a difficult EOL situation in the hospital, the medical team may feel a desire to care for the family in need or may not want to help, for some of the reasons highlighted in the case study, but help anyway. Not only does the medical team have an obligation to care for the family, but they also have an obligation to empathize and have compassion for the family.

Theologically speaking, the obligations I pulled out of Pannenberg’s anthropology provide a firm foundation to make the argument for this obligation of compassion. Because we are all created in the image of God with the capacity for openness to the world, we are to honor each person and have compassion for them in their time of
need. The exocentricity of humans allows them to be open to the world, open to the world and not bound within the self. Openness to the world because of one’s ability to step outside of the self allows one to participate more fully in the process of becoming. Openness to the world allows us to be open to the needs of others when they are in distress. We can step outside of ourselves to empathize and have compassion for the suffering. Because we all experience the suffering and joys of being human, we have an obligation to care for the suffering out of our common humanity. When people are suffering and in despair, empathy helps, as much as possible, to understand and enter into that moment of distress and bring some hope and unity to people. Because we are dependent on our social relationships and the basic trust of the world that can be cultivated in those relationships for our being, we have an obligation to have compassion for and a love for those in distress that resonates with a basic trust in the world.

Continuing on to psychology, the basic premise of Martin Hoffman’s empathy and moral development is the ability of a subject to respond to the distress of another. Some definitions of empathy stop at the understanding of the mental and emotional experiences of others. For Hoffman, however, empathy requires that one respond to the distress of others out of the principles of caring and justice. In this way empathy contributes to justice, for in one’s ability to understand, recognize, and feel the distress of persons and communities, one will be able to respond more specifically to their needs.

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195 There are obviously non-theistic paradigms that support compassion for people. For a non-theistic yet spiritual perspective see Hans Alma, “Self-Development as a Spiritual Process: The Role of Empathy and Imagination in Finding Spiritual Orientation,” *Pastoral Psychology* 57 (2008): 59-63. In place of God language and concepts, and drawing on the philosophy of Charles Taylor, Alma speaks of spirituality as “what is of crucial importance to us,” thus connecting spirituality to values about the world. In empathizing with others, our spiritual orientations qua values are confronted with other values. The results of this confrontation are to help people to understand and respect others.
Martha Nussbaum, in terms of philosophy, draws on compassion and vulnerability as contributors to the public good and healthy communities. Compassion stems from emotional development. In the process of development, emotions are crucial to naming what is good and bad about the self and the world. Especially in the naming and experiencing of what is “bad” about the self, one can experience shame and guilt. Caregivers, hopefully secure and comfortable with what is good and bad within themselves, ought to respond to feelings of shame and guilt in children with compassion and embody a vulnerability about their own “goodness and badness” for the child. For Martha Nussbaum, the dynamics of compassion and vulnerability are important for creating whole and healthy communities and are necessary if we ever hope to be able to come together as a community and care for each other working toward flourishing communities.

The Case Study

I think insights of all three of our thinkers can be captured by a principle of caring within the case study. Pannenberg’s anthropology provides us with obligations to care for people who are suffering; Nussbaum stresses compassion for others throughout her philosophy; and Hoffman’s principle of care addresses many issues in the case. The principle of caring encapsulates each thread from above that relates to responding to the distress of others with compassion. The family and the medical team disagreed about what such a response would look like, however. Even within the groups of the medical team and the family there was disagreement over what the response (i.e., the plan of care) should be for David.
The principle of caring took different shapes within the case study. The family of David and Karna had different understandings of caring than some members of the medical team, and within those two broadly drawn camps there were different understandings of caring. Karna wanted to care for David in such a way that aligned with their beliefs about what constitutes death and a life worth living: his heart was still beating and he would accept the quality of life he would have in a nursing home. She loved him and wanted to honor him in this way. Ann, Sarah, and Steve did not share the same outlook on their dad’s situation. Ann leaned toward the beliefs of the medical team but wanted her mom to make the final decision; Sarah sided more with her mom and her grandparents; and Steve occupied a middle ground between Ann and Sarah. All of the family members wanted to care for David—care for him because they saw him in distress, in pain, and in need of help—even though they had slight variations of what this meant.

The medical team also had different interpretations of the caring principle when applied to David. The attending and resident ICU physicians did not understand why the family would want David to go to a nursing home; the neurologist attending would not have made the decision the family made but felt okay with their decision because of her past experiences and embrace of the unknown; and the clinical coordinator, chaplain, and social worker focused more on trying to get the medical team to understand the perspective of the family. These are all different interpretations of David’s case, but each of the members is trying to care for him. However, for the medical team, I think the principle of care should focus more on the experience of the family. One may wonder how I can ask so much of the medical team in terms of empathy and care. After all, the
medical team members are not detached observers with no stake in the decisions the family makes; they are charged with putting together a plan of care and a possible discharge plan for the family. Frustration with the family could make it difficult to empathize. I recognize this reality and will say more about it in the final chapter.

**Limits in Our Ability to Empathize**

We have almost arrived at providing normative guidelines for hospitals. Before getting to that, however, we need to touch on the limits of empathy in order to present a more complex picture of how it might work in end-of-life ethics disagreements in the hospital. When I present my normative guidelines for hospitals, we must present a complete picture of empathy for those guidelines to have any real significance and impact for hospitals. I briefly mentioned empathy’s limits in the introduction so as to plant the seed in the readers mind that empathy is not a magic pill that will fix all difficult end-of-life situations.

We generally think of empathy as a good thing. However, even our thinkers are aware of its shortcomings—some explicitly comment on empathy and others provide insights into empathy’s limits via their anthropology. Theologically speaking, we have seen in Pannenberg how humans can exhibit openness to the world but they can also be closed off to the world, what he calls centrality. Philosophically speaking, Nussbaum does not fully support empathy and prefers the concept of compassion; for her, at its best empathy is only able to understand another’s situation and is a cognitive exercise that does not enter into another’s suffering. Psychologically speaking, Hoffman acknowledges the mixed motives of empathy and psychological biases that can take place in our
attempts to empathize with others. We will start with the theological limits, move to the psychological limits, and conclude with the philosophical limits.

Theology

Within discussions of openness to the world and exocentricity, we have already heard a little bit about how humans are closed off to the world, a force that struggles against being open to the world. Part of the human process of becoming the image of God as Pannenberg defines it is centrality. We could call this a variety of things: self-centeredness, egoism, or self-love. These concepts do not touch on exactly how Pannenberg defines centrality, but these terms may reverberate in the reader’s mind and help the reader generally understand the concept.

Pannenberg first defines the centrality (as distinct from openness) as a state of being dependent on one’s environment and simply reacting to it. He defines centrality in this way to show how we are bound by the world, bound in that people are sometimes unable to step outside of themselves and their context and are simply reacting to it. Our inability mentally to step outside of ourselves and reflect on our thoughts and actions is centrality. If we are simply reacting to and bound by the world, then we are not open to the needs and concerns of others who are in distress. In moments of centrality, we have a center within ourselves—the center that is not open to the world and keeps our motivations, desires, emotions, and actions within ourselves. One can see how in these moments of centrality it is difficult to empathize in such a way that focuses on the person in distress. I do not think empathy is impossible in these moments, but the intersubjective

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encounter becomes clouded with the caregiver’s thoughts, feelings, and experiences more than with the care receiver’s.197

In end-of-life situations, we can see how centrality could impact the exchange between the family and medical team. Each of the people involved in this difficult decision are part of the struggle between openness to the world and centrality. The wife, the primary physician, the chaplain, and the patient’s children embody this struggle at various points in the case. The wife and the children struggle within the family relationships to empathize with each other. More importantly, the medical team struggles to empathize with the family. Their empathy, or lack there of, was characterized by centrality. Some of the members had a hard time stepping out of their own understanding of David’s case and trying to experience it from the perspective of the family. This dynamic or tendency is not something that we can ever completely overcome. It is simply part of being human as we wrestle and struggle in our becoming the image of God. I do not fault the medical team for this in our case study, but it is important to be aware of this tendency as well.

This core limit of empathy is part of the psychological and philosophical limits that follow as well. Each of the limits that our thinkers address is part of this over all tendency and humans in ability to step outside of themselves. Whether we think about that philosophically (i.e., treat empathy as a mere cognitive exercise) or psychologically

197 Speaking of human self-centeredness in this way is common in the history of theology. Martin Luther wrote extensively on human reason and the will. He argued that the human will is bound and largely focuses on its own needs and desires because humanity selfish. Augustine referred to our selfish tendencies as amor sui—the greed and self-love that is part of being human.
(i.e., the biases and mixed motives) they both speak to what Pannenberg calls centrality.\textsuperscript{198}

Philosophy

Nussbaum speaks of empathy’s limits in a way that resonates with what Pannenberg said about centrality. Her primary concern with empathy is that it does not go far enough if we are actually trying to think of and respond to people that are in distress. She does not deny the importance of empathy but she does not find it useful in and of itself. Empathy fails to actually enter into and respond to pain in the world. She says all of this because she understands empathy as follows: an imaginative reconstruction in an individual’s mind of another’s good or bad experience. In this line of thinking, empathy is more of a cognitive understanding of a good or bad experience; empathy is not about responding to that experience. Because of this, she sees empathy as something that creates a boundary or distance between the caregiver and the one who is suffering.\textsuperscript{199} We can see how this is similar to what Pannenberg said about centrality. In a sense she is saying that one stays cognitively and emotionally trapped inside their own mind if they only empathize with someone in distress. Empathy opens us up to the world and the needs of others—since we are able to and interested in mentally reconstructing other’s experience in her paradigm—but it keeps us mentally and emotionally bound.

\textsuperscript{198} I am reminded here of Don Browning’s claim in Religious Thought and the Modern Psychologies of how modern intellectual disciplines have a “religious horizon” that shapes how they frame the questions they attempt to answer and how they explore those questions. Browning makes the claim that the modern psychologies, while they may not speak of theology or use explicitly religious terms, they depend on the theological and religious metaphors to frame and structure their conclusions about what it means to be human. Don Browning, Religious Thought and the Modern Psychologies (Minneapolis, MN: Augsburg Fortress Press, 2000).

