

CHAPTER 13

Clinical Ethics Consultation

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In season five of *Designing for the Sexes*, a television series on HGTV hosted by interior designer Michael Payne, a young couple, Jan and Dave, have recently purchased their first home together, but neither feels equipped to make design decisions about the living or dining room. The current furniture consists of matched, off-white couches against an off-white floor and walls. Although they both agree the room needs a facelift, their stated visions for the room differ wildly. Jan wants “a rich, stylish, eye-catching atmosphere.” She likes “comfortable” and “casual.” Dave, on the other hand, “envisions a simple blend of old and new, comfortable furnishings.” He wants “rugged” and “a little bit country.” Seemingly at an impasse, they are stuck in decorating paralysis, and the room remains bland and unloved by both parties.

Rather than continue to live with the space as is and realizing their own limitations, Jan and Dave call Payne to consult about it. His goal is to help create a space that both can enjoy and to resolve the design tensions that have Jan and Dave frustrated and ill at ease in their own home.

While their design struggles persist, imagine that Jan’s mother, Betty, has recently had a stroke that has left her unable to speak for herself. Betty requires complex, intensive medical interventions, and should she survive her stay in the hospital, she would have to go to a nursing home that can deal with such complex care—a nursing home that most likely will be many hours from the family’s hometown. Jan, as one of two daughters to Betty, is wrestling with what Betty would want and, thus, what is best for her. Jan believes that Betty is a fighter and would want every chance to continue living and get better. Betty’s other daughter, Pam, believes that her mother has only a very small chance of “meaningful” recovery, and she believes it might be best to stop the intensive treatments and only provide comfort for Betty’s pain and suffering until she dies. At an impasse, Jan, Pam, and Betty’s physicians are unsure how best to proceed, and thus, they remain at status quo, with Betty lying in the intensive care unit for weeks. Jan wonders out loud whether there is a health-care equivalent to Michael—someone who can help work through these health-care decision differences to find a reasonable resolution for her mother’s care.

Turns out there is.

THE RESPONSIBILITIES OF HEALTH-CARE PROFESSIONALS

Medicine is neither easy to learn nor to practice. Health-care professionals are tasked with helping individuals (even society) live healthy lives. But to do this, several things must

happen. First, communities and governments must help develop the conditions for healthy living. Among other things, streams of water must be free of contaminants; sewage must be taken away from where people live; air must have oxygen in it and pollution out of it. Second, people must visit health-care professionals, both to help prevent illness and to treat disease or injury. Avoiding the physician or lacking access to medical care undermines the ability of health care to help. Finally, health-care providers must get to know not only the biophysiology of their patients, but also patient interests and values that shape the meaning of what “healthy living” means to each patient.

Given these three important requirements at the intersection of health care and healthy living, both states and their citizens, laypeople and patients, providers and other health-care professionals all have responsibilities, and these responsibilities rest on value determinations. Is it more important to provide clean water or to allow businesses small levels of contamination so that they can stay in business? Should access to health care be universal for all citizens of the state, thus raising tax levels, or should market forces be the primary factor in determining health-care access? Or, to make this all more specific and personal, what care options are best for Betty, and who is best positioned to make those decisions?

This latter set of questions that arises in hospitals and clinical settings is the catalyst for what is known as *clinical ethics consultations*. Since the mid-1970s, clinical ethics consultations, whether by individual ethicists, teams of consultants, or committees of health-care and lay professionals, have become increasingly common in large hospitals across the United States and internationally. But although this fairly young health-care practice is quite common, the decades to come will continue to see the practice of ethics consultation both adjust to the changes in medicine and grow with the needs of medical providers and patients alike.

This chapter will look at the purposes, premises, and practices of clinical ethics consultation. It will explore why they are requested, how consults are done, and how they might help. The chapter focuses on how the moral character of medicine results in the need for careful ethical reflection, on how ethicists can help in those reflections, and what occurs in a consultation that systematically moves reflection forward to help in patient care.

THE ETHICAL WORLD OF MEDICINE

In the following scene from the television series *The West Wing*, at a preprimary presidential campaign talk in Vermont, Governor Jed Bartlet is speaking before a small audience in a VFW hall.

FARMER: Governor Bartlet, when you were a member of Congress, you voted against the New England Dairy Farm Compact. That vote hurt me, sir. I am a businessman, and that vote hurt me to the tune of, maybe, ten cents a gallon. ... And I'm here, sir, and I'd like to ask you for an explanation.

[*Grumbling in audience; pause before responding*]

JED BARTLET: Yeah—I screwed you on that one—

FARMER: I'm sorry?—

JED BARTLET: I screwed you; you got hosed—

FARMER: Sir, I—

JED BARTLET: And not just you, a lot of my constituents. I put the hammer to farms in Concord, Salem. ... You guys got Rogered, but good.

Today, for the first time in history the largest group of Americans living in poverty are children. One in five children live in the most abject ... poverty any of us could imagine.... If fidelity to freedom and democracy is the code of our civic religion, then, surely, the code of our humanity is faithful service to that unwritten commandment that says, "We shall give our children better than we ourselves receive."

Let me put it this way: I voted against the bill because I did not want to make it hard for people to buy milk. I stopped money from flowing into your pocket. If that angers you, if you resent me, I completely respect that. But if you expect anything different from the President of the United States, you should vote for someone else.

Thanks very much, everybody. Hope you enjoyed the chicken.

(*The West Wing*, 2000)

Ethics is a term that lends itself to multiple meanings. Colloquially, the term *ethics* concerns how each individual deals with right and wrong, good and bad. As with Governor Bartlet's claim that what you see is what you would get as president, personal integrity and habits of action are at stake. We think of ethics, in this light, as speaking to who we are, the beliefs and interests that we take to be fundamental or integral to us, and the reputations we have and cultivate. Taken in this way, ethics is about *values* and *character*.

In addition, however, all individuals have their place in society. We all are members of a family, of communities, of professions—that is, role-based considerations come into play. From these roles arise commitments and obligations. Governor Bartlet owes his constituents an accounting for why he voted as he did. Married spouses should not cheat on each other or abandon the family. Community members should help one another in times of crisis and follow the laws of the society. Professionals should abide by the codes of conduct set forth by the profession itself. Again, the roles we play place on us responsibilities and obligations, and others hold us accountable for fulfilling these responsibilities. This use of ethics often is associated with judgments of what actions or behaviors are *right* and *wrong*.

Finally, carrying values is not unique to any one individual but is ubiquitous across humankind. Often, between personal interests, cultural values, professional and relational obligations, it is not uncommon that conflict will arise between people and even with(in) institutions. But such conflicting concerns can lead to questions about ends to be pursued and what means are appropriate in those pursuits. Children live in poverty; milk prices are high; farmers want to get fair pay. Whose values trump the other? Should state interests trump individual citizens? And whichever values trump, what ways are there to fulfill the values we believe should be championed? This way of seeing ethics can be characterized as weighing *good* and *bad*, *better* and *worse*.

