

Understanding Criticisms of Clinical Ethics and Ethics Consultation¹

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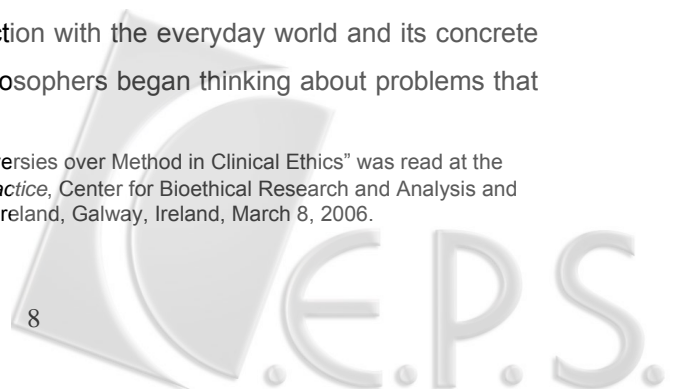
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Controversies over clinical ethics have continued since the earliest days of applied ethics and the beginnings of bioethics and clinical ethics. Beneath the well-known debate between defenders of a principle or theory-based method, and those who would urge a casuistic or narrative approach, lay deep disagreements and uncertainties about the nature of clinical ethics itself, which has often been the field where these disagreements are set. In this paper, I offer a historical sketch of the background for criticisms of clinical ethics showing that the criticisms reflect concerns from the perspective of the critic about what clinical ethics might be rather than a critical assessment of the field itself. Many criticisms of clinical ethics and ethics consultation fail to appreciate the nature of clinical ethics as a practice and, instead, express theoretically based concerns that may not accurately reflect the field.

Beginning in the 1960s, the literature on applied ethics confronted the question of whether ethics can or should be applied. These questions were raised at a time when the dominant view of ethics featured analytical approaches concentrating on descriptive ethics, metaethics, and normative ethics. Except for descriptive ethics, which most philosophers marginalized as a subject of study, metaethics and normative ethics had little or no connection with the everyday world and its concrete ethical problems. In reaction, some philosophers began thinking about problems that

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occurred in the actual world utilizing the term applied ethics as a way to capture their concerns. A full historical account of the development of clinical ethics is beyond the scope of this paper. However, some points can be highlighted to show that its emergence served as a lightning rod for a set of critical concerns embedded in the philosophical and ethical interest in medicine and the life sciences that inchoately emerged in the 1960s and 1970s.

The term bioethics was introduced in English for a discipline envisioned as an environmental rather than a specifically medical ethic by Van Rensselaer Potter in 1971¹. An earlier, but largely unknown paper, "Bio-Ethics: A Review of the Ethical Relationships of Humans to Animals and Plants" by Fritz Jahr was published in 1927.² In this paper, Jahr redefined moral obligations towards human and nonhuman forms of life and he set out the concept of bioethics as an academic discipline in a broad way. Within philosophy, the applied turn engendered a lively debate. By 1976, Stephen Toulmin, in a provocatively entitled article, "How Medicine Saved the Life of Ethics," came to argue that the engagement with medicine had restored a relevance to ethics, which was "lifesaving" for the discipline.³ This view, however, while important for the bioethics and clinical ethics, did not quell concerns about philosophers who ventured in the world of medicine. Two developments outside academics, however, forced what might otherwise have remained an academic set of concerns about the application of ethical theory or normative analysis to concrete problems, and the related question of the expertise or qualifications of those individuals so involved into a public discussion. Three developments promoted the emergence of the social role of the ethics consultant at the bedside: First, public ethics bodies, like the President's Commission for the Study of Problems in the Biomedical and Behavioral Sciences, showed that one can achieve broad consensus on controversial ethical issues. Second, a consensus emerged that most conflicts over withholding or withdrawing life-sustaining treatment are best addressed within hospitals rather than the courts. Third, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) accreditation standards revised in 1992 required that hospitals have an "ethics mechanism" to address ethical questions and problems arising within the health care organization.⁴ These developments provided a framework of incentives that spurred the development of ethics committees and ethics consultation.