\textsuperscript{199} Nussbaum, Upheavals of Thought, 301-303.
Like centrality, I agree that empathy can be tainted with the cognitive needs and concerns of the caregiver, but I do not think empathy is merely the imaginative reconstruction that fails to move us to respond to others’ experiences. Empathy includes an entering into and a response to suffering. I am not alone in seeing empathy as including a response to distress of another and attempting to address, and therefore care for whatever those needs are.\footnote{Beyond Hoffman’s psychological arguments in this dissertation, see Frans De Waal, \textit{Primates and Philosophers}, 27. Empathy involves involuntary and voluntary processes that are activated in the brain when attending to another’s emotional state. Empathy for De Waal is also the presence of a mechanism with the ability to evaluate and respond to the emotional states of others.} I think this response is important because we cannot simply make our way through life by imagining others suffering. This would either lead to apathy or overload, different responses to just simply imagining others suffering. We achieve a resolution, so to speak, if we actually respond to and attempt to help those who are suffering. I am not sure why she cannot expand her understanding of empathy to what she calls compassion. Thus, not only is Nussbaum’s definition of empathy reductionist, understood in this way it will not be helpful for the caregivers in my normative guidelines. My definition of empathy encompasses what Nussbaum says about compassion.

Jesse Prinz has noted other limits to empathy in his philosophical perspective that elaborate on Nussbaum’s understanding of empathy.\footnote{Jesse Prinz, “The Emotional Basis of Moral Judgments,” \textit{Philosophical Explorations} 9, no. 1 (2009).} First he does not see empathy as very motivating since it is simply imagining what somebody else feels or thinks. Not only is it simply imagining what somebody else feels, we tend to do this more with people that
are relationally close to us;\textsuperscript{202} empathy is biased towards those we love and care about, and we may not want to or be able to show the same concern for more distant persons. He elaborates more but these are mostly variations of how empathy can be biased towards certain people: cuteness or attractiveness of the other person impacts empathy, ability to empathize with someone is connected to relational and geographical proximity, and empathy can be manipulated by someone else’s perspective.

Nussbaum and Prinz’s comments on the limits of empathy help us further to see what the struggles in our end-of-life case might be. If we take Nussbaum’s primary objection to empathy and place it over our case, then we can see how empathy might create distance between the medical team and the family. Is the medical team simply imaginatively trying to understand the family’s situation as some sort of cognitive exercise? Possibly, but I do not think it is because they see empathy as merely a mental exercise for the mind to try to understand someone else’s situation. The medical team may be drawing boundaries between themselves and the family, and I think these boundaries are more likely part of the overall dynamic that Pannenberg sees as part of being human. If the medical team and any of its members are only cognitively empathizing, then that is because of the condition that he names. That is to say, Nussbaum’s understanding of empathy may be correct if taken with Pannenberg’s understanding of centrality. If there is the human tendency to focus only on the self, then our ability to empathize may be a mere imaginative reconstruction of another’s suffering

\textsuperscript{202} We are also not obligated to empathize with every person. Galia Patt-Shamir, “The Limits of Empathy: A Mengzian Perspective,” \textit{Comparative and Continental Philosophy} 2, no. 2 (2010): 253-274. Here Patt-Shamir makes the case for not empathizing with a Nazi general who shows no remorse for the atrocious acts committed during the Holocaust.
without actually entering into and responding to that suffering. Both Nussbaum and Pannenberg show us how empathy can be limited by the human tendency to focus on the self and not entering into another’s pain.

Psychology

Hoffman acknowledges two main limits of empathy, though these are not unique to Hoffman. First, he highlights what he calls empathic over-arousal: “One’s empathic response to the distressed individual becomes so distressing that it becomes personal distress, which moves someone out of the empathic mode.” When the caregiver’s distress becomes strong enough, it is no longer possible to empathize with and provide helpful support for the person in need. This mental state is linked to what Hoffman calls “egoistic drift” in that one stops empathizing and focuses more on one’s own distress than the other’s. Compassion fatigue, in caregiving professions, is also a symptom of over arousal and is made manifest because of the cumulative effect of caring for people. This fatigue is more commonly referred to as burnout or secondary traumatic stress in healthcare. People end up developing defenses such as hardening or indifference to the situation of distress. There are a variety of individual differences leading to over arousal:

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204 There is no agreement on the relationship or hierarchy of compassion fatigue, burnout, and secondary traumatic stress. Along with B.H. Stamm, I prefer to see burnout and secondary traumatic stress as versions of compassion fatigue, with the latter being more acute. B.H. Stamm, *The Concise ProQOL Manual*, 2nd ed. (Pocatello, ID: ProQol.org, 2010). “ProQOL” is the Professional Quality of Life Scale. For its use as a valid measurement tool, see page 13: “There is good construct validity with over 200 published papers. There are also more than 100,000 articles on the internet. Of the 100 published research papers on compassion fatigue, secondary traumatic stress and vicarious traumatization, nearly half have utilized the ProQOL or one of its earlier versions.”
more empathic individuals, one’s sense of one’s helplessness or helpfulness, and inability to regulate one’s emotions.\textsuperscript{205}

Second, there are a variety of relationships that may bias our ability to empathize. There is in-group bias where people empathize with individuals they interpret to be similar to themselves and part of the same culture.\textsuperscript{206} There are three sub categories for in-group bias. First, friendship bias is empathizing more with one’s friends. A study involving four to five year olds showed more empathy toward friends than acquaintances.\textsuperscript{207} Friendship bias distorts empathy and care because one empathizes more with people they know and love. For example, if a member of the medical team was a friend of David’s family, that member might empathize more with David’s family than if they were strangers. Second, similarity bias is a relational bias that relates to more concrete (like in-group) aspects of a person (skin color, sex, gender, age, etc.), and works less with more abstract ideas like personal interests. For example, as a cisgendered Caucasian male, it may be easier for me to empathize with people that also fit those criteria. This distorts the caregiving relationship if I empathize less with someone simply because they do not look like me, so to speak. Third, here and now bias favors victims in the immediate situation more than in a situation perceived to be distant. The here and now bias can result from any connection made with an individual that makes one feel

\textsuperscript{205} Ibid., 205.

\textsuperscript{206} Jakob Eklund also notes a bias that he frames as “empathy is evoked primarily when a person in difficulty is viewed as a subject.” See Jakob Eklund, “Empathy and viewing the other as a subject,” \textit{Scandinavian Journal of Psychology} 47 (2006): 399-409.

\textsuperscript{207} Hoffman, \textit{Empathy and Moral Development}, 207.
closer to that person. Our case does not involve geographical distance. The medical team and family are in very close relationship. However, there may be relational distance resulting from the friendship and similarity biases.

Looking to the Final Chapter

This chapter served to reframe Pannenberg, Nussbaum, and Hoffman’s insights from chapter five into definition of empathy to be used for the normative guidelines of the following chapter. It was also important to acknowledge the limits of the practice of empathy between people. So, what did we learn in this chapter?

First, the emotional dynamic and relationship with our caregivers in the early years of our development play a crucial role in our ability to empathize with others; if we are empathized with and feel cared for, then we might be able to empathize more easily with others. It is important for us as we develop to feel as though our caregivers know how we feel—to feel felt, as described above in the developmental antecedents section. However, our ability to empathize is not set in stone by our early psychosocial development. While feeling felt and experiencing empathy from our caregivers early on is important for our ability to empathize, we can learn how to practice empathy later in life as well.

Second, in order to empathize with others, we must be able to separate the thoughts and feelings of others from our own. We must be able to understand the nuances

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208 The counter to some of these biases is also drawn from human observation and studies. There is familiarity bias, but people are prone to help strangers: one can imagine the stranger is someone they know.208 Here and now bias exists as well, but part of the moral life and making moral claims is being able to look beyond one’s situation. Very few people readily empathize with strangers, thus empathic over arousal is unlikely in the general population as that would lead to over arousal.
of others’ thoughts and feelings, and to distinguish those from the nuances of our own. As we saw in the case study, this is very difficult to do for the medical team. Pannenberg, Nussbaum, and Hoffman demonstrate that we are prone to empathize more with people that we know and feel close to in some way; there are also times when we cannot care for and empathize with another because we are only worried about our own feelings and thoughts.

Third, we need to respond to other’s distress with compassion. Responding with compassion requires understanding the mental and emotional states of others, and being able to separate our own thoughts and feelings from the thoughts and feelings of others. Responding to distress with compassion contributes to the distressed persons feeling felt. Responding to distress with compassion is part of loving the neighbor as they want to be loved—loving them in a holistic way that honors and respects them as unique people. The neighbor (i.e., the family in our case) could experience this sort of love as their specific feelings, thoughts, and beliefs are honored. Compassionate responses to those in distress, is not always easy, however. As humans, we are wrapped up in our own thoughts and desires, and we can have a hard time responding compassionately to those whom we see as different from ourselves in some way.

The definition of empathy in this chapter will help inform the guidelines in the last chapter. As we explore these guidelines, it will be important to remember the limits of empathy. No matter how much we understand the importance of and practice empathy, there will be limits in our ability to empathize with others. Nonetheless, empathy is important in the context of healthcare and especially in difficult EOL cases.
CHAPTER SEVEN

STRATEGIC MOVE: NORMATIVE GUIDELINES FOR HOSPITALS

Introduction

We have arrived at the final chapter. The last chapter ended with a nod to the limits of empathy. The heart of the previous chapter, and the reason I spent so much time exploring and defining empathy, is because the definition of empathy in the previous chapter will serve as the foundation for the normative guidelines in this chapter.

There are many strands that need to be brought together in this chapter, and the strands need to point to normative guidelines for hospitals, specifically medical teams, as they try to practice and embody empathy with families in these difficult end-of-life situations. All involved are trying to decide what should be done in a particular case. I have used the example of David’s brain injury and admission to the ICU as an example of such a case. Continuing to use this case as an example, we will return to various arguments brought forth in previous chapters and use the normative guidelines to help answer any lingering questions the reader might have about the ultimate trajectory of my argument. Some of the threads that will be tied off are as follows: the ways in which empathy and emotion are central to making moral claims and important at the end of life when there are disagreements, the nature of loving our neighbor as they want to be loved and the role that empathy plays, and my vision for making the ideal of empathy a reality in end-of-life situations. I am sure there are others that the reader might find important—
theological, philosophical, medical, or psychological—but alas I cannot attend to all unanswered questions.