The history of Western moral philosophy shows that many thinkers have attempted to determine which sense of ethics is the proper conception to hold. It seems clear, however, that each of the given meanings of ethics captures something important about moral life, and thus, no one of these three senses of ethics should be ignored, nor is any one of them always dominant. It is worth noting that each of us is a "values carrier," whether as a product of biology, nurturing, education, or some other means. Furthermore, we do, in fact, find

ourselves in relation to others—familial, professional, and so forth—and those relationships commit us to others and to expectations for which we are held accountable. At the same time, in a finite universe of limited abilities and resources, with a plurality of individual and communal interests, we often are confronted by concerns for what we should do, and why.

Ethics, then, concerns each of these aspects of moral living—values (character), duties (roles), and goods (ends). We might say, then, the field of ethics—that is, the territory of values and interests covered by moral considerations—includes those *evaluations* of human (and some other animal) values-based conduct, both arising from and affecting character, which result in appraisals of good and bad, right and wrong.

If ethics, then, concerns human conduct, medical practice, as a form of human conduct, falls within the realm of ethics. Of course, that does not make medicine unique, but that is, in part, the point. Medical practice, like all human practice, implicates character, roles, and outcomes for patients and professionals alike. Although medicine does involve specialized knowledge and skill, that knowledge and skill are implemented in the service of human beings, affected by the values and interests of those it is in service to. As such, it is rife with ethical issues. Medicine's aim is to promote healthy living for patients through physiological and psychological interventions, and this is no insignificant matter to human beings. Medical decisions and actions, as well as the character of practitioners and patients, are readily on display, and the implications can be of intimate and vital human importance. As philosopher John Dewey (1859–1952) notes,

Healthy living is not something to be attained by itself apart from other ways of living. A man needs to be healthy in his life, not apart from it, and what does life mean except the aggregate of his pursuits and activities? ... [W]hat a man needs is to live healthily, and this result so affects all the activities of his life that it cannot be set up as a separate and independent good. (1920, 175)

Healthy living is personal and cultural, not just cellular and functional. As such, the challenge of providing good medicine is a moral, not simply a biophysiological, challenge. Health-care decisions are made in light not only of lab values and imaging studies but also of individual interests and communal values.

WHY HEALTH-CARE ETHICS COMMITTEES AND CLINICAL ETHICS CONSULTATION?

Patrick was born with Hirschsprung's disease, a disorder of the digestive tract, and after years of surgery to snip out parts of his intestine, he was left unable to digest food.... Patrick was ... on a ventilator suffering from pneumonia, with a tube down his throat to help him breathe. He was conscious, and he was miserable. His feeding line was working in fits and starts, clogged by infection. He was being simultaneously kept alive and tortured by a nightmare of an antifungal drug called amphotericin B. ...

"He'll need a new line soon ... ," [noted the physician]. "We know he'll need another one after that and another one after that. Do we keep opening his chest over and over? Without a new line, he'll starve. Which is worse?" ...

[Questions like these] seem dramatic and rare until you spend any time at all in a hospital. Then you realize that questions this complicated are asked every single day. (Belkin 1993, 4–7)

Given that medicine is a moral endeavor, medical practice requires moral sensitivity, even insight. As physician and bioethicist Edmund Pellegrino (1920–2013) has said, “In making the ‘right’ decision for an individual patient . . . , personal, social, economic, and psychological characteristics of the patient must be factored in” (1979, 181). As Albert Jonsen writes in *The Birth of Bioethics* (1998), to help develop that sensitivity and insight, over the past forty-plus years, health-care schools and colleges have provided ethics instruction, courses, and curricula. Although the content of that instruction varies widely among professional disciplines and colleges, the purpose of such education intends to make health-care professions better able to deal with the daily ethical issues and concerns that arise in their practices.

During the same forty-plus years, clinical ethics consultation has arisen as a professional practice in medical centers. Philosophers, religious ethicists, lawyers, clinicians, and others have stepped into the role of “ethics consultant,” listening to complex cases, helping clarify ethical concerns, and even making recommendations about decision making and ethically appropriate care options. With several generations of health-care providers being taught ethics during their training, it is reasonable to ask why the practice of clinical ethics consultations exists and whether it is needed at all. Bioethicist Mark Aulisio raised this very concern when he notes, “Some have suggested that there is no need for ethics consultation, since doctors, nurses, and other health professionals can and should handle ethical issues as they arise” (Aulisio, Arnold, and Youngner 2003, 4). Furthermore, he adds, “some would argue that medical practice was done quite well without such outside intrusions as ethics committees and consultation services” (5). Let us follow this logic a bit.

It is hard to disagree with the claim that physicians and other health-care providers, themselves, have a responsibility to deal with ethical concerns as they arise. Particularly, if we argue that medicine is constitutively a moral practice, one simply cannot do medicine without accepting the moral implications of the practice. Take this analogy as an example of what this means: the heart and its functions are central to healthy living, and thus, to medical practice. In fact, every physician has training in cardiovascular physiology and pharmacology, to diagnose and treat heart-related illness. And yet, the medical profession has developed a subspecialty in cardiology, and we encourage the practice of consulting such subspecialists when patients have significant issues with their heart.

The reasons for such specializing in medicine is that the human body and healthy living are complex, not simple. Having the knowledge, skills, insights, and training necessary to deal with the intricacies of medicine requires special attention. Of course, every health-care provider requires some level of knowledge of all organ systems, among other things, but we would place patients in greater peril if we did not produce professionals capable of being able to hyperfocus on more delimited areas of medicine. Is ethics the kind of discipline and knowledge area that requires this kind of hyperfocus? On one view, maybe it is not. For all the discussion about duties and consequences and character, you might simply say that each of us is raised with values, and we are all confronted with questions of right or wrong and good or bad throughout our lives. Why is this not enough to be well-equipped in these matters?

We must be careful, however, not to confuse the field of ethics and confronting ethical concerns with the careful reflection and practice of ethics. The former is most assuredly a part of the human condition, but the latter requires training. Just think for a moment about Patrick’s situation and the concerns and questions of his physician. In the everyday business of growing up in a family, with friends, becoming educated in school, maybe having

religious values, what in all that would necessarily make any individual prepared to deal with the complexities and consequences of the decisions to be considered for Patrick? Motivating values must be identified; significant obligations must be met; potential consequences must be weighed. But which values matter, what obligations win, and how are consequences weighted? These are not easy questions for anyone to answer, but there are learned reflections that exist on these questions that most everyday people do not have the time to understand. The history of moral philosophy has given us many ethical theories and methods—Aristotle’s (384–322 BCE) virtue ethics, Immanuel Kant’s (1724–1804) deontology, John Stuart Mill’s (1806–1873) utilitarianism, and Carol Gilligan’s (1936–) ethics of care, casuistry, narrative ethics, pragmatism, and so forth—and the much briefer history of bioethics has a variety of reflective methodologies. However, short of a full-blown course in (bio)ethical theory and method, no one can be expected to have a firm handle on all of these theories. Short of such a robust education, reflections on ethical issues may be compromised.

