Episode: *Author Interview: "Why Prospective Bereavement Counseling Is Crucial for Peace-Finding After Loss"*

Guest: Ramona Fernandez, PhD, MEd
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Transcript: Cheryl Green

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[bright theme music]

[00:00:03] TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Ramona Fernandez, a registered psychotherapist employed at Western University in London, Ontario, Canada. She's here to discuss her article, "*Why Prospective Bereavement Counseling Is Crucial for Peace-Finding After Loss,*" in the November 2024 issue of the Journal, *Peace in Health Care*. Dr Fernandez, thank you so much for being here. [music fades]

DR RAMONA FERNANDEZ: Thank you. Tim. It's absolutely an honor to do this podcast series with you.

[00:00:46] HOFF: So, what is the main ethics point of your article?

FERNANDEZ: So, one of the delightful and challenging things about this particular paper is that it actually takes up three very lofty ethical issues, all in one paper. Typically, bereavement counseling is offered after a death has occurred. And in this article, I'm trying to position that we upfront the timeline in which we offer it, with the idea here that being able to do so brings alongside a hope that we can maximize quality of life while the person is still alive, for them, for their loved ones. Bringing alongside bereavement counseling early in the process prospectively also allows us to align with goals of care during times of intervention into some sort of meaningful pathway. The hope is that this maximizes quality of life, that it allows for more meaningful care planning and goals of care, and ultimately, as a bereavement counselor, what I call management of future regrets.

So, in order to help put this into some sort of framework that we could translate from concept into practice, I proposed a set of three guiding questions, which then have some further follow-up questions. The first one is, "Are you at peace?" which aims to have a check-in point about being able to identify and put into place addressing concrete actions that could support peace. The second question is around, "How can I help you find peace?" if the answer to the first question is, "no, I'm not at peace." The third part is, "How do we know that we are successful?" And so, that's a two-part. There's a patient-facing portion where we ask. We continually check in iteratively to find out whether we are moving towards peace, whether we're diminishing their peace, or whether it's remaining status quo. The other part is about quality improvement and

thinking about peace as a quality indicator. What kinds of ways could we improve quality of care?

[00:02:51] HOFF: So, what should health professions students and trainees at the beginnings of their careers take from this article?

FERNANDEZ: So this is a really great question, and I'm going to come back to the early days of my clinical training when I was so worried about getting it wrong. And so, some of that humility, I think, that we aspire to as reflective practitioners is remembering that what we know now we didn't always know. And one of the things that I was so focused on was, "Tell me what to do. Tell me how to do it. Tell me if I'm doing it correctly. Am I doing it wrong? Am I doing it right?" and kind of like following a recipe. But existential aspects of care, compassionate-based interventions—peace being one of those—requires a different type of learning, and it's really about a mindset. And so, we have this big concept of peace. And this is where I think the shift is, is from not just thinking about what to do, but also how to be, how do we show up, and remembering one of the things my former mentor used to say is, "You can be there, you can be still, you can be present." And that helped me shift from a mindset of doing to a mindset of showing up and being. And that's part of a compassionate-oriented mindset when we're looking at existential concepts of health care.

So, the way that I land with it in this article is peace is and could be a constructed clinical outcome If we look at the dimensions of what peace is, if we think about how we could put those into actionable steps, how we could align meaning and purpose and have a reflective process of what we're doing and why we're doing it. And so, thinking about it in that way, along with opportunities to foster peace, really, what we, what I would say that as students, as trainees, as professionals, no matter how many years in practice that we could take away is to think of it as a constructed clinical outcome in which all of us coming into that space—whether as patients, as health providers, as loved ones, as administrators—we all share a role in bringing together a co-creation around that clinical outcome of peace.

[00:05:35] So, there's a doing and there's a being. But what I want to hope that someone would take away from this article is that if we think about it as a clinical outcome, it means that it can come with a set of skills. Which means we can teach it, we can learn it, we can practice it, we can put it into practice, we can refine it in implementation. So that's what I would hope that would be the takeaway for someone at any stage of their career wanting to engage with this.

[00:06:05] HOFF: And finally, if you could add a point to your article that you didn't have the time or space to fully explore, what would that be?

FERNANDEZ: So, I really like this question because it was a lot to pack in a very tight word count. For this particular question I think I'd like to focus on is the unseen labor of the clinician in doing compassionate care work because compassionate care interventions are underfunded if they are funded at all. And so, if I could get really frank here to expand my point that at the end of the article, I make a point that ultimately,

compassionate care interventions and work, including peace, ultimately depends on operational support at a systemic level, a mezzo level at an institution, but also a macro level. We live in a world that is very billing oriented, and so therefore constrained for time, for resources. And peace is greatly desired for patients, for clinicians, for the ethos of what health care should be, but it's not on a billing code. And so, what ends up happening in reality is peaceful care, a good life, a peaceful death really comes and happens at the generosity, emotional generosity, of the staff.

[00:07:29] And adding to that, being in situations where we are present and witnessing and bearing witness to difficult and existential circumstances runs the risk of vicarious exposure time and time again. We have to think about that. So, when the goal has been met, when peace has been created for the patient, for the family, there's also an unseen part about what it took as a toll on those serving that mission to create peace, which has important implications for staff burnout, for sustainability of people staying and enduring in professions. And so, what I would say is this: Peace can't sustainably be created by people who are existentially exhausted. And yet, that is what the system asks of clinicians every single day and expects. So I think an article about peace and health care, we can't have it be absent of the emotional labor, the emotional generosity of the staff, the toll that it takes, burnout, compassion fatigue, and occupational stress injury. [theme music returns] And so, if we want it to sustain, we need to make space for these things to also be recognized.

[00:08:55] HOFF: Dr Fernandez, thank you so much for your time on the podcast today and for your contribution to the Journal this month.

FERNANDEZ: Thank you so much for having me.

HOFF: To read the full article, as well as the rest of this month's issue for free, visit our site, journalofethics.org. We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.