**Looking Back**

However, before I do that, I want to provide a quick summary of where we have been so far. Part one included my introduction, my argument for empathy in clinical ethics, and my methodology. I began in chapter one by saying that we are facing a unique cultural phenomenon. We live in an increasing intercultural world, and by intercultural I don’t mean there haven’t been diverse cultures up until this point, but that these cultures are interacting in unprecedented ways; there are many more points of contact and more fluidity and flexibility present between cultures then there has been in history. This reality is present in hospitals particularly in end-of-life situations. Because of this intercultural reality, empathy is needed in these difficult situations. Empathy is needed because values and beliefs can differ to a large degree and the emotions are central to deciding what should be done in the end-of-life situations. Empathy helps the medical team connect with family and help them feel cared for so that a resolution is possible. The composite case highlights that better reasoning will not necessarily bring the medical team and family to the “right” conclusion.

Following the claim that empathy is important, in chapter two, I demonstrated not only how emotions are central to making moral claims but also that empathy is necessary given the intercultural reality and the inability of “loving our neighbor as ourselves” to truly meet the needs of the family in distress. Loving the neighbor as ourselves arose out of a cultural climate when it seemed possible to assume that loving our neighbor was essentially loving another version of ourselves. One’s neighbor generally (but not
specifically) looked like, talked like, and believed like ourselves. I ended this chapter with a short summary of the three thinkers that would take up the rest of the dissertation while highlighting empathy’s importance.

Chapter three consisted of laying out an interpretive paradigm that I called revised fundamental practical theology. I selected this interpretive paradigm to help provide a foil for exploring empathy’s role in difficult end-of-life situations and the dense thinking of Pannenberg, Hoffman, and Nussbaum. A practical theology that focused on the practical moral reasoning of Don Browning seemed an apt companion for clinical ethics at the end of life. I will not detail the methodology again here. The various levels of my interpretive paradigm guided the majority of the dissertation: descriptive move, intercultural practical moral reasoning move, and this final chapter, the strategic move.

Part two consisted of chapters four through seven, the final chapter. These chapters contained my revised fundamental practical theology. Chapter four was the descriptive move and included an in-depth description of the case in the ICU, which served as a fertile ground to explore empathy. Chapter five was the IPMR move and stepped away from the case study using the paradigms of our three thinkers to reflect on and provide insights into the concept of empathy so as to arrive at a definition. The case, though in the background, was never very far from the IPMR move. Chapter six, also part of IMPR, put the insights into empathy from the previous chapter together in a definition of empathy, grounded in the case study, that will serve as the foundation for the normative guidelines proposed in this chapter.
Normative Guidelines

These guidelines arise out of everything that has come before them. They are the heart of the dissertation and focus on my goal of exploring the role that empathy plays in difficult EOL ethics cases. The guidelines will address how important emotions and empathy are at the end of life, what it is precisely that I mean when I say “love your neighbor as they want to be loved,” and how hospitals and ethics committees can practice empathy and bring these guidelines to life in their context. Answering these threads within the normative guidelines will help to demonstrate why I think empathy is a major part of the answer to difficult end-of-life cases instead of some other answer. To put my thoughts more colloquially, medical teams have to show the family they care before the family will care what they say. The hospitals and medical team need to embody greater affectivity to help these cases not only be less distressing for the medical team but also to help the medical team embody empathy for the family so a resolution is reached.

The Medical Team is Required to Empathize with the Family

This first guideline comes out of the over-arching vision that each of our three thinkers cast and the nature of the relationship between the medical team, the family, and the patient. From this case and the vision of care that our authors cast, I interpret a mandate to care for the suffering. In the context of my argument, I extend this to propose a mandate for the medical team to empathize with the family in their suffering. The dynamic between the medical team and the family is such that medical care providers are charged to take care of sick and they have the expertise, the resources, and power in their encounters with family. The family came to the hospital in the state of anxiety and chaos, and they look to the medical team to help them. I am not proposing this mandate because
I think medical staff would treat the family poorly by default, but because in situations like our ICU case it can be very difficult to empathize with the family when the values differ and each would decide on a different plan of care for David.

**Connection in Life’s Tragedies**

We know that tragedy is part of life, or at least we ought to know this. Humans experience times of distress and loss. In these moments of tragedy, it is part of our call as God’s children to reach out to others who are suffering tragedy. Pannenberg, in response to the common theme of misery in the human condition, calls us to reach out and care for those who are suffering. Nussbaum provides the most explicit directives in the midst of life’s tragedies. Out of the recognition of our own vulnerability, tragedy strikes to the heart of being human and we are called to have compassion for those who are suffering.

The overall thrust of Nussbaum’s theory of emotion is that a society that practices empathy and compassion is able to flourish and live more complete lives. Again, her perspective comes from a realization that tragedy strikes all of us and societies need to be able to have compassion for those that go through such tragedy: “Tragedy asks us … to acknowledge that life’s miseries strike deep, to the very heart of human agency itself. And yet we are to insist they do not remove humanity, the capacity for goodness remains when all else has been removed.”209 When a society stresses the importance of empathy and compassion, citizens are able to empathize with the joys and the sorrows of human life and experience. Communities must respond to people in distress with empathy and compassion; medical teams must respond to families in distress with empathy and

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compassion even when they do not agree with the family’s decision about what should be done.

There are many places in Pannenberg where we could make the argument for a mandate to empathize with the family. However, since we are focusing on the dynamic between the medical team and family and why there is a mandate to empathize with a family in distress, Pannenberg’s interpretation of sin, despair, and suffering provides more fertile ground for this guideline. Our mandate arises from the fact that, knowing our own true nature, we respond to the same dynamics in others. Here the other might not be suffering exactly as I am (i.e., they are not another self) but has similar vulnerabilities. The family is in a state of suffering and despair over David’s brain injury and what this will mean for his life and their life. Because all of us are part of creation and experience brokenness in a variety of ways—broken and sick bodies, broken social relationships, and broken systems where the powerful benefit from the poor—we have a mandate to take care of those who are suffering.

Because of our true nature as humans who experience illness, fractured relationships, and unjust systems, we have a mandate to empathize and respond to other’s distress through love. This is God’s essence and what God calls us to in the process of becoming human. Nussbaum’s interpretation of tragedy and the human condition resonates with the idea of brokenness; both necessitate a response to that suffering with love. The medical team, via the pathway of empathy, can begin to respond to the family’s distress with compassion and love. In this response to the brokenness of the world, we can think of God as present calling us, in the concrete moment of end-of-life decision-making, to love the family. This is a concrete moment in the life of the world when the
grand theological speculations on God’s relationship with the world and what it means to love the neighbor can become a reality. Neighbor love is not some antiquated abstract religious dictate from a bygone era. The people of God can become the flesh of their words and beliefs. There are many times when God’s people talk about neighbor love and believing we are called to help people in distress. We must use our ears to listen empathically to people in need; we must use our arms to embrace those who are crying; and we must use our legs to walk toward people who are in pain. We must use our flesh to love people who are crying out for help.

**Care as Normative Frame for Life**

Like the mandate to care for those who are suffering tragedy, there is an argument to make caregiving a normative frame for one’s life. Pannenberg, Nussbaum, and Hoffman’s arguments for caring for others are the core of this guideline. We are to be open to the needs of others, take care of those who are in pain, help others flourish through compassion. All of these are part of why I think the medical team must empathize with the family in difficult EOL situations.

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210 There are many researchers who study the relationship between care and justice. Martin Hoffman is one such researcher, but Carol Gilligan is another. Gilligan interprets two main moral perspectives from her research: care and justice. Within both of these perspectives she is focused on interpersonal relationships in communities and how people address moral dilemmas in these relationships. One, from the perspective of justice, relationships are organized in terms of equality, thus moral concerns focus on lack of the quality or oppression. Two, from the perspective of care, relationship connotes responsiveness and the responsibility, thus moral concerns focus on detachment or abandonment and responding to those needs. Both men and women raise justice and care concerns when reflecting on moral dilemmas, but women tend to focus more on care and then on justice in Gilligan’s perspective. See Carol Gilligan, *Mapping the Moral Domain*. I find the idea of human need and dependency on each other a compelling combination of the concepts of care and justice. To help people flourish, we must care for each other because we are in need of each other. Pannenberg hints at this when he argues our identity is formed through our social relations. See also Sandra Sullivan-Dunbar, “Gratuity, Embodiment, and Reciprocity: Christian Love and Justice in Light of Human Dependency,” *Journal of Religious Ethics* 41, no. 2 (2013): 254-279.
For Pannenberg, I would argue the process of becoming a child of God necessitates caring as a frame for one’s life. In moments of brokenness, we are to be open to others and reach out to them to help. Though Hoffman doesn’t emphasize tragedy and brokenness like Pannenberg, his psychology and principle of caring contain a similar response to the pain and suffering of the world. The principle of caring is something that calls us to care for those who are suffering. Caring is concern for the well-being of others—their need for food, shelter, avoidance of pain, and self-respect—and helping those in need or distress. Here again we see that there is a mandate to help those in need. Especially for Hoffman, this principle of caring catalyzes caregivers to empathize with people in distress. If someone holds to the caring principle strongly enough, it can even pull someone out of the state of indifference and apathy to reach out to those who are in need of our help.

I would argue that regardless how any particular member of the medical team feels about David’s family, the caring principle in Hoffman, based on his review of numerous psychological studies, provides the mandate for the medical team to empathize with the family. This is not to say the medical team lacks care in David’s case. As medical professionals, there is a great amount of care and concern for the family and David. Not only do they care for the family through their actions as medical professionals (i.e., care as receive medical care), but they also exhibit care in the emotional sense for the family. Again, one of the reasons some of the team members are distressed by the family’s decisions is that the team members care about (i.e., are concerned about) David’s suffering. But the mental and emotional framework of their care may not focus on the family, the people who have less power and control in this situation. Empathy with
the family helps shift the dynamic between the team and family so that family feels cared for, honored, and respected.