Each of our actions is not performed in isolation, nor are policies written in a vacuum. *Reasons and justifications are necessary* components of ethical determinations, whether concerning particular situations or institutional policies. Furthermore, consistency of considerations is not unimportant either. Consistent reasoning stems from justified principled positions, and those positions arise from long processes of inquiry into the moral life itself. It is not good enough simply to care about the consequences of our actions for some issues and about our dutiful obligations toward others depending on our mood. We must be able to account for the legitimacy of the methods and theories that underlie the deliberations we perform and decisions we make.

Closer to home, we might also say that there is a “kind of progress possible through reflection in ethics” (Buermeier 1923, 323), which may be noted in four types: First, ethical reflection can bring our own values to light, “values which we might otherwise overlook” (323). Second, reflection aids in clarifying our aims and desires. Third, ethical reflection allows us to separate wheat from chaff, helping “us see what problems really are most vital, and thus bring[ing] us nearer to actual solutions” (324). And fourth, reflection leads us to own our actions, making “our conduct more fully our own, more voluntary and less of a blind obedience to custom” (324).

These are laudable, even necessary, goals to strive for, and so, again, simply put, there is no reason to expect health-care professionals to be fully equipped to do this kind reflection without the aid of persons trained in ethics. Again, as Aulisio points out, “today’s complex medical decision making goes on in a broader societal context of value heterogeneity and a growing recognition of the implications of individual rights for that decision making, which combine with the current clinical reality to create the need for ethics consultation” (Aulisio, Arnold, and Youngner 2003, 6).

WHAT IS A HEALTH-CARE ETHICS COMMITTEE AND CONSULTATION SERVICE?

Julian Byrd ... had read of a few hospitals that had ethics committees, and he decided to form one at [his institution].... For several months, the small group discussed ethics only in the theoretical sense. They developed a list of committee bylaws and a statement of purpose, but they didn’t hear a case. Then one morning in

October ... Randy Gleason, the hospital's lawyer, arrived at a meeting with the tale of a seventy-three-year-old woman who had peripheral vascular disease. The circulation to one leg was so poor that the leg would have to be cut off. She refused the operation, and her doctor asked Randy for his opinion. The Ethics Committee was in business. (Belkin 1993, 69–70)

Beginning in the 1960s with decisions about who should get kidney dialysis, suggested by courts in the 1970s, required by the Baby Doe regulations in the 1980s, and proliferated in response to the Joint Commission on Accreditation of Healthcare Organizations' (known as the Joint Commission as of 2007) accreditation requirements in the 1990s, health-care ethics committees (HECs) are now mainstays of hospitals in the United States. According to Ellen Fox and her coauthors (2007), exact numbers are not available, but a conservative estimate would be that thirty thousand people (and probably double that) in the United States currently serve in some manner on an HEC.

What is an ethics committee? Most HECs were developed to be the mechanisms that handle ethically challenging issues in a hospital or other health-care institution. The membership of an ethics committee typically is composed of institutional staff members—physicians, nurses, social workers, even chaplains, administrators, and sometimes legal counsel (these last three groups are not always included because of conflict-of-interest concerns). Many employ community or unaffiliated people as well to serve as a check on institutional bias and to provide greater insight. When available, someone educated in philosophical or religious ethics is often included as well.

What functions does an ethics committee serve? The traditional threefold mission of an HEC has not changed substantially since the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research formulated it in 1983. The most visible and controversial role is to consult on difficult clinical decisions. Equally important, although sometimes forgotten, are the other two functions of an HEC: (1) formulating institutional policies (consistent with the organization's function and mission) to guide the professional staff in making ethical decisions, and (2) educating hospital personnel about these policies and about health-care ethics in general.

Not all committees perform all three functions, as some institutions have a separate ethics consult service and some ethics committees may do little to no policy review or other "organizational" ethics activities—instead, these may be done by other committees or by a compliance or ethics officer in the institution. The Joint Commission's mandate that ethical issues be handled in some way, however, does put emphasis on the function of case consultation, and consults may occur in three general ways:

- Singular consultant—an individual (one hopes well trained) is tasked (either by the institution or the committee) with consulting. That person would take the call and respond as needed. This process allows for maximum expediency and flexibility, but a minimum of perspective.
- Small team consult—some institutions use a small team (typically three to five people from the larger ethics committee) to consult. This process provides a bit less flexibility and expediency than the single-consultant model, but in turn, it provides more perspectives.
- Full committee consult—at least a quorum of the entire committee meets to discuss an ongoing case. Needless to say, this is the least expedient and flexible approach, but it maximizes the perspectives brought to bear.

The details of how a consult occurs will be specific to each institution. In fact, some institutions may use a combination of the consulting models just listed, depending on the type and source of the consult request. Furthermore, in most institutions, a consultation can be requested by a wide variety of people—not simply by attending physicians or unit directors, but by almost anyone in the institution, including patients and family members. Once a request comes in, the consultation process begins, and it is the purpose and process of consultation, whether by individuals, teams, or committees, that are the focus of the rest of this chapter.

THE PURPOSE OF CONSULTATION

CARLA ASTON: When designing for couples, has there ever been one person in a relationship who tried to dominate all the creative decisions that needed to be made in a project? If so, how did you help the other half find and exert their voice?

MICHAEL PAYNE: Yes. This happened several times on *Designing for the Sexes*. One instance that sticks out in my mind was the time where the woman of the household actually said this on camera ...

“You don’t need to speak with ... Joe, because I actually do this sort of thing for a living.... So you don’t need to speak with him at all.”

Obviously, she was being completely dismissive of her husband. So, after learning long ago that you can say just about anything with a smile on your face, I replied ...

“Well that may be the case in the past, but this is now, and this is a show, and I really want to know what Joe feels about all this. I want to know his tastes, too.”

After I made my point, I launched into asking her about her taste, her preferences, her style, and her likes and dislikes. Then I questioned her on what she didn’t like about [the] room we were to design, why she wanted to change it, and what her expectations were.

After listening to her responses, I then—almost literally—turned my back on her and said ...

“Okay, Joe. Let’s talk about this. What do you have in mind? What are you seeing that’s going to be in this new space?”

And whenever she would try to sort of jump in, I’d say, *“No. I really want to know what Joe feels like about this.”*

Honestly, the feedback I received was oftentimes better when I was spotlighting Joe, because he was speaking from the bottom of his heart.