This development was not without its skeptics and critics. Whereas the earlier criticism of applied ethics and philosophy primarily involved academic concerns, the emergence of ethics into the public space engendered a political criticism. The locus classicus of this critique is Cheryl Noble's broadside against ethics experts, whom, she alleged, claim to have ethical expertise. She argued that deferral to the judgment of these so-called ethics experts, especially in the public sphere, is inconsistent with the values of a democratic society; furthermore, the existence of such putative experts threaten democratic processes and undermine liberal principles. Similar and parallel claims have been made with respect to the involvement of ethics consultants and ethics committees in the resolution of conflicts in medicine. Thus, the criticisms of clinical ethics consultants and ethics committees should be seen against a larger debate over expertise in ethics and the debate over the legitimacy of ethics experts in society.

A number of specific complaints have been leveled against clinical ethics and/or the "experts" that this field cultivates. These criticisms can be summarized in the following points:

First, the functions performed by the clinical ethicists are unnecessary.

Second, even if needed, the tasks could be better performed by others.

Third, the problems addressed are typically not ethical, but rather communication or psychosocial problems associated with facing and making hard decisions.

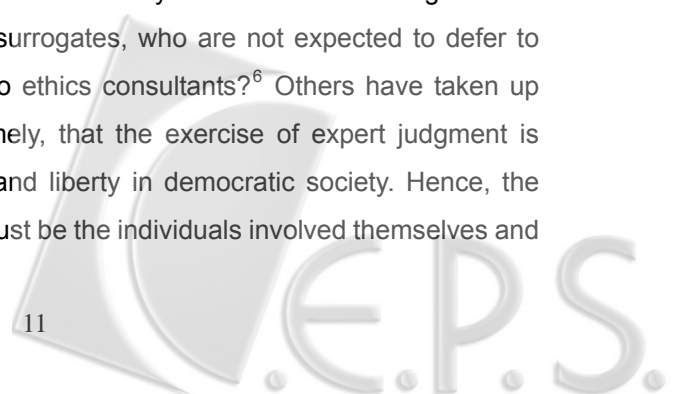
Fourth, clinical ethics consultants, who are "strangers at the bedside,"⁵ override the rights and/or judgment of autonomous patients, their surrogates, and health care professionals.

The underlying worry is that the clinical ethicists and ethics consultants encourage a deferral of judgment and an objectionable abrogation of responsibility for making important decisions by patients, families, and health professionals. At the worst, clinical ethicists usurp the rightful authority of patients and health care professionals. The implicit belief seems to be that, if there are genuine and irresolvable conflicts or disagreements in patient care, then the law is the best place for their resolution, because only the law can provide the legitimate normative guidance that is

needed. Thus, in ethical issues arising in patient care, law is given—without argument, I might add—the authoritative voice on this view. This belief seems to persist despite the fact that the law in the United States has, for decades, sought to return conflicts over medical decision making back to their original clinical settings, and social policy seems to strongly support the use of ethics committees and consultants to resolve these matters. Rather than preferring that these difficulties be resolved in courts of law, which are not equipped to deal with emergent issues, the consensus in the United States is that ethical problems are best resolved as close as possible to the “bedside.”

The question is, “Why have these controversies and concerns about ethics consultation persisted?” First, many commentators seem to implicitly view the ethical questions and conflicts that arise in patient care as matters primarily, if not exclusively, of decision making. The paradigm situation is that the doctor or health professionals want a procedure done, or do not want to provide a procedure, whereas the patient and/or patient's family take the opposite view. On this interpretation of the nature of ethical questions and problems in patient care, clinical ethics consultation is understood to involve the rendering of expert judgment on disputes much like a judge (or jury) renders an authoritative decision to decide a case for or against the parties involved in litigation.