**Medical Team’s Empathy and End of Life**

This first guideline partially addresses of the way in which empathy helps the medical team love the family as the family wants to be loved. On the one hand, I do not interpret this to mean that the medical team is required to do absolutely everything that the family asks of them; hospitals are not like an à la carte cafeteria where families simply pick whatever they want. On the other hand, the medical team cannot practice paternalistic medicine by drowning out the voices of the family. Loving the family as they want to be loved is more about shifting the perspective of the medical team to enter into the thoughts, perspective, and feelings of the family instead of loving the family from the team’s perspective. This guideline speaks to the overall dynamic between the medical team and the family in an effort to shift the focus to the family’s experience. Requiring empathy from the medical team will push the team to focus their care, compassion, and insight through the hopes and values of the family. Empathy will not only help the medical team to get a sense of the family’s experience on a superficial level, but also will change the intersubjective experience of the encounter. The more that the medical team can embody what it means to be human—their own emotions, their ability to take care of people, and their desire to help people who are in distress—the family and the medical team will experience the relationship differently. When the family feels felt by the medical team, trust and comfort may enter the intersubjective encounter.

Having worked with many different medical teams in my time as a chaplain, I understand how difficult this guideline could be for the medical team. I also struggle with
this at times as a chaplain for a variety of reasons. There are times when I completely disagree with a family and cannot fathom why they want to keep their loved one full code, for example, or why they want to send their loved one to a skill nursing facility given the likelihood that their loved one will likely only minimally recover neurologically—never knowing who they are or who they are with. Overall, it can be hard to empathize with people that we have just met, do not agree with, and are not part of our intimate relationship circles. As we were reminded multiple times in the limits of empathy, empathizing with distant others for people that aren’t our kin is difficult to do. As a chaplain, starting with empathy, even in the face of its limits, helps me to embody neighbor love and overcome some of the obstacles. These moments of difficulty are opportunities to become the flesh of my words. Chaplains are responsible for providing spiritual care to people of all belief systems, and in these moments of difficulty I can use my flesh and body to provide spiritual care to people with whom I disagree. I can enter the room and sit beside someone; I can listen to their distress and help them process what this means for their life; and I can help them sort through end of life decisions in light of their belief system.

The Medical Team Must Attune to the Family’s Emotional State

This guideline comes from numerous threads throughout my argument: Hoffman’s human development and its implications for emotional awareness, the concept of basic trust in Pannenberg, and Nussbaum’s concept of a moral “map of the world.” The second guideline will help address how the medical team is to love the family as they want to be loved, and how emotions and empathy play a role in resolving intractable end of life cases. First, the reader will note the onus is placed on the medical team to attune to
the emotional state of the family, a position I espoused in the first mandate when addressing “loving the family as they want to be loved.” The family of David is experiencing suffering and it is the role of the medical team to attune with their emotional state. The medical team can obviously care for David and the family without bothering with the emotions of the family, but this is incomplete care. It has been demonstrated, not only by Hoffman’s developmental paradigm but also in the research cited in chapter four, that empathizing with the emotions of the family helps their healing and helps build trust with the medical team. Second, connecting with the family on an emotional level is central to providing care for the family and empathizing with them. As I showed in chapter two, it is a well-known historical and philosophical fact that emotions play not only a vital role in healing and building community, but also in making moral claims and the decision making process. Aristotle, Aquinas, Hume, Schopenhauer, and our three thinkers illustrate the importance of emotions in the moral life and in the decision-making process. Given these historical and contemporary realities, a guideline for attuning to the emotions seems necessary.

**Emotional Map of the World**

Understanding the mental and emotional state of the family is part of empathy. I will not reiterate the details of Hoffman paradigm. Emotion is at the heart of his concept of empathic distress and the cultivation of principles. Emotions are part of the dialogue care and how we respond to people in distress. For the nebulous emotional world of a young child, it aids their growth and well-being to have their emotions soothed and responded to so that young child feels loved and validated. In adulthood, this takes on more nuanced forms but the need remains throughout life especially in situations of
extreme distress and uncertainty, similar to what David’s family experienced in the hospital. It is vital for the medical team to empathize with the emotions of the family and try to understand their emotions so that the family can begin to integrate this devastating experience into their understanding of the world, but more importantly so the family feels the love and care of a medical team.

We already know about the importance of emotion and its role in helping society flourish, but more specifically related to the feelings of care and trust are Nussbaum’s views on how we develop a map of the world. Developing a map of the world depends on the ways in which one has experienced shame, guilt, despair, joy, hope, and love. The map of the world can operate within us on a conscious and unconscious level. We can see specific things in the world as good or bad, trustworthy or untrustworthy, and/or it can be a general sense or expectation about the world and our life. A “good” map of the world is not a complete absence of “badness.” A map of the world that is good will be one in which we have felt shame, guilt, and mistrust, but when we experience these they need to be met with the forces of love, care, and hope. Regardless of how the family has constructed their map of the world, it is important for the medical team to validate and hear the intense emotional experience of the family of David. This will help the family’s experience in the hospital and in this pivotal moment in their life. They will hopefully feel cared for and be able to have a good map the world in this specific situation. The distress of the family needs to be met with the forces of empathy and love from the medical team. The family members will bring their maps of the world along with them to the hospital, but the medical team can help the family see the hospital as a place of goodness, trust, and care on the family’s respective maps.
Basic Trust and God’s Love

Basic trust resonates with how Nussbaum develops a map of the world. Like a “good” map of the world, cultivating basic trust with the family may help them have some hope, generally speaking, in the midst of their distressing situation. Our deep trust comes from caregivers reaching out when we are afraid, in need, and distressed. We can think of this reaching out and felt presence of love as God working through God’s people. When people experience brokenness in the world, a sense of basic trust can help them feel loved and have hope when they face despair and pain. Basic trust is not something that we just have; it is something that grows and gets cultivated throughout life. It is equally possible to have a basic trust in the world or to lack this trust, depending on our experiences. Our sense of the world can also change throughout our life—at times feeling hope in the world and at other times not. For those times in life when we feel this radical trust in the world, and in those times when we are pulled out of hopelessness and feel love, we can think of this as God’s love and presence in, under, and through the auspices of those who care for us.

David’s family is in a situation of despair and hopelessness, and we can think of the ability of the medical team to connect with the family’s distress and fear as God reaching out to the family with love. When fear and hopelessness are so strong, emotionally connecting with the family, and validating that fear, lets them know that they are not alone in their despair. This is where we can think of God’s love as present—present by simply attempting to understand and feel with the family in their need.
**Emotions are Central to Empathy and End-of-life Cases**

This guideline addresses why empathy is important at the end of life, why I interpret empathy as a sacred ethic, and why empathy helps us to love the family as the family wants to be loved. First, let us address the nature of empathy as a sacred ethic. Empathizing with the emotional state of the family can help them feel loved. We can think of this moment of love as God’s presence between the family and the medical team. Our empathy with people who are in distress and suffering is a moment when we can think of God as present calling us to love the family. The other’s distress resonates with them and we can notice this distress in our own bodies. There is a vague sense awareness that something is stirring, and when we intersubjectively experience this distress, we can think of this experience as God calling us to love. Just as we can experience the warmth and comfort of emotional resonance with another, so to we can experience the distress—a distress to which God calls us to respond with love.

Second, empathizing with the emotional state of the family helps the medical team love the family as they want to be love. Like the first guideline, this is not about following absolutely every medical intervention that the family requests, but is about entering into the lived reality of the family as much as possible—a shift in the mental and emotional states that helps the medical team focus on the needs of the family.

Third, is the simple fact that emotions, and therefore empathy, are central to the process of making decision are at the end of life. Emotions and feeling like others understand ones emotions helps one develop a basic trust in the world, a map of the world that is at times good and hopeful, and helps one to understand other’s emotions. This is well-documented not only in the history of philosophy and theology, but also in
the medical world as helping in the relationship between the medical team and family. In intractable end-of-life situations empathizing with the emotions of the family can only help these difficult cases find a resolution. If we remember from chapter two in the discussion of clinical ethics, the EOL of decision-making process I outlined lacked adequate acknowledgment of the emotional nature of clinical ethics. Emotions play a role in making moral claims and in making decisions about what should be done at the EOL. If the medical team can empathize with the emotions of the family, it will help the family and medical team come to a resolution.

From my experience as a chaplain I know that connecting with the emotional state of the family can be challenging. A medical staff person may be going through their own distress either from their work in the hospital or from a myriad of other reasons in their life. As we saw in the discussion about the limits of empathy, the very important need for us to focus on our own distress can cloud our ability to sense or tap into the emotional experience of family is in the hospital. There are also days when it is very difficult to exert the energy that this requires. This could be from compassion fatigue and empathic over arousal, and it could be simply part of the vicissitudes of being human. One possible remedy for such a situation could be hospital policies or culture that encourages hospital staff to be open with each other and honest about when they are struggling, so that others can take over and provide care. I think hospital policy and culture could encourage team members who are finding the work of empathizing with a particular family to admit that and ask for help. If the medical staff is able to connect with the emotional world of the family and help the family develop a sense of trust in the medical team, this will help difficult EOL situations find a resolution.
Medical teams must empathize with the values and beliefs of families

This guideline will sound very familiar to anyone that works in healthcare and especially in hospitals. For a long time hospitals and healthcare institutions have been talking about cross-cultural education and training for their staff. Medical staff attend seminars on cross cultural encounters in healthcare, watch online content about different cultures, attend workshops on eliminating unconscious biases that whites have for nonwhites, and participate in a variety of other things to educate them about respecting different beliefs, cultures, and values. Therefore, my suggestion that staff is open to different worldviews and cultures may sound silly to people that work in hospitals. They may say, “we are well aware of how important this is in and practice this already. We know it is important to respect other peoples beliefs.”