Finally, after collecting his input and her input, I sat down and designed their space, making sure he got a lot of what he wanted, and she got a lot of what she wanted.

(Payne and Aston 2012)

Not unlike the competing differences that stimulated the design intervention at the opening of the chapter or the concerns expressed by Payne in this interview with Carla Aston, the

practice of clinical ethics consultation arises in light of the complexity of health-care decision making and the diversity of values, interests, and beliefs that patients, families, and professionals carry with them into challenging medical contexts. Surely, health-care professionals are expected to develop an awareness and sensitivity to ethical issues in their practice, and patients and families have the responsibility to grapple with the ethical considerations that health status and decision making present, but being able to analyze, synthesize, and act on the ethical challenges may be too great a burden to place on people not otherwise trained in, or at least decidedly determined to provide, ethical analysis, especially when they have specific investments in the situation that might blind or bias them to outcomes that otherwise do not hold up to ethical scrutiny of the given situation.

Mary is an infant with hypoplastic left heart syndrome (the left side of her heart is small and nonfunctioning) and other congenital anomalies that resulted in her living her entire nine months of life in the cardiac intensive care unit of a children's hospital. Her mother lives over an hour away and has two other young children. She visits Mary about every three to four weeks.

Whenever Mary's mother is asked by the attending physician if she would like to continue intensive care and keep Mary as a "full code" (providing CPR [cardiopulmonary resuscitation] if her heart stops), her mother says, "yes." The nurses at the bedside are distressed because they believe that Mary is suffering and that the care that is being provided is, in their words, "futile." They are also upset that the mother does not visit, and they believe that she is not truly an engaged parent. However, they feel compelled to continue their intensive treatments because of the stated wishes of Mary's mother.

While designers like Payne are called in to navigate design challenges between couples, clinical ethics consultations are employed in cases like Mary's to take on ethically difficult situations in health care, addressing moral matters head-on by filling the gaps in knowledge, skills, or even perspective. How this gap is (or should be) filled is a matter of some debate.

In its report, *Core Competencies for Healthcare Ethics Consultation*, the American Society for Bioethics and Humanities (ASBH) states, "Healthcare ethics consultation ... is a set of services provided by an individual or group in response to questions from patients, families, surrogates, healthcare professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care" (ASBH 2011, 2). Again, medical practice is not merely about the conditions, function, and effects of human biophysiology. Health care is value laden. Clinical ethics consults, per ASBH, are directed toward "resolving" value-laden concerns that are "uncertain" or "in conflict." Accordingly, constitutive of clinical ethics consultation is an aim toward resolution. But not everyone agrees.

In discussion with different stakeholders, it is discovered that the surgeons believe that further surgery for the heart could keep the child alive for many months, maybe a couple of years, if other co-morbidities do not make living impossible. Thus, they offer to keep Mary on intensive care if the mother desires. Also, Mary's mother has no transportation, and must rely on others to get her to the hospital.

Some argue that the aim of consultation is primarily both situational and "values" clarification. Admittedly, such clarification is not merely an end-in-itself, but it may provide a means to the end of resolving ethical dilemmas. However instrumental, situation and values clarification is taken by some to be a worthy "end in view" that, if achieved, marks the limits of clinical ethics consultations—ceding the responsibility to achieve "resolution" to the affected parties. Although such clarification is a useful, even necessary, part of a

consultation, it ends precisely where many of the parties involved need the most help—namely, adjudicating and weighing the values at play to move forward in the case. Physicians feel obligated to offer surgery, even though the long-term prognosis is dismal. Nurses feel compelled to act on parental decisions, even though they believe those decisions are causing bad outcomes for Mary. Mary’s mother chooses to continue to keep her child alive, but she is hampered by circumstances to share much in her daughter’s life. For each of the affected parties, ethical challenges arise. And, again, recognizing and working through ethical issues takes training, not just life experience.

Given the pressures of health-care decision making and the kinds of conflicts (as in Mary’s case) that create ethics consults, there is little dispute that the driving purpose of clinical ethics consultation is resolution, although debates about the form of and the parties affected by that resolution do remain.

MODELS OF CONSULTATION

The following scene from the “Twelve Angry Men,” a 1954 episode of *Studio One in Hollywood*, occurs in a jury room after a six-day trial of a nineteen-year-old male who is accused of killing his father.

[JUROR NUMBER] THREE: Do you really believe he’s not guilty?

EIGHT: I don’t know.

SEVEN: After six days, he doesn’t know.

TWELVE: In six days I could learn calculus. This is A, B, C.

EIGHT: I don’t believe that it is as simple as A, B, C.

THREE: I never saw a guiltier man in my life.

EIGHT: What does a guilty man look like? He is not guilty until we say he is guilty. Are we to vote on his face?

THREE: You sat right in court and heard the same things I did. The man’s a dangerous killer. You could see it.

EIGHT: Where do you look to see if a man is a killer?

Some situations in life, like the preceding deliberation in “Twelve Angry Men,” appear uncompromising. The parties are set off against each other. The decisions are resolute, although they also may be unspoken. This happens in legal matters, in relationships, in business, and certainly in health care. But ethics consultations, as we have said, aim at resolution, and if this is true, then consultation models should be structured to achieve that aim. In this light, some have suggested what ASBH has termed the *pure facilitation* (1998) or *pure consensus* (2011) model. This model is predicated on the idea that resolution is met through the development of consensus among the affected parties. Some individual values and practices are morally questionable, however, and the “pure” consensus model could lead to “resolutions” that “fall outside the boundaries of widely accepted ethical and legal norms and standards” (ASBH 2011, 7). Also, some ethical conflicts are morally intractable, and seeking consensus as the primary aim of a consult in those cases would necessarily leave the consult without resolution.

Two models, then, have been proposed that are intended to achieve resolution of an ongoing case, where possible, but not rely solely on group agreement to get there. These two

models are *ethics facilitation* (ASBH 1998, 2011) and *bioethics mediation* (Dubler and Liebman 2004, 2011).

ETHICS FACILITATION

Ethics facilitation is considered by ASBH to be “most appropriate” (ASBH 2011, 7) for clinical ethics consultation and is probably the most common method of consultation in the United States. It consists of helping to “elucidate issues, aid effective communication, and integrate perspectives of the relevant stakeholder” (7). Ethics facilitation relies on skills of active listening and the clarification of values. While it does not necessarily aim for recommendations, it “does not preclude making recommendations.... On the contrary, specific recommendations are often helpful and appropriate” (8).