It is remarkable that many commentators and critics from different perspectives and disciplines share this rather simplistic view of ethics consultation. For example, some philosophers have claimed that because true “expertise” is impossible in ethics generally, since ethics is not a science open to conclusions based on evidence, then clinical ethics, in principle, cannot render anything approximating an “expert” judgment. Hence, any resolution of ethics problems or conflicts in patient care must involve an imposition of an authoritative decision making by a person or committee who is vested with unjustified power. This is seen as particularly problematic given the prominence of patient autonomy in medical ethics. In light of this principle, why should patients or their surrogates, who are not expected to defer to physicians, should nonetheless defer to ethics consultants?⁶ Others have taken up the line first articulated by Noble, namely, that the exercise of expert judgment is inconsistent with individual autonomy and liberty in democratic society. Hence, the fundamental arbiter in ethical matters must be the individuals involved themselves and



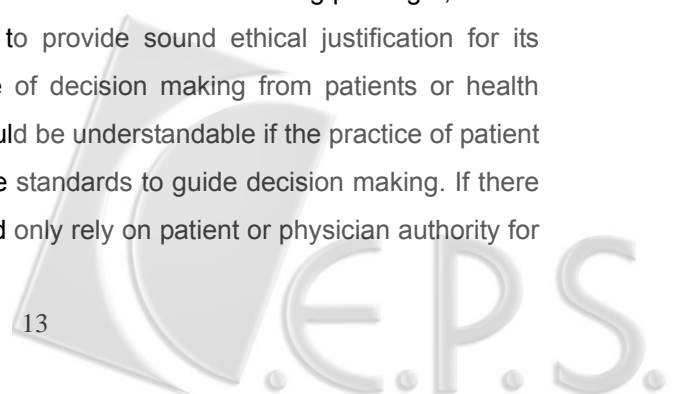
not some philosopher wearing a white coat, or a health professional masquerading as someone qualified in ethics to render definitive judgments. When patients and their surrogates are in conflict with their health care providers about important medical decisions, then courts of law are the most neutral location for settling these disputes. But is this view of clinical ethics accurate?

The notion that clinical ethics renders a definitive and authoritative ethical judgment not only elevates the clinical ethicist to a position of privilege, a view which, however, is not corroborated by the empirical research on ethics consultation, but also presupposes that the paradigm ethical issues in health care involve conflicts over medical decision making. In fact, a careful review of the literature on clinical ethics and ethics consultation will show that ethics consultants actually make modest rather than grandiose claims regarding ethical authority. It is widely accepted that the process of ethics consultation is primarily a process of facilitation, one that uses ethical analysis, argument, and communication to identify options, recommend courses of action in ways that utilize a range of techniques such as conflict resolution or mediation, but infrequently engages in proffering binding recommendations or decisions.⁷ There is, therefore, a striking discordance between the critics of clinical ethics and ethics consultation and the circumscribed statements about ethics consultation and clinical ethics. The presupposed paradigm of conflicts between patients and their surrogates on the one hand, and healthcare professionals and/or healthcare organizations on the other, vastly oversimplifies the complexity of clinical ethics. This view overlooks the ethical questions, quandaries, concerns, and problems that arise when healthcare professionals, operating from different and sometimes divergent individual ethical and professional ethical perspectives, confront confusions about their responsibilities and how to best meet them in complex patient care situations. It also oversimplifies the conflict as one between patients and their families on the one hand, and health professionals on the other, when not only are there disagreements and confusions on the side of health professionals, but families and patients, too, can struggle with conflicting expectations and beliefs about what is appropriate in particular clinical situations. Thus, the ethical questions and difficulties that make up the field of clinical ethics involve much more than straightforward conflicts of decision making. More frequently, the complex emotional relationships among family members and the patient as well as the uncertainties and anxieties that arise when patients and family

members must deal with serious or critical health issues engender ethical questions and concerns as well as conflicts. Why these complex value questions are addressed within health care are addressed by ethics consultation rather than other existing mechanisms and services, such as pastoral care, social work, or ombudsman services, has not been sufficiently examined, but it is a fact that this has occurred.