I will grant that hospital staff are aware that they need to respect other peoples beliefs, but if caring for a patient and family were merely about intellectual and cognitive ascent to the notion of respect, then there wouldn’t be such a visceral reaction to families who pursue courses of treatment with which the staff don’t agree. I am not talking about situations in which respecting someone’s beliefs and different values simply takes a few minutes to make dietary changes in the hospital menu for that patient or allowing the family to have their religious leader come to the hospital room, for example. As in our case with David’s family, I am speaking about the places where the values between members of the medical team in the family differ at their core. For example, David’s family sees the cessation of heartbeat as death, not the injury to higher cognitive faculties. These are the disagreements of which I speak. “They don’t get it … They are being unrealistic … Don’t they understand how sick he is and that he won’t recover … I feel
like I am torturing him and don’t they know he is suffering,” are some of the things I have heard in response to these cases. Those who have uttered similar things have every right to these feelings. I have had these thoughts and feelings on more than one occasion. When staff have these feelings, empathy with family members is important. Empathizing with the beliefs and values of the families is about making an effort to understand the family’s worldview and experience. Emotional empathy, so to speak, can lead to a desire to honor the other by making an effort to understand. Empathizing with the values and beliefs of a family is a consequence of emotional empathy. Let us take a close look at being open to the dissimilar values of others and how we can love the neighbor.

**Openness to the World and Honoring Each Other**

There are many theological and philosophical threads from history on which to draw to make this point. From my perspective as the chaplain, we have a God given ability to be open to the world. We are, as I have stated numerous times, able to step outside of our mental and emotional experiences and not only reflect on our own feelings and thoughts but opened to the thoughts and feelings of others. We are made this way and have this predisposition.

The medical team has the ability to be open to the values and beliefs of David’s family. The medical team does not prevent David from going to another facility as the family requests, so one could argue that in allowing this to happen they are open to different values and beliefs about what should be done in David’s case. After all, they met with the family twice, once in an ethics meeting and then in a family care conference, and explained what they would recommend for David. Even though the family and medical team did not agree, the staff explained their opinion respectfully and honored the
family’s wishes. However, there were moments when the family could feel the anger and frustration from the staff, where the family felt confused by the need for multiple meetings with the team to keep talking about David’s prognosis, and moments where the staff amongst themselves spoke about David and the family disrespectfully. “They don’t really get it … they are not understanding or accepting reality,” so the thoughts of the medical team went. Again, I too have shared in these thoughts about patients and their families. I think practicing the first two guidelines will help with this guideline. If the members of the medical team can empathize with the family, and in that understand the family’s emotional state, being open to the values of the family will have a tendency to follow from this.

For further support of this guideline we return to Nussbaum’s obligations of respecting and honoring people other cultures, as well as her critique of the disastrous effects that shame has on communities. I quoted Nussbaum’s primary obligation to respect others in chapter five and I quote again here:

In particular, I assume that an adequate [normative] view should make room for mutual respect and reciprocity; that it should treat people as ends rather than as means, and as agents rather than simply as passive recipients of benefit; that it should include an adequate measure of concern for the needs of others, including those who live at a distance; and it should make room for attachments to particular people, and for seeing them as qualitatively distinct from one another.211

I have italicized two important points in her obligation that relate to my third guideline. The first, dealing with agency, applies to how the medical team should relate to the family. David’s family is not simply the passive recipients of the expertise and care of the medical team. The expertise and experience of the medical team took care of

211 Nussbaum, *Upheavals of Thought*, 12.
David, but the family also has dignity as human agents and to have their wishes for David respected. The second, dealing with the balance of focus on the family, has been well explicated in previous sections. The medical team must make allowances for the needs of the family. It is my interpretation that following the first two guidelines that I laid out, will significantly contribute to openness to the values and beliefs of the family when they differ to a large degree at the end of life. Connecting with the emotional distress of the family through empathy will help the medical staff learn the story of the family, learn what is important to them, what they value, and why David’s hospitalization is difficult.

**Neighbor Love and Dissimilar Beliefs**

The guideline “the medical teams must empathize with the values, beliefs, and worldviews of families” picks up the threads from a slightly different angle. There is less affectivity in this guideline, though it is still an important part of it. Overall, this guideline continues to emphasize why empathy is important particularly at the end of life in difficult end-of-life cases. The struggle is usually over whether the patient should be placed on comfort care or whether the patient should go to another hospital or care center in hopes that they will make some sort of recovery. Empathy is important in these cases because values of the team and the family can differ to such a large degree and these two options feel emotionally very different—one is a comfort care dying process and the other is care that involves prolonged respiratory and physical rehabilitation. Openness to and empathizing with the perspective and values of the family can help the two sides come together. The intercultural reality of ethical strangers takes time and patience to overcome. Given the limitations of empathy and our ability as humans to embody empathy in helpful ways, using empathy in EOL situations may not always help.
However, as humans we should have hope in the power of empathizing with each other and our incredible ability to be open to others. As I have said, my hope is that empathy helps the medical team and family reach a resolution—resolution simply being a plan of care that honors the patient and the family.

So, how can this be done? Pannenberg speaks of love as a radical and reckless abandon force in the world. It is my belief and hope that if the medical team takes a step with empathy in those cases in the hospital where this feels impossible, the family and the medical team will experience a deep resonance with this radical love that I think of as God. The family’s beliefs may seem ridiculous and absurd; the family’s beliefs may seem irrational and unrealistic; but if the medical team takes this step towards empathy I think there will be unpredictable surprises in the family and the medical staff can come together to find a resolution to an intractable case.

**Bringing the Guidelines to Life**

How are hospital staff that are involved with difficult end-of-life cases supposed to make these guidelines a reality so that they actually impact clinical practice in the hospital? I want to close by offering what I hope are helpful ways hospitals, and the medical teams that provide care within them, can make these guidelines come to life. I think my suggestions will work for the innumerably different contexts in which medicine is practiced. My suggestions are aimed at helping staff learn how to embody the guidelines in their clinical practice. One could say I am trying to cultivate the practice of empathy by making it a habit.

These suggestions come from two places in my life. One, some of my experiences as a chaplain comes from working in teaching hospitals that have resident physician
training programs. I observed how the attending physicians used different approaches to educating the resident physicians. Not all the methods of medical education are directly transferrable to my goals here, so I will primarily draw on my observations of simulated patient and family encounters. Residents would work through simulated patient and family cases (surgical cases, medical cases, and sometimes family care conferences) and then have time for reflection with a peer group on the process. Two, my training to become a chaplain included case discussions with a supervisor and a group of peers. One of the chaplains presented a case (e.g., verbatim) with an analysis of a patient’s psychosocial spiritual dynamics and a record of the conversation noting the chaplain’s internal dialogue during the visit. Discussing these cases provided opportunities for me to grow in my therapeutic listening skills as I struggled to empathize with patients and families. Working through cases in the following two ways can help medical team members empathize with the family, empathize and attune to the family’s emotional state, and cultivate openness to the beliefs of others.

Patient Case Simulations

One of the ways to bring the guidelines to life would be to work through simulated patient cases with various members of the medical team. I imagine this taking place in a conference room where the medical team, ethics committee, and family would normally meet to have a family care conference on EOL decisions. The simulated case would be a simulation of a family care conference with people playing the family and medical team. It would help the learning if the people playing the family members and members of the medical team had only general guidelines about the personality, values, and role of their character. If the responses are too scripted, it can be difficult to fully
experience the struggles and benefits of empathizing with someone. Here is an attenuated version of such a simulated case. This is a case I helped develop with members of an ethics committee to use to train new resident physicians in difficult EOL family care conferences. Some of the medical terms may be hard for the reader to understand. I want to provide an example of something that could be used with medical staff. I have provided footnotes for the terms that may be new to some readers. I have copied the case summary from this case here.

An Example ICU Case

The Case Summary

The medical team is about to have a second care conference with a family. Here is the background information for this care conference. Frank is a 58-year-old male and was hit by a commuter train in Minneapolis. He may have fallen or just stepped into its path, thus this may have been a suicide attempt but this is not clear. He sustained a serious head injury. He also has a broken hip, wrist and pelvis and a shattered ankle. At the scene of the accident, Frank had a Glasgow Coma Scale score of 8. Upon arrival to the ED, the computerized tomography scan (CT scan) revealed a subdural hematoma, he began declining (consciousness decreased, blood pressure fluctuated), which required an

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212 For the full example case, see Appendix A.

213 Paramedics and first responders (and other medical professionals) use the Glasgow Coma Scale to assess a person’s level of consciousness after a head injury. A score of 8 means he was responsive and obeying commands but had a moderate brain injury. The scores range from 0-15: 0 is legally brain dead, less than 8 is a severe brain injury, 8-12 is a moderate brain injury, and 13-15 is a minor brain injury.

214 A subdural hematoma occurs when blood gathers between the dura mater and the brain tissue. There are various layers of the brain and skull. The dura mater and subdural space are the layers just beneath the skull. The arachnoid mater and subarachnoid space, pia mater, and then the brain tissue follow the dura mater and subdural space.
emergent craniotomy\textsuperscript{215} to remove the hematoma. In the ED trauma room, he had a passive blood alcohol level of 0.15.\textsuperscript{216} He was admitted to the surgical intensive care unit. He has a ventriculostomy\textsuperscript{217} in place and he is on a ventilator. He is sedated and has no decisional capacity. When the sedation is lightened, he becomes anxious and his intracranial pressures increase.\textsuperscript{218} He does not localize to noxious stimuli\textsuperscript{219} and does not follow commands.

After one week there was a care conference led by neurosurgery and the SICU physicians who described his uncertain neurological prognosis. His wife Patti and youngest son Jim who is thirty-eight attended that care conference. Patti left him 10 years ago because of his drinking and abusive behavior. While she devoted most of her life to her children, it was very hard for Patti to leave Frank and seek independence. She works as an executive secretary currently. They are separated but not divorced. Patti said Frank has a sister Sarah who lives in Vermont but does not really talk to or see Frank very much. Her (their) oldest son Michael lives in California with his wife and two children. Michael is connected with his mom but not his dad. Patti seems to favor less aggressive

\textsuperscript{215} A craniotomy is a surgical procedure where part of the skull is removed to perform brain surgery. In this case, it was necessary to address the bleed in Frank’s brain.