BIOETHICS MEDIATION

Even with the broad practice of ethics facilitation in US hospitals, bioethics mediation has become increasingly popular as a model for performing an ethics consultation. Although the facilitation approach often can be fairly unstructured and makes the consultant the locus for ethically evaluating the situation, bioethics mediation involves the consultant taking on the role as mediator to negotiate an ethically “principled resolution ... that is comfortable for all parties” (Dubler and Liebman 2011, 13). The mediator, rather than carrying the burden of fashioning an ethical outcome, works with the conflicting parties to ensure that each party is able to exercise his or her autonomy, that the decisions made are well informed, and that relevant aspects of the mediation remain confidential. The process begins with an ethically informed mediator and invites parties to the table to work through a dispute. Bioethics mediation must come to resolution, even if that resolution is “a series of default rules for determining who makes decisions” (Dubler and Liebman 2011, 24).

As noted, both facilitation and mediation as models of case consultation are implemented in the midst of ongoing patient situations. However, moral concerns often linger, regardless of outcomes for the patient, family, and health-care providers, and some have argued that it is in retrospect or, at least, in some distance from the actual experience, that ethical reflection can best occur. In this light, some have suggested that consultants do a form of “debriefing” with professionals. Dutch professionals (see, e.g., Molewijk et al. 2008) have implemented a process called *moral case deliberations* instead of providing bedside consultations.

MORAL CASE DELIBERATIONS

The purpose of moral case deliberation is to provide a determined time and place in which professionals can reflect on moral aspects of their practice by reviewing cases. Although this can occur while a case is still ongoing, often this process happens after a case has been completed. Like ethics facilitation, moral case deliberation involves multiple people but is not necessarily aimed at a specific resolution or recommendation. Like bioethics mediation, the ethics consultant is not tasked with developing the moral evaluation but rather is trained to facilitate a structured discussion among the individuals who attend. Unlike both facilitation and mediation, moral case deliberation is restricted to professional participants, not families and patients.

Arguments have been made for each model of consultation described previously (as well as some others), but clinical ethics consultants are probably best served by having facility with each of the models and using one or the other depending on specifics of the situation at

hand. But models are large frameworks that must be operationalized, and we will call that operationalizing a consultation *method*. Many methods of consultation have been suggested and are in use around the country. The Veterans Administration, for example, uses what they call the CASES method, in which a consult is broken into five steps: clarifying the consultation request, assembling the relevant information, synthesizing the information, explaining the synthesis, and supporting the consultation process. In “Ethics Consultation Process” (2012), Jeffrey Spike has suggested *GiNo’s DicE*, an acronym to remind a consult of the necessary activities for a comprehensive consult: get information, negotiate options, document the consult, and evaluate the outcomes and processes. Similarly, Wayne Shelton and Dyrleif Bjarnadottir (2008, 58) describe a method of structuring a consult around what should be reported clinically: demographic information, reason for consult request, informants, a systematic description of the case (utilizing a framework adapted from Jonsen, Siegler, and Winslade 2002), assessment, discussion and analysis, and recommendation.

Further examples of consultation methods can be enumerated, but I offer up a discussion of my own particular method that is applicable in many ways to any of the consult models mentioned thus far. Unlike some other models, it is not intended to be comprehensive regarding all steps of the consultation, but instead it is intended to focus specifically on those moments during a consultation that are focused on ethical evaluation of a case. As such, it is decidedly aligned with the facilitation (recommendation) model, because facilitation is the most common model currently used for clinical ethics consultations.

A METHOD OF CONSULTATION

Consider the following situation adapted from an ethics consultation chart note:

Situation: The patient, Mr. Q (26 years old) was brought to an outside medical facility with severe head pain. He was told to go to the academic medical center (AMC) 45 miles away after CT scan at the outside facility indicated a large brain mass. At the AMC, the patient arrived at the Emergency Department and was immediately admitted for surgery on a brain tumor.

Unfortunately, during his stay, his brain hemorrhaged, rendering him completely unresponsive and requiring a ventilator, tracheotomy, and feeding tube. Patient remained in ICU for 3 weeks, and was able to be moved to step-down on week 4. The patient is unable to respond meaningfully to questions, and part of his skull has been removed until his head stops swelling.

With the patient’s condition now stable after surgery, the neurosurgeon indicates that the patient can be moved out of the hospital, though it will be many months before another surgery will be performed to replace the missing part of his skull. Case management has discussed future discharge options with family. The case manager discussed nursing home options, and noted that his state-based insurance was going to stop paying for his care in the hospital within a couple of weeks. To all this, the family expressed concern that the patient was being moved out prematurely.

That patient lives with his grandmother, and his father lives nearby. There are conflicting reports from both family and health-care providers about whether Mr. Q suffered from some mild form of developmental delay prior to this hospitalization.

Ethics was contacted by risk management after learning that the family contacted the newspaper to complain about the patient being discharged because they could not

pay. The ethical concern was that the hospital's resources were being unduly taxed by caring for a patient who could be served in a rehab or long-term care facility.

The clinical ethics consultant talked with bedside nursing, a resident, and the attending physician to better understand the medical situation. He also discussed the patient's situation with the family every day for one week. These discussions led to three health-care team conferences.

That family felt obligated to protect the patient from undue harm that they believed would more easily occur if not in the hospital. They were not interested in moving to a nursing home, believing that nursing homes would not be able to provide adequate care. They were confused by why their loved one was being sent somewhere else when his head was still not fully recovered, and they were not clear on how long it would be until that recovery might occur.

While the health-care providers recognized the family's distress, they also did not believe that keeping the patient in the hospital was, in fact, protecting him from undue harm. Hospital-acquired infections and other problems can arise in acute-care facilities. They also believed that as an acute-care facility, they should not be obligated to take on chronic-care patients whenever the family was uncomfortable with long-term care options.

The risk manager was concerned that the hospital's reputation had taken a hit that it did not deserve, that it was obligated to find an appropriate long-term care facility, and once one was found that could take the patient, funding would run out.

Most clinical ethics consultations, then, have at their core the aim of stimulating moral reflection on different aspects of the medical situations that call forth consultations. Moral reflection is an important and complex process. It aims at better understanding of morally challenging situations and, possibly, providing insight and direction for morally acceptable responses to those challenges. On its face, moral reflection, then, seems a skill worthy of cultivation, but it can be difficult to motivate such development.

On the one hand, as Dewey has noted (1922), morality simply is social. We grow up acting in a world of others, and others do hold us accountable for those actions. From the earliest age, parents tell us what is and is not acceptable, and they correct us when we miss the target of acceptability. But moral direction is not simply supplied by adults to children, peer-to-peer evaluations also occur when our friends and playmates challenge and condemn us for what we do and say. Given this, we can readily say we are beings ever immersed in morality, and as such, suggesting there is a need to cultivate our moral processes is, at best, redundant and, at worst, patronizing.