Thus, while critics may bemoan this development, their criticism misses its mark if it assumes that ethics consultation is simply or primarily a matter of decision-making that has thrust itself into health care with the audacity to presume ethical expertise in making decisions rather than having emerged in response to a rather diffuse set of unmet needs. Such critics need to confront the reality that so much of the empirical literature, including formal studies and reports of ethics consultation, note that ethics consultation is dominated by the task of dealing with communication confusions and occlusions. Addressing these concerns, more than resolving the standard ethical issues as defined in bioethics textbooks, makes up the bulk of ethics consultation. This is an important point that critics overlook. Aside from the fact that there is ignorance or misunderstanding of ethics consultation by some of its critics, we need to ask the question, "What promotes this misunderstanding of the field?"

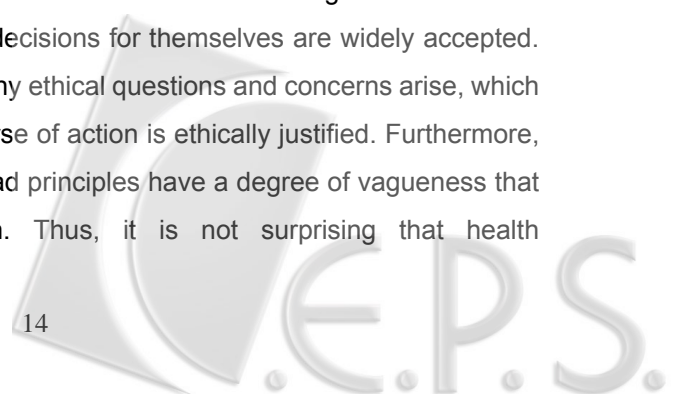
One reasonable hypothesis is that critics of clinical ethics or ethics consultation conceive ethics consultation primarily in terms of an idealized paradigm of ethical decision making. This model is based more on theoretical concerns than on a sound understanding of ethics consultation as a practical field, which involve a wide range of communicative, deliberative, and interpretive interactions designed primarily to facilitate the resolution of an equally wide range of ethical problems within patient care. On this hypothesis, clarification in ethical and practical problem solving is more characteristic of ethics consultation than is a process of using formal methods for reaching normatively strong decisions.⁸ Under the decision making paradigm, clinical ethics is criticized for not being able to provide sound ethical justification for its recommendations, or for usurping role of decision making from patients or health professionals. Some of the criticism would be understandable if the practice of patient care lacked broadly accepted normative standards to guide decision making. If there were no such standards, then one could only rely on patient or physician authority for



making decisions. But if such standards exist and health care is structured by their ethical norms—and I assume without arguing the point here—then ethics consultants or committees who provide services to elucidate and apply these standards would not imply their usurping the authority of patients or health professionals that critics allege.

To be sure, some standards deriving from law and professional guidelines, and expressed often in health care organization ethics policies, are clear, but others are open to interpretation and dispute not only theoretically, but also as they are applied in complex or difficult circumstances. Involving persons skilled at negotiating the communication conflicts and occlusions, as well as in interpreting and applying ethical standards in complex situations, is legitimate so long as these individuals operate within appropriate boundaries. Given that there is broad consensus about the general ethical principles of ethical health care, ethics consultation is wrongly characterized as a process in which ethics consultants make and impose decisions on patients, families, or health professionals. Instead, the process of ethics consultation is better understood as an activity primarily concerned with clarifying confusions and developing consensus about how to proceed in light of practical problems that obstruct the achievement of the accepted norms. If critics argued that the boundaries for ethics consultants are not well defined or publicly available, then there would be no dispute. Unfortunately, critics confuse their concerns about potential abuse, which are legitimate, with actual abuse for which there is no evidence.