\textsuperscript{216} Passive blood alcohol levels are recorded if the medical team cannot get the patient to blow into the breathalyzer. One of the medical staff will place the breathalyzer in the patient’s mouth and record the number when the patient exhales normally. I have only seen this occur in the ER when the patient is disoriented or unconscious.

\textsuperscript{217} These are drains that drain fluid off the brain. They are inserted through a hole in the skull into the cerebral ventricles. The ventricles are cavities within the brain.

\textsuperscript{218} Intracranial pressure, or ICP, is the amount of pressure inside the skull, thus in the brain tissue. As the pressure rises, it becomes harder and harder for the brain to get adequate blood flow, in which case the brain doesn’t get adequate oxygen.

\textsuperscript{219} This is a fancy way of saying the patient does not try to get rid of an annoying stimuli. The patient must show intentional or purposeful movement to eliminate an irritating stimulus.
care. Jim has lived with his dad for eight years. Jim does not really talk to Michael, his older brother. Jim completed two tours of duty in Iraq and has struggled to find work. Jim said his father worked until he was laid off 18 months ago when the business closed.

Frank is at the end of his unemployment and although he has looked, there is no work in his field and he says he is too old to retrain. He is worried that his dad will lose his house. He cannot recall his father ever going to a doctor and does not know much about his dad’s medical issues, but Frank seems depressed and does drink a lot. Jim sometimes drinks with Frank. Jim is Frank’s POA and Frank is Jim’s POA. Jim seems to favor a more aggressive care plan. This is the second care conference because Frank has been in the SICU for two weeks. The next potential intervention would be to place a tracheotomy tube and a feeding tube. His estranged wife Patti, his eldest son Michael, his youngest son Jim, and his sister Sarah attend this care conference.

Reflection with Medical Team Members

After the case has been acted out, there would be time for the participants to reflect on what happened and where there was empathy, emotional resonance, and openness to the belief of others. The following questions could be used as general guides through this reflection process:

1. Overall, how did the family care conference go?

2. Where were there places the medical connected with the family’s emotional state and the family responded well?

3. Where were there missed opportunities to empathize with the family?

4. How would you compare your ethical worldview to that of the family?
5. What were your thoughts and feelings about the family before the meeting, during the meeting, and then after the meeting?

Verbatims with Medical Team Members

In addition to going through simulated patient encounters like the one above, it can be helpful to work through real cases. Medical teams could make time to debrief after an EOL family care conference and focus on empathy for these debriefings, but the reality of life in a medical setting makes this difficult. Team members rarely have time to set aside for these professional development opportunities. After a family care conference, staff are usually off to their next commitment. The best venue to review actual cases could be in empathy medical rounds, so to speak. A member of the medical team would be responsible for writing up a verbatim and presenting it for feedback. A verbatim includes the following: a brief summary of the hospital course, a brief summary of the family’s psychosocial dynamics, the dialogue of the family care conference, and then an analysis of the family care conference. The dialogue needs to include the thoughts and feelings of the presenter as he/she as they occurred in the care conference. The analysis would need to focus on the relationship between these internal dynamics and empathy, as well as an analysis of the family’s inter- and intrapersonal dynamics.

Verbatim Case

Here is an example from the dialogue section of a man who unexpectedly lost a family member in the hospital. “C” refers to the chaplain, “F” refers to the family member, “MD” refers to the physician, and “N” refers to the nurse.

<p>| C: I know this is hard right now, but could you come back into the meeting room for now. |</p>
<table>
<thead>
<tr>
<th><strong>I wonder how useful this is for the family. How can he possibly be taking all the medical information in and digesting it right now?</strong></th>
<th><strong>MD:</strong> This is a lot to hear right now F, but I am going to tell a bit about how it happened. (MD goes into a long discussion of the hospital course and the difficulties of the patient’s condition.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I feel terrible for MD. I know he must feel completely responsible for what has happened. I know how meticulous he is with his patients.</strong></td>
<td><strong>MD:</strong> Yes, I looked at it and another doctor did as well. We could see the inflammation and were worried about infection and a few other things. We wanted to do this to help reduce the inflammation, and we were aware of the possible risks of doing so.</td>
</tr>
<tr>
<td><strong>I want to know what exactly he means by that. I am hesitant to broach the issue fearing he may blow-up at the doctor. That phrase causes me anxiety...malpractice? Informed consent to do the procedure?</strong></td>
<td><strong>F:</strong> (He keeps muttering to himself, “That just don’t work for me … it don’t work for me right now.” F gets up and walks around to the window.)</td>
</tr>
<tr>
<td><strong>I feel unsettled sitting next to him. He feels this way as well right now. He can’t handle what has happened.</strong></td>
<td><strong>MD:</strong> I know how this must feel, especially given how things turned out. We saw him getting better and thought this would help him along even more … possibly get to a point where he would be able to talk to us. He was beginning to track with his eyes…barely…but he was. This was a step in the right direction. He was doing fine after the procedure, but then today we ran into the problems.</td>
</tr>
</tbody>
</table>
| **C:** (F keeps quiet for awhile and shakes his head. I sit down on the couch next to him.) This must be so overwhelming right now … to hear all this. | **F:** This all don’t sit with me right now … it just don’t work. (Pause) Can I go in and see him?
<table>
<thead>
<tr>
<th>I am glad the care conference is over. I want to talk to F alone.</th>
<th>C: (I make eye contact with Dr. F to make sure she does not have anything left to discuss.) Sure, J and T we can go in and see E. (I lead them down to E’s room.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F: (He tears up as we enter the room. They pull back the sheet in order to see his face and head. F puts his arms down on the bed and puts his face in his hands.)</td>
<td></td>
</tr>
<tr>
<td>C: (We stand around the patient’s bed for about five minutes while they emote. F strokes the patient’s hair.) I am so sorry F. It is so hard to lose a loved one … so much grief.</td>
<td></td>
</tr>
<tr>
<td>I finally want to ask him what does not work for him, though I have a pretty good idea by now.</td>
<td>F: I know… I know. This just don’t make sense. He is so young … so young. They said they thought it would help. It just don’t make sense to me … it don’t work.</td>
</tr>
</tbody>
</table>

This case was obviously not about a difficult EOL ethics care conference, but it highlights the layout of the dialogue section. With the dialogue laid out in this way, the medical team members can help each other identify places where they could have empathized and places where empathy occurred. (A video recording of an actual family care conference could also serve this function, but there are a privacy issues to work through with the hospital and the family.) Analyzing the analysis section also serves this purpose. Did the presenter miss any obvious psychosocial spiritual issues with the family? Do any members of the peer group have a different interpretation on the presenter’s analysis of him- or herself? Picking apart a case like this is challenging work and can be stressful for members of the medical team, but it is ultimately worth it since the difficult work will help families feel cared for on a deeper level.
The Chaplain

In addition to the exercises listed above, the physical presence of a chaplain can be an empathy-teaching tool. Not only is the training and skills of a chaplain helpful for learning how to practice empathy in the hospital, but the way chaplains are, their being, can impact the team and the hospital staff. First, large part of the training and skills of a chaplain revolve around therapeutic listening, and empathy with those in distress is crucial for effective therapeutic listening. Chaplains have a master’s degree in religious studies or theology. After the master’s degree, they have to seek further training in clinical pastoral education (CPE). Chaplains have to have a minimum of four units of CPE. Each unit of CPE is three months or around four hundred hours of clinical work. The chaplain spends half the time in education and with a peer group, and the other half of the time visiting patients, families, and staff in their clinical setting. The master’s degree usually includes a course in spirituality and counseling, but the CPE training includes more rigorous training in therapeutic listening. Similar to the verbatim exercise mentioned above, CPE requires each chaplain to do multiple verbatims. Presenting one’s own verbatims, listening to others present their verbatims, and visiting the patients, staff, and families all help a chaplain develop their therapeutic listening skills and empathic abilities. Once a chaplain starts working as a staff chaplain, they continue to hone these skills through self-reflection and continuing education. The empathic and therapeutic listening skills of a chaplain are analogous to the diagnostic skills of nurses and physicians. Chaplains listen to and observe nuance in verbal and non-verbal communication with the same attention that clinical staff give to lab results, what they can see and hear, and imagery and ultrasounds. These skills are with chaplains when they
move around their clinical setting and provide emotional and spiritual support to staff, patients, and families. Given these skills and training, other members of the medical team could observe the chaplain as a way to learn about the practice of empathy. The team members would learn what it looks like to practice empathy in one’s day-to-day interactions in a clinical context as the chaplain encounters families and patients in the hallways, talks to staff members, and meets with patients and families in private rooms.

Second, while a chaplain is working within his or her clinical setting, the very presence and being of a chaplain can encourage the medical team to practice empathy in their encounter with a family. Given the training described above the chaplain can not only teach the medical team about empathy through their skills, but can also create a shift in how the medical team experiences the patient and family. The chaplain brings an empathic perspective to every visit and encounter in a clinical setting. As a chaplain, I have seen this take place during my encounters with staff. I will briefly describe an example of the shift in perspective to which I am referring. I have changed some details to protect the privacy of the hospital staff, patient, and family.

An American Indian family made a request to perform a smudging ceremony in their room. Their loved one, the patient, was currently on a ventilator with a tracheostomy. She could mouth some words but was unable to speak. This family approached the charge nurse for the unit and asked if they could perform this ceremony. On this particular unit, these ceremonies were not performed very often, and the charge nurse responded in an irritated way, “Yes, the family can do this but it will take some time for the hospital to set this up; the smoke detectors needed to be turned off and other staff members needed to be notified.” The charge nurse paged me to let me know about
the request. I visited the family and discovered they were not allowed to perform this ceremony at the previous hospital, even though a smudging ceremony was very important for them. The patient and her family had been experiencing family stress and grief this year, and the patient had told them it would help her feel less distressed.

After visiting with the family, I went to speak to the charge nurse to make a plan for the ceremony. The charge nurse rolled her eyes in reference to the family while I was speaking with her. The nurse proceeded to tell me, “I am pretty sure the oldest sister of the patient came to visit the patient a couple days ago while high.” At this point I tried to shift the dynamic of the conversation to one of empathy. I acknowledged I heard about the older sister as well. I then spoke about how the family was under a great deal of stress from the trauma of the patient’s hospitalization as well as grief and loss from earlier in the year. Also, the family was not able to perform a smudging at the previous hospital and it would be a very meaningful and life-giving ceremony for the patient. When I spoke about the grief and stress of the family and how the smudging would help them, the nurse’s body language and tone of voice changed. To me, she seemed much more compassionate and understood the family’s request as a something that would help the patient and family feel less distressed and more hopeful about the patient’s hospitalization. The family’s request was no longer a source of irritation for the nurse.