On the other hand, however, experience alone is unsystematic, producing unreflective habits at best, and generally we believe that careful development of our habits in light of the purposes to which we would like to put them affords the opportunity to improve them. Surely, every person with working muscles in her arm and hand can throw a ball. But when that "natural" experiential ability is tasked with throwing a baseball sixty feet, six inches to cross a fifteen-inch surface at a height roughly between twelve and forty-eight inches off the ground, many are unsuccessful. As such, no one seems taken aback when it is suggested that if not simply throwing but pitching a baseball is your desire, you should develop a systematic approach to develop the "arm mechanics" to get the ball consistently over the plate for a strike. Such an example (and many others) seem obvious. Driving a car, shaving our faces or legs, or shooting a basketball are all readily seen not simply as

muscular movements but rather as habits that require some reflection and cultivation to make them work for us regularly and successfully. We must be careful that we do not let the physical nature of these activities fool us into thinking that careful habit formation is merely for physical processes. Mental and cognitive aspects of our lives are prone to be habituated as well, and like their muscular counterparts, they can be developed over time, not simply set loose. That is, we can think, emote, and respond differently to the world around us than we do by “nature.” Yes, our brains will produce thoughts and ideas without any purposeful reflection, intentionally brought to bear. But we would, then, never be able to read or write, discern classical from pop music, or enjoy the complexities of wines and craft beers.

So, again, having desires about what you want and see as good is our natural starting point for morality, but it is not the end. The world is full of moral challenges that involve others’ interests and desires, values and beliefs. Navigating all this complexity implicates the full scope of moral considerations. To leave our moral sensibilities to their own devices without some careful attempt at mature development and habituation seems foolish, at best—and unethical at worst. Put differently, why should our cognitive and moral “habits” be any different than our physical ones, especially given that some moral challenges we face are significantly complex?

As we have discussed, medicine is rife with moral issues, complexities, and considerations. Clinical ethics consultations, thus, attempt to flex reflective, considered habits of moral reflection, habits that must be cultivated. To build those habits and have them operate in the professional sphere, in conference with others, at the bedside of patients, the process of consultation must be carefully developed and enacted. That process can be broken down into different, but intimately related, parts: moral evaluation, moral considerations, moral instrumentation, and moral argumentation.

MORAL EVALUATION

Clinical ethics consults are forms of moral evaluation in which ethical problems are identified and solutions explored. Some of these consultations result in ethically grounded recommendations, and others simply provide the opportunity to think through the ethical issues and values at play. But either way, a moral evaluation occurs, and careful evaluation is multifaceted.

Clinical ethics consultations begin as a hallway conversation, a phone call, or an e-mail. A nurse or resident physician, an attending physician or social worker, even a patient or family member, is troubled by some aspect of a situation in the hospital. People wonder whether what is going on is “right” or “good,” and this leads them to reach out. The clinical ethics consultant, then, is confronted by a request for help and that request typically is predicated on there being a problem to avoid or solve. In fact, a frequent question the ethicist will ask early on is, “What do you think the ethical problem is?”

Problems are puzzles to be solved, irritations to be eliminated, or concerns to be met. They are the stimulants for reflective thought, and they set the agenda for that reflection. Every identified problem only admits to a finite set of solutions, and thus, a well-developed problem is half solved. Thus, carefully understanding and investigating the problem itself is an important first step in consultation.

Once a problem (or set of problems) has been identified, consultants begin to explore the range of possible, reasonable solutions. Any ethically challenging situation is precisely a

challenge because goods compete or obligations conflict. In such situations, obviously acceptable solutions are not readily identified because multiple, competing solutions have their supporters and detractors. For a physician to tell a woman that she is at risk of a sexually transmitted disease from a patient who is her philandering husband would meet the good of protecting her. At the same time, it would violate the obligation of confidentiality. Both meeting her good and fulfilling the obligation to him have good reasons that would support going in one direction or the other. Is it clear on its face which should win? If not, then we must investigate both further before making a final, morally based decision. If so, what do you tell the party whose good you denied or obligation you violated were the reasons for doing so?

This last question, then, leads to another aspect of moral evaluation—justification. To say something is wrong or bad versus right or good simply stimulates the next question: what makes it wrong or bad versus right or good? “It just is” is the weakest answer possible, for the claim is one of moral ontology and intuition—that is, the claim is that some things just *are* good or *are* bad. But again, in the face of competing possible solutions to the moral problem, such a response rings hollow. What is required are reasons and justification. In the development of reasonable solutions, an investigation ensues. Strengths and weaknesses are explored. Values and principles are brought to bear. And this provides the support for any of the reasonable solutions being investigated, and justifications are required precisely because competing values and solutions are at play.

Through the investigation, it is hoped that the moral situation and morally acceptable solutions come clear. If so, the clinical ethicist should put forth a recommendation in light of the results of the investigation, which completes the moral evaluation.

MORAL CONSIDERATIONS

You will note that in discussing moral evaluation, nothing was said about what should be investigated and what kinds of data and concepts make for moral justification. So, although the evaluation is a process, what, then, is the content? To look at content comprehensively, I suggest the use of the following acronym: GRACE.

G—Get the Whole Story. As mentioned earlier, clinical ethicists will often ask what the requestor believes is the moral problem, but why take his or her word for it? Furthermore, problems lead to solutions, but what solutions are reasonably available in any given situation? To answer these questions, the clinical ethicist must find out what is going on. Individual lives and communal or cultural experience can be seen as different life stories or narratives. Clinical situations are no different. What is the medical condition of the patient? What is the prognosis, and on what evidence is it based? Who are the stakeholders, decision makers, and affected parties? What are their personal stories? How do their values and beliefs affect the actions and choices in the case? What are the policies and laws that are implicated by the situation?

For example, in the consultation about Mr. Q, the medical facts are that his neurological condition requires long-term nursing care. Furthermore, his grandmother is ill-equipped to provide that care at home. Neither his grandmother nor his father want him to go to a nursing home, in part because they believe that high-end hospital care is safer than the care he would get at a nursing home. All this, and much more, is part of the story that shapes the decisions to be made.

Clinical ethics addresses real-life issues that happen in real time. To understand the ethical issues at play, the concerns to be addressed, and the problems to be solved, the clinical ethicist must investigate the ongoing narratives in the situation, because those narratives give rise to the moral issues, and it is those narratives that will be affected by the process and product of clinical ethics evaluation.

To put it differently, a common claim made by clinical ethicists is this: good ethics begin with good facts.

R—Recognize Obligations. One set of facts (debatable as they may be) is the collection of obligations that each of us carry with us. As mentioned earlier in the chapter, each of us takes on roles and commitments that obligate us. If we have a spouse, we are obligated through marriage to meet certain expectations of that spouse. If we practice a religion, religious maxims and tenets exist that we should fulfill. And if we are professionals, the professions we serve require that we act and practice in particular ways to remain within the bounds of the profession.