Of course, this point does not address the skepticism about the existence of accepted that may underlie some of the criticism of ethics consultation. Such skepticism, however, seems to be more a theoretical concern about the adequacy of the justification of norms than a practical concern about the existence of norms as socially accepted. It seems undeniable that fundamental patient rights such as informed consent, refusal of life-sustaining treatment, confidentiality, privacy, and the acceptance of patient decision-making and the reliance on surrogates or advance directives when patients cannot make decisions for themselves are widely accepted. Within this framework, nonetheless, many ethical questions and concerns arise, which contribute to confusion about what course of action is ethically justified. Furthermore, policies for applying what are often broad principles have a degree of vagueness that requires interpretation and reflection. Thus, it is not surprising that health

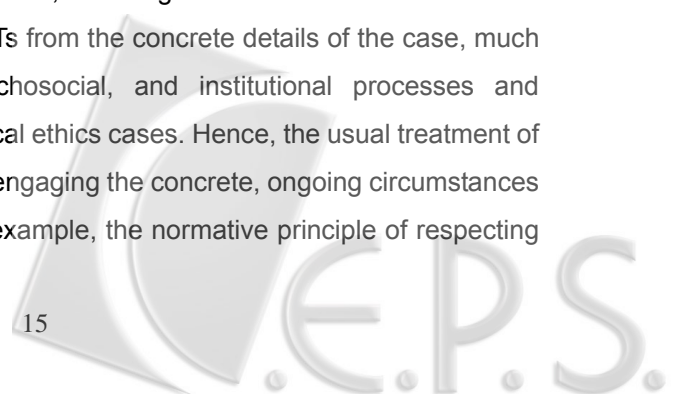


professionals as well as patients and families have found ethics consultation services useful, and have increasingly relied upon them to help clarify their understanding of the ethical dimensions of their decision making and provide moral reassurance and support. In this regard, ethics consultation has successfully created a space within which ethics can be safely addressed within the institution.⁹

Despite the prominence of worries about the abuse of authority or power of the clinical ethicists, the concerns are often overstated. The fact is that many statements of ethics consultation offer a weak view of the authority of the ethics consultant; for example, the Core Competencies for Healthcare Ethics Consultation of the American Society for Bioethics and Humanities views ethics consultation as a process of facilitation.¹⁰

Many of the criticisms surrounding clinical ethics are premised on a deep confusion about clinical ethics that underlies these concerns, a confusion based on a misunderstanding of the clinical or practical nature of the ethics consultation. In a paper entitled, "The Question of Method in Clinical Ethics,"¹¹ I undertook the task of staking out the conceptual terrain of what the question of methodology involves, namely, the various elements and features that conceptually make up method. I concentrated on the notion of a rule defined in a rather Wittgensteinian fashion. Rules clearly have normative force. The rules involved in ethics consultation, however, also have the important and peculiar feature that they function, as Wittgenstein points out in his concept of a language game, in defining a practice. The rules of a practice exist in their use rather than as stated in a grammar, and they have to be understood in terms of their use. This means that the rules are embedded in or are part of the very actions making up the practice.

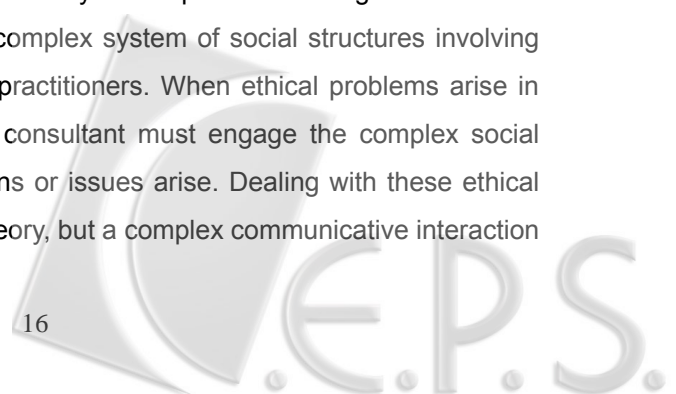
In contrast to the normative function of rules in a practice, the normative function of ethical principles and theories, which gets the most attention in the bioethics literature, typically ABSTRACTs from the concrete details of the case, much less the actual communication, psychosocial, and institutional processes and circumstances that make up actual clinical ethics cases. Hence, the usual treatment of the rules is done ABSTRACTly without engaging the concrete, ongoing circumstances or the actual reality of the case.¹² For example, the normative principle of respecting