My example is a small way in which the chaplain, because of her or his empathic perspective, can shift the dynamic between the family and medical team. These shifts could occur in larger ways as well: during difficult family meetings between the family and medical team, when a hospital writes new policies related to patient and family care, and even as a hospital or healthcare system re-envision its mission and values.
Concluding Thoughts

My hope is that these guidelines and my few suggestions for bringing them to life will be helpful for the medical team. Given the power that emotions play in EOL decisions, I think it is vital that medical team members learn how to empathize with patients and families. Hospitals will continue to encounter ethical strangers as medical staff wrestle with difficult end of life cases. God calls us to empathize with those who are in distress, to love them in a way that coalesces around their experience of distress, and to be open to the experience of others. If hospitals can continue to teach empathy, I think this will help the family and medical staff decide what should be done in difficult EOL cases.
APPENDIX A: PATIENT CASE SIMULATION

Scenario

- Frank is a 58-year-old male and was hit by the light rail in Minneapolis. He may have fallen or just stepped into its path, thus this may have been a suicide attempt but this is not clear.
- He sustained a serious head injury. He also has a broken hip, wrist and pelvis and a shattered ankle. At the scene of the accident Frank had a GCS of 8. Upon arrival to the ED, the CT revealed a subdural hematoma, he decompensated, which required an emergent craniotomy to remove the hematoma. In the ED stabilization room, he had a passive blood alcohol level of 0.15.
- He was admitted to the surgical intensive care unit and is intubated. He has a ventriculostomy in place and he is on a ventilator. He is sedated and has no decisional capacity. When the sedation is lightened, he becomes anxious and his ICPs increase. He does not localize to noxious stimuli and does not follow commands. After one week there was a care conference lead by neurosurgery and the SICU physicians who described his uncertain neurological prognosis.
- His wife Patti and youngest son Jim who is 38 attended that care conference. Here is what each family member said at the first care conference.
  1. **Patti** left him 10 years ago because of his drinking and abusive behavior. While she devoted most of her life to her children, it was very hard for Patti to leave Frank and seek independence. She works as an executive secretary currently. They are separated but not divorced. Patti said Frank has a sister Sarah who lives in Vermont but does not really talk to or see Frank very much. Her (their) oldest son Michael lives in California with his wife and two children. Michael is connected with his mom but not his dad. Patti seems to favor less aggressive care.
  2. **Jim** has lived with his dad for eight years. Jim does not really talk to Michael, his older brother. Jim completed two tours of duty in Iraq and has struggled to find work. Jim said his father worked until he was laid off 18 months ago when the business closed. Frank is at the end of his unemployment and although he has looked there is no work in this field and he says he is too old to retrain. He is worried that his dad will lose his house. He cannot recall his father ever going to a doctor and does not know much about his dad’s medical issues, but Frank seems depressed and does drink a lot. Jim sometimes drinks with Frank. Jim is Frank’s POA and Frank is Jim’s POA. Jim seems to favor a more aggressive care plan.
- This is the second care conference because Frank has been in the SICU for two weeks. The next potential intervention would be to place a tracheotomy tube and a feeding tube.
His estranged wife Patti, his eldest son Michael, his youngest son Jim, and his sister Sarah attend this care conference.

**Family/Friends Roles**

*Estranged Wife: Patty*

**Scenario:**

- Your estranged husband was hit by the light rail in Minneapolis with a blood alcohol level of 0.15. It seems this may have been a suicide attempt but it is hard to know for sure.
- He has a head injury. At the scene of the accident your brother had a GCS of 8. Upon arrival to the ED, the CT revealed a subdural hematoma, which required a craniotomy to remove a clot.
- He was admitted to the surgical intensive care unit. After one week, there was a care conference lead by neurosurgery and the SICU physicians describing his poor neurological prognosis.
- This is the second care conference and your brother has been in the SICU for two weeks.

**Instructions for the Estranged Wife:**

1. **Interrupt the physician at the beginning to introduce yourself if he/she forgets to initiate introductions.**
2. **Ask for clarification when the physician uses medical jargon**
3. If the physician does not ask about our beliefs regarding your estranged husband’s situation, jump in with your opinion that he was not concerned about his health in the past and does not believe he would care for himself in the future.
4. The physician will need to discern that you have had little contact with him and have over the past 10 years because of how he treated you and the children particularly when under the influence of alcohol.

**Information about the Estranged Wife:**

- You left the patient 10 years ago. The relationship was tumultuous as he was verbally abusive.
- You are glad that Michael moved away to lead his own healthy and productive life without the stress he endured living at home.
- It was everything it took for you to have the courage to leave him and build your own life and vocation. You received a 2-year training course after which you became an executive secretary.
- You have little compassion for the patient and feel that “he has made his bed” and the way he lived his life contributed to his demise.
• You agree with Michael’s position that given all the medical resources available to perhaps survive this injury, Frank would not take his medical needs seriously and resume his drinking.

Frank’s Younger Son: Jim

Information for Jim:

• You are 38 yrs. old and have lived with your father for eight years. You moved in after completing two tours in the National Guard in Iraq. You have had difficulty finding a good job but have worked on and off and although. You probably could not manage the house on your own. You are working with the VA on getting some disability for PTSD.
• You are not very close to your Mom. You think she favors Michael and do not like her because of this.
• Your Dad is also a vet and has always sort of taken care of you. You are very close. Your dad made you his POA. You wonder if this does not mean you should be making medical decisions for your Dad.
• You are embarrassed about not being more successful and really don’t like your brother Michael who thinks he is a big deal and gets on your back about not working harder. Since your Dad’s accident Michael has tried to take over all the decisions although he has not seen your Dad in a long time. Michael thinks he knows everything about medical stuff. He has had almost no contact with your Dad for years and has not helped him with any money since he lost his job. Every time Michael starts in you want to tell him to shut up. He does not know or care about Dad like you do.
• You know your Dad has been depressed but you think this is understandable because of his job situation. You know he drinks but do not think it is more than a lot of guys he worked with or hangs out with in the neighborhood bar. You don’t see your Dad as a quitter and he has been working on a few leads for a job now that the unemployment is ending,
• You know that your Dad is in for a long rehab and may have some disability but he has been a hard worker all his life and can do hard things. You are really willing to help him get through this.

Instructions for Jim

• Please bring up the following concerns:
  o Are the doctors worried that he has no insurance and this is why they are really not supportive of long term rehabilitation?
  o You recall a conversation with your dad where he said he would want to live no matter what.
  o I have POA, shouldn’t I be making the decisions about dad?
• During the conference you repeatedly challenge the physicians every time they talk about a poor prognosis. You ask them how they know for sure. Isn’t it true that people can surprise them? Why can’t they just give him a chance?
• You feel that you are the only one who knows your father and the only person on his side.

*Frank’s Sister: Sarah*

Information for Sister:

• You live in Vermont and do not have a lot of contact with your brother.
• You know he has been separated from his “wife” for around ten years, and you know Jim his son lives with him. Mike your other nephew and his family live out in California. You do not have a lot of contact with Mike either since you are not in Minnesota or California to see your family very much, even around the holidays.
• You want your brother to have a tracheostomy and a PEG tube placed so he can go to a long term acute care hospital (LTACH) for vent weaning and neurologic recovery over time.
• You and your brother grew up in a religious community until you left home. Frank only went when he was with his wife and attendance was still pretty sparse. You attend a religious community regularly.
• Your particular form of religious belief makes you feel there will be a miracle and that making him comfort care is tantamount to actively killing him. First, God is using the doctors and the medical devices to keep the patient alive so he can fully recover. You asked God about a miracle and you are sure God said yes. He needs to go to a LTACH. Second, making someone comfort care is like actively killing them. The family and medical team are not the ones that decide when the patient dies.
• You disagree with your nephew Mike and your sister in law Patty because they want to make him comfort care. You are very angry about their desire to do this.

Instructions for Sister:

• Interrupt the physician at the beginning to introduce yourself if he/she forgets to initiate introductions.
• *Ask for clarification when the physician uses medical jargon*
• If the physician does not ask about your beliefs regarding your brother’s situation, jump in with your claim about there being a miracle because God told you there would be.
• The physician will need to discern your relationship with your brother and how good of a surrogate you really are.
If the physician does not ask about the (distant) nature of your relationship, claim that you know him well and that he was also a religious person.

If the physician does ask, be honest about how little you know of your brother but stick to your religious beliefs.

**Frank’s Older Son: Mike**

Information for Mike:

- You are 40 and Frank’s oldest son. You left home for California when you were 20 and have not been back to Minnesota for over 10 years.
- You think of yourself as the only one in the family who has been successful and you are a know-it-all. You like to ask the doctors sophisticated questions about your dad’s condition and use medical terms that other family members won’t understand to show off you medical knowledge which you learned as part of your job as an adjuster for Aetna, a Health Insurance company. You think that you are the only family member who is competent enough to make medical decisions about your Dad.
- You are married and have 3 children under 10 who have not met their grandfather.
- You always fought with your Dad about his drinking and were happy when your Mom finally left him when Jim was out of high school. You take care of your Mom with extra money and have flown her out to California twice to see her grandchildren. You want to have nothing to do with your father and do not recall talking to him in the last 15 years.
- You think Jim and Dad should not be living together. You think they drink too much and do not do much to improve their situation.
- You keep in touch with your brother and know he is having a hard time after Iraq but think he is not using the VA enough to get medical or employment help. You think your brother would have a hard time without his father but that he might be more motivated to get his life going if he were on his own.
- You know how expensive medical care can be from your work as an insurance adjuster. You worry about the cost off all the surgeries and the effort needed for rehabilitation when your Dad has taken poor care of himself in the past and in your opinion, will not work hard at rehab. You do not actually know this but it seems likely given how you are told he lives his life.
- You carry a huge resentment towards your Dad for his treatment of your mother and although you would never say it, you do not think he is really worth all this effort and cost.
Please bring up the following:

1. The cost of medical care
2. That the treatment might not benefit his Dad
3. Bring up Jim’s stake; that he lives in Dad’s house and might have to move if his father dies.