All of these, and many more, are obligations that come out in ethics consultations. You can see in Mr. Q's case that his grandmother, as caregiver, is deeply concerned about making decisions that might put her grandchild in harm's way. She feels obligated to fight to provide him the best care available. Physicians, nurses, and other health-care providers all experience the constraint of obligations—whether that be keeping patient conversations confidential or demanding blood transfusions for pediatric patients whose parents refuse but allowing such refusals by adult patients.

The clinical ethicist, then, must attempt to map out the many obligations at play in the situation. To fulfill or violate an obligation takes an understanding of its value in relation to other obligations and ethical considerations. Although they may not be determinative by themselves, these obligations have moral weight in any ethical evaluation.

A—Accept Responsibilities and Avoid Overreaching. One of the challenging things about obligations is that sometimes they compete. A physician, for example, may need to be home after school gets out to pick up his or her children and feed them dinner. That same physician may also get a page at 4:00 PM that requests his or her expertise on a patient matter right away. Determining which to fulfill will be based on a number of factors: Is the physician the only one available to take the call? Can the children remain at school in an after-care program? Is there a spouse? Is he or she available? However it gets worked out, there are responsibilities to be fulfilled, and the physician *must* fulfill them. If the physician decides to pick up the children, she or he must find another physician to cover the call. If the physician decides to stay at work, the children or spouse need to be alerted to the change in familial planning. Accepting these responsibilities, not just merely acknowledging them, is of vital importance.

Furthermore, in determining obligations to be fulfilled, professionals often are confronted by their own personal values—that is, values they have come to hold because of their lives outside their profession, whether from families, religions, or education. As professionals, however, the ethical situations that call forth consultations must be navigated carefully so that the professional does not “overreach.” In practice, there is a concept known as “scope of practice,” in which professionals are expected to do only what is in their training to do. Physicians, *qua* physicians, are not spiritual guides. Nurses, *qua* nurses, are not psychotherapists. Social workers, *qua* social workers, are not police officers. This, too, holds

for ethical considerations. Physicians, qua religious believers, cannot let their belief in the healing power of a deity interfere with providing evidence-based medical care. Nurses, qua spouses, cannot let their concern for a wife's unknown risk of a sexually transmitted disease undermine their obligation to confidentiality of their patient. Social workers, qua citizens, cannot have hospital security hold an adult patient against his or her will simply because the patient has a mental illness.

In a clinical ethics consultation, is it necessary not only to map out the obligations at play but to look at what responsibilities will need to be fulfilled. Who owes what to whom? How will that reckoning take place? And what happens when some responsibilities go unfulfilled?

C—Consider Consequences. Whichever obligations are fulfilled or responsibilities accepted, all choices promote actions that lead to consequences. Even the best of intentions to fulfill necessary obligations can go astray—as the saying goes, the road to hell is paved with good intentions. Consequences matter. In fact, whatever our motivations, they lead us to an attempt to achieve some end, and those ends should be evaluated, not simply accepted.

Admittedly, in ethical deliberation, although some consequences have more evidence and some much less, all consequences under consideration are speculative. Thus, consequential considerations are challenging. Will Mr. Q get an infection in the hospital? Will the nursing home meet its obligations to care for him properly? We must act on probability and pragmatics—that is, what we think will happen and what we believe is most worth our efforts in trying to achieve it given our lack of certainty that it will, in fact, come to pass. The former turns on evidence, the latter on character.

E—Evaluate Character. A final consideration, then, concerns who we are and who we want to be—personally, professionally, and institutionally. As with Mr. Q's situation, risk managers, while primarily managing risk, are often concerned about “how will it look?” This can smack of being unduly self-serving, but all our actions say something about us—as people, as professionals, and institutions. The obligations we fulfill or violate say something about us and about our roles. The consequences that follow our actions affect our future pursuits—validating or undermining our values, beliefs, decisions, and processes. To make choices is to express our values through the choices we make. And the result of actions are ours to own.

Each clinical ethics consultation has the potential to say something about the many parties at play. But even further, the decisions and outcomes say something about the institution in which they occur. The consultant needs to keep this in mind to fashion an outcome that can be owned by the institution (or, more importantly, must be owned by the institution). For this reason, some ethics consultations lead to policy review and development.

MORAL INSTRUMENTATION

Moral considerations are but one aspect of evaluation. With obligations seemingly coming from every direction and consequences of all stripes following from actions, how do we take all these considerations and begin to reason through them? Moral considerations function in a moral evaluation like wood, wallboard, cement, and paint do in building a house. They are the raw material. The material becomes a structure (or becomes structured) using instruments or tools. In home building, those tools are

hammers, power drills, mixers, and brushes. The tools of moral evaluation are principles, maxims, rules, and more.

Elsewhere in this text you will have read about basic biomedical principles, such as respect for autonomy, beneficence, and justice. We might also enumerate principles of utility and fidelity, among others. But even more broadly, we might use principles to guide action, such as “only act so as to promote good and minimize harm to all those affected by the propose action,” or “cultivate habits that moderate among extreme outcomes.” We also follow maxims, such as “treat others as you would want to be treated” or “act in a way that you would be willing for anyone else to act under similar circumstances.” Furthermore, we abide by moral rules, such as “do not harm innocent others,” “tell the truth,” and “be kind.”

Each of these concepts are moral instruments (i.e., ethical norms) that can be applied in situations given the moral considerations under scrutiny. Which ones to bring to bear, however, is probably the most challenging question of all. Clinical ethicists, like their theoretical counterparts, come in all ethical stripes. Every ethicist should do as comprehensive a job as possible rooting through and out the moral considerations in a case, but which tools to use to put those considerations into an evaluation is highly individualized. Some ethicists are primarily worried about meeting certain moral demands or duties; others are moved mostly by consequences; still others find that focusing on moral virtues best moves thought forward. Whichever approach is taken, ultimately, decisions must be made and justification given.

MORAL ARGUMENTATION

Moral evaluation as a process of identifying moral problems and attempting solutions results in taking a moral position. To do so requires comprehensive work on moral considerations honed by moral instrumentation both crafted by and resulting in moral argumentation. An argument is not simply a dispute between people. In fact, some arguments are done so well that at the end of it, there is no dispute at all. What is meant, then, by argument is a logical structure that puts data and evidence (sometimes called *premises*) together to support a claim (or *conclusion*).

Data and evidence can be physical facts or moral beliefs, cultural norms or statistical outcomes, emotional responses, or scientific discoveries. They are fit together with principles of support—whether of the kinds of moral instruments just mentioned or logical tools such as creating valid deductive arguments or identifying argument fallacies. Without the fit, data are bare and meaningless. Principles give data meaning. For example, an argument could be made as follows:

Kareem Abdul-Jabbar scored more points than any other NBA player (38,387).
(This is a premise.)