patient rights, or the legal surrogate's right of decision making, is frequently next to useless in actual cases, because the question is not what principle the physician should follow, but how, namely, what actions should the physician engage in to comply with the principle in this case. The case and fact circumstances require the ethics consultant to engage in a process of inquiry and communication that itself involves rules, which when followed (or not) characterize a good practice of consultation. These process rules, which I call rules of enactment, are far more important for clinical ethics as a practical discipline than the usually understood normative ethical principles. Saying this is not to deny the relevance of ethical theory, concepts, and principles, but to make the claim that these usually require interpretation and application in ethics consultation cases. To the extent that there is settled agreement about the high-level ethical principles, what is required is less knowledge of these matters, than the ability to reason about them and to apply them in the clinical circumstances.

Beyond these considerations, however, there are other rules for ethics consultation that are important. This can be illustrated by reflecting on the process of learning to work with wood. The master woodworker can point out that the book or manual says to use one tool rather than another in cutting and shaping the wood, but to the apprentice or learner, knowing which tool to use does not yet specify how to use the tool. Further specification in a manual about how firmly the tool is held cannot, of course, provide a direct guide to the amount of pressure or tension in the novice's hands and shoulders as one works the wood. That "rule" is learned as one acquires the skill and it is experience-based. The rule, as it were, is one with the experience, and its achievement makes up the skill or the competence that differentiates the accomplished craftsman from the novice.

Clearly, in a communicative field laced with significant intellectual and cognitive content, the rules involved in ethics consultation as practical enactments will be complex. The care of patients, particularly in hospitalized settings where most ethics consultation occurs, is a highly complex system of social structures involving cooperating hierarchies of specialized practitioners. When ethical problems arise in the course of patient care, the ethics consultant must engage the complex social setting within which the ethical questions or issues arise. Dealing with these ethical questions or issues is not a matter of theory, but a complex communicative interaction



with all of the individuals involved in the issue. The skills that need clarification and the rules that need analysis with respect to ethics consultation turn out to be fundamentally different from what critics of ethics consultation usually have in mind.

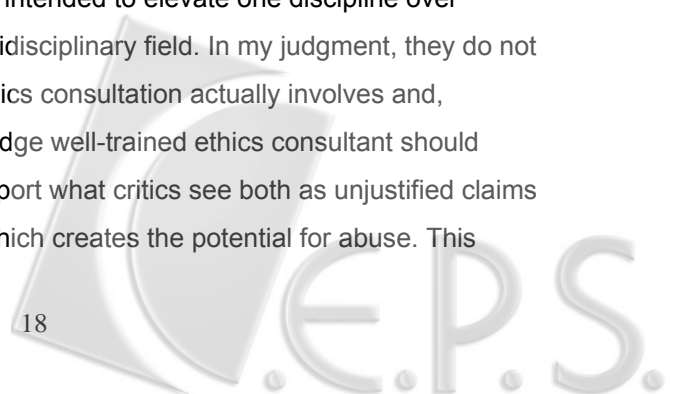
The critics assume that ethics consultation involves authoritative decision making, but they operate within an inflexible notion of authority that associates it more with power than guidance.¹³ Thus, to understand why a cutting tool that was improperly sharpened, a teacher could tell the novice that it