**Physician Roles**

**Neurosurgeon**

Instructions for Neurosurgeon:

- Introduce yourself and explain the reason for the meeting.
- Ask to go around the room and have each member introduce who they are and how they are related to the patient.
- Ask the primary participants what their understanding is of the patient’s current situation.
- State that you will review the general course of events and current situation.
- Admitted with a severe traumatic brain injury requiring surgical evacuation of a blood clot.
- Swelling of the brain, need to drain excess fluid to help prevent additional damage. This drain will be weaned off over time. You expect another 10-15 days of ICU care, because of the need for medications and the ventilator.
- Unsure of the long-term outcome, and will need transition to a long-term acute care hospital. He will have some deficits, but it is too early to know how severe they will be. In conjunction with the SICU team, you are recommending a tracheostomy and PEG procedure. At this point, ask the SICU physician to describe these procedures more.
- Once the SICU physician is done, ask if there are any questions.

Information for Neurosurgeon:

- You are the chief resident of the primary team caring for this patient; you discussed the case with your attending prior to the conference.
- The hematoma was removed quickly, intracranial pressures have fluctuated, but are controlled with drainage and medications and you believe the ventriculostomy will come out without difficulty.
- There is a reasonable chance of recovery over time; however, this is not certain.
- It is likely the patient will require some degree of assistance long-term, but the extent is not known.
Talking points for the SICU physician:

- The Neurosurgery physician will lead the conference.
- Introduce yourself as the resident intensivist in the SICU. Your team manages the ventilator, IV medications, and day-to-day operations.
- Once the Neurosurgery physician asks for your input, you describe the tracheostomy and PEG procedures: The procedures are done at the bedside; there are some minor risks (bleeding, infection, and conversion to open procedure). Patients are more comfortable after the procedures, can start to lighten sedation more.
- Stress that this is typically a temporary measure and very common for patients with this type of injury. Eventually, the PEG is removed, typically in 6 weeks or so after placement, if he becomes more alert and it is safe to start eating. Typically the tracheostomy helps wean from the ventilator more quickly, and a speaking valve can be attached once that happens, if the patient is more alert. Typically, the tracheostomy is removed in several weeks and heals up with a small scar.
- There is a reasonable chance of recovery over time; however, this is not certain.
  - It is likely the patient will require some degree of assistance long-term and the extent is not known at this time.

Information for the SICU physician:

- You are the third year resident in charge of the day-to-day management of the SICU patients. You have discussed the patient with the attending staff.
- There is a reasonable chance of recovery over time however this is not certain. It is likely the patient will require some degree of assistance long term and the extent is not known at this time.
APPENDIX B: CHAPLAIN VERBATIM EXAMPLE

Verbatim Reflection Format

<table>
<thead>
<tr>
<th>Chaplain:</th>
<th>Verbatim (# /7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Race/Ethnicity:</td>
<td>Your age (optional):</td>
</tr>
<tr>
<td>Your religious tradition:</td>
<td>Date written:</td>
</tr>
<tr>
<td>Date of visit:</td>
<td>Location of patient (Include hospital and unit):</td>
</tr>
<tr>
<td>Length of Visit:</td>
<td></td>
</tr>
</tbody>
</table>

I. **What are you hoping to learn by bringing this verbatim to your supervisor and peers?** How does this connect with your learning goals? Be as clear as you can, and refer to your specific learning goals, as appropriate. While you might write this section last, it is the most important part of your verbatim.

II. **Data about the patient and goals:** provide a brief summary of the relevant information about the patient and/or the person you are ministering to if it is someone other than a patient
   A. Demographic information: pseudonym for the person, age, gender, religion, race and ethnicity
   B. Physical dimension: date of admission, diagnosis, brief medical history as appropriate
   C. Your goals: any specific results you wanted from the encounter, anything you wanted to avoid

III. **Your awareness of self:** Prior to the ministry encounter, what was your own cognitive, emotional, and physical state? Were you tired, apprehensive, angry, excited, etc.? During the ministry encounter itself you may become aware of physical, emotional, cognitive changes within yourself. Indicate these in the right-hand column as you record your conversation.

IV. **Your first impressions and observations:** Describe briefly the person and her/his environment. What is going on in the area? What is the person’s physical appearance? What non-verbal messages are you receiving? What are your assumptions based on your impressions and observations?

V. **Your ministry encounter:** This is to be as nearly verbatim an account as possible. Report pauses, interruptions, facial expressions and any other clues, which may reveal something about relationships within the situation. Include also--in the right-hand column--what you experience within yourself (feelings,
questions, etc.). Your main purpose in presenting your verbatim is to present your ministry encounter in such a way that you and your peers and supervisors can understand it. This requires careful attention to detail, honesty, and a fair amount of vulnerability on your part. Your verbatim represents a privileged conversation which must be treated with respect and handled in a professional manner.

**Dialogue**

Please identify the speakers; for example: C=Chaplain, P=Patient, N=Nurse.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>D?</td>
<td>I asked while I knocked at the doorway.</td>
</tr>
<tr>
<td>P2</td>
<td>Yes, come in.</td>
<td>Her voice is weak; I wonder how strong/well she is. She was fairly strong the other day when I saw her.</td>
</tr>
<tr>
<td>C3</td>
<td>Hi, it’s Chaplain _____. I’m here to see how you are doing.</td>
<td></td>
</tr>
<tr>
<td>P4</td>
<td>Who?</td>
<td>Oh, oh! I feel anxious. Does she remember me? I’ll tell her again who I am so that she doesn’t have to guess.</td>
</tr>
<tr>
<td>C5</td>
<td>Chaplain _____. I visited with you yesterday.</td>
<td>Good! There’s a glimmer of recognition. I feel more confident.</td>
</tr>
<tr>
<td>P6</td>
<td>Oh yes. Thank you for coming.</td>
<td>She is saying more but I can’t understand because she is very quiet and the TV speaker is quite loud. I feel annoyed. I have to get that TV turned down.</td>
</tr>
<tr>
<td>C7</td>
<td>Do you mind if I turn down the TV volume because I can’t hear very well.</td>
<td>I’d like to turn it off but at least turn it down.</td>
</tr>
<tr>
<td>P8</td>
<td>Go ahead. I am not sure how to work those things so I am never able to do things like that.</td>
<td>So many people have that trouble. Maybe I should remember with elderly patients to ask them about the TV and radio.</td>
</tr>
<tr>
<td>C9</td>
<td>That’s OK. So, how are things going today?</td>
<td>I turn down the volume.</td>
</tr>
<tr>
<td>P10</td>
<td>Not very well. I don’t want to be here anymore. They just won’t let me go. They come in and do therapy with me. They try to have me walk but I tell them that it won’t do any good because I don’t need it. I don’t want to be here any more.</td>
<td>What’s she talking about? Going home from the hospital? Dying? Is she tired of living? Is she depressed? She doesn’t sound as if she’s just complaining about things. Therapy is difficult and many people complain about it. But this seems to be more than that. Is she with it? Or is she just rambling? Seems to be with it. I feel afraid.</td>
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</table>

**Assessment**

**VI. Process Assessment**

a. Summarize the dynamics and flow of the visit. Did it have a question and answer feeling to it, or was it a dialog? Where did the direction of the conversation change, and who changed it?
b. What kinds of responses did you use? (e.g., summarization, empathy, interpretive, reflective, question, self disclosure, teaching affirmation, challenge, etc.) Assess the strengths and weaknesses of your responses based on the other person’s responses.

VII. Your Self Assessment
a. **Spiritual assessment:** What feelings did this person seem to be experiencing, and how did you know? How would you describe the spiritual needs or “main message/concern” of the patient? Regarding the person’s situation and main message/concern, what spiritual/theological issues do you see? (e.g., faith, doubt, temptation, sin, guilt, shame, despair, pride, blaming, conflict, judgment, estrangement, punishment, works righteousness, self indulgence, humility, confession, penance, forgiveness, repentance, discernment, transformation, rededication, hope, communion, love, joy, peace, patience, kindness, goodness, gentleness, self-control, grace, etc.) Did you identify any spiritual resources the patient already has? How did you address the spiritual needs of the patient? Do you have any thoughts about how you might contribute to the overall care of the patient? What is going to be your pastoral care plan for this person/family?

b. **Psychological/mental/emotional/social dimensions:** Comment on congruencies or incongruences in the person’s situation, thoughts, feelings, and behaviors. What social conditions, systems and structures did you see affecting the life of your patient and how were they affecting them? How did you address this in your ministry?

c. **Self-evaluation:** (As you write this part of your reflection indicate in parentheses where you see yourself doing whatever it is you are talking about; e.g., C1, C2.)
   i. **Connections:** Where did you feel a connection with the patient? Where did the patient seem to feel a connection with you? Did you feel yourself disconnecting or wanting to leave the room at any particular time? If so, what was happening then?
   
   ii. **Strengths and Weaknesses:** What were your strengths and weaknesses in this ministry encounter? What went well? What can you celebrate? What might you try to do differently next time? Did this verbatim activate a desire to learn more about particular issues related to self-awareness, interpersonal awareness, and pastoral concepts, functioning as a pastor, or ministry development and management?

   iii. **What major life events, relationships, assumptions, values** of yours are you aware of as you reflect on this visit? How did your life history influence your ministry practice?

VIII. Theological Reflection:
   a. How did you experience being connected to God during this visit? Were you able to help connect the patient with God?
   
   b. Discuss any spiritual/theological issues that this visit raised for you. Where did you see God connecting with you and the patient?
c. What theological understanding led you to do what you did in this visit? Write about stories, passages, themes, and images from Holy Scriptures or any other source of truth that come to mind for you.

IX. **Your chart note:** what did you chart? If you could write more freely, what would you chart?

X. Please go up to section I and further reflect and write on what you’d like from the group.
Bibliography


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