He won six NBA and three NCAA championships. (This is another premise.)

Therefore, he is the greatest basketball player ever. (This is conclusion.)

This is an argument because it contains both data and evidence for support and a conclusion from that data. Now, you might disagree. Some, in fact, argue that Michael Jordan (1963–) is the greatest basketball player ever. But how can that be? The data given about Kareem Abdul-Jabar (1947–) are true; they are facts that cannot be contested. So, how can we contest the conclusion? Simple, really. We can contest the *meaning* of the given data. Why should we accept that both (or either) 38,000-plus points and total

championships won mean that you are the greatest basketball player? Well, hidden in the argument are a number of unstated premises that are doing a lot of the logical work. This premise is what is making the data meaningful for the purpose of the argument. It might go something like this:

Winning games, championship games, is the whole point of playing competitive sports. (This is an unstated premise.)

Basketball games are only won if points are scored. (This is an unstated premise.)

A player scoring more points puts you in the position to win. (This is an unstated premise.)

Other options for unstated premises would still give useful meaning to the data in relation to the conclusion, but the point is that whatever the unstated premises are, they are doing the work of what has been called a *warrant*—that is, what makes bare data meaningful in an argument.

In an ethics consultation, the data and evidence are gathered through the process of getting the whole story (talking with professionals, families, friends, and the patients—where possible), recognizing the obligations at play, accepting responsibilities that flow from those obligations, considering possible consequences that would follow from proposed actions, and evaluating the character of those people and institutions affected by the decisions to be made. But then, clinical ethicists are challenged with connecting all the data elements up into an argument, and that connection occurs through the use of moral instruments that bring ethical meaning to the data.

It would be impossible to recount in full detail all the elements of a case consultation in anything less than a short book, but the chart note at the start of this section gives an idea of how some of these elements come together (both explicitly and implicitly) irrespective of the method (GRACE, CASES, etc.) used. To understand where cases sometimes end up, the follow-up notes are provided:

Recommendation: The case highlights ethical tensions among doing what is best for the patient, what his decision makers are requesting, and the appropriate stewardship of medical resource. The hospital is obligated to provide the best care possible, but tertiary, acute care hospitals are not the best environment for long-term care patients. The family's concern about nursing homes was motivated, in part, by having very little knowledge of what kinds of nursing homes were available in their area. It is recommended that the family be given the opportunity to visit nursing homes in their area in order to identify a suitable long-term care facility. Furthermore, the family would like better head protection of the patient before leaving the hospital, and it is recommended that an occupational therapy (OT) helmet be ordered and fitted. Finally, the family appreciates the work of the neurosurgeon, and so it is recommended that the neurosurgeon take the time to explain carefully, slowly, and comprehensively the current situation, short-term processes, and long-term prognosis.

Resolution: After three care conferences with the family and different members of the health-care team, the family indicated that they understood that the patient's care was going to take months, maybe even years, and that the hospital was not the best place for the care to occur. They were assured that he would be given more surgery for his head and skull, but only after his brain had recovered enough. The patient was eventually moved to a nursing home within 10 miles of his family.

A BRIEF CODA: SCOPE OF PRACTICE

The preceding consult note shows not only ethical concerns about beneficence, harm, and familial duties, but also about how or whether health-care providers do a good job of conversing with family, hearing their needs or concerns, and speaking their language. In practice, it is certainly not the case that all ethics consultations rely on merely moral evaluations. Clinical ethicists often are called on to triage challenging issues that ultimately are referred to other experts in the institution—risk management, social work, psychiatry, and more. Furthermore, as a practical matter, many consults are the result of poor or erratic communication among important parties in the situation. Health-care providers disagree about what is best for the patient, and this can be an ethical issue. But the conflicts are exacerbated by the team members not talking about these differences among themselves. Families may struggle with what is best for their loved one, and surely this raises some moral concern. But underlying family dynamics that undermine their ability to talk among themselves, rather than differences in values or fundamental moral beliefs, often lead to decision-making struggles.

Clinical ethicists, while not always the best trained or positioned to handle these kinds of communication problems, often are called on to work with the various parties because institutions do not always have other professionals who are available and trained to do so. The question then becomes: should the clinical ethicist take up the role of communication facilitator because otherwise no one will, or should the clinical ethicist take a pass on these kinds of requests so as not to practice outside his or her expertise? There is no single right answer to this question, and different ethicists will take on or push off these responsibilities, depending on their comfort level and the resources otherwise available. What must be weighed are not just professional but moral considerations—or more precisely, the ethics of professional considerations. To take on such consults is to put patient needs first, but it comes with its own risks—namely, practicing beyond one's (typical) training in ethics. Just like the need to avoid overreaching by physicians and nurses, ethicists, too, must identify the limits of their scope of practice. And yet, if no one helps work through conflicts of communication, problems persist and ethical issues arise.

Summary

Gyges was a shepherd in the service of the king of Lydia; there was a great storm, and an earthquake made an opening in the earth at the place where he was feeding his flock. Amazed at the sight, he descended into the opening, where, among other marvels, he beheld a hollow brazen horse, having doors, at which he stooping and looking in saw a dead body of stature, as appeared to him, more than human, and having nothing on but a gold ring; this he took from the finger of the dead and re-ascended. Now the shepherds met together, according to custom, that they might send their monthly report about the flocks to the king; into their assembly he came having the ring on his finger, and as he was sitting among them he chanced to turn the collet of the ring inside his hand, when instantly he became invisible to the rest of the company, and they began to speak of him as if he were no longer present. He was astonished at this, and again touching the ring he turned the collet outwards and reappeared; he made several trials of the ring, and always with the same result—when he turned the collet inwards he became invisible, when outwards he reappeared. Whereupon he contrived to be chosen one of the messengers who were

sent to the court; where as soon as he arrived he seduced the queen, and with her help conspired against the king and slew him, and took the kingdom. (Plato 1892, 359d–360b)

Medicine, like Gyges, begins humbly. People fall ill, as bodies are vulnerable to disease and injury. But medicine is also powerful stuff, and its ultimate power can be unknown even to the one who creates or discovers it. The power can further be corruptive, as particular goals create questionable outcomes. Medicine, as with the Ring of Gyges, may be all too consuming, too tempting to use its abilities in unjust ways. And yet, the Ring could be used for good as well. The cloak of invisibility is a power that can lead to good ends for others, for communities, not just the selfish interests of one. So, too, with medicine, and it is the moral core of medicine that must keep the corrupting power of the Ring at bay. In this world, clinical ethics consultations are an instrument employed to keep medicine just, focused on the service of patients and public health through careful consideration of the moral conditions at play in any given health-care situation brought forth. Consultants are tasked to help resolve the ethical tensions experienced by both health-care providers and patients and families, through the use of ethical consideration to evaluate ethically challenging cases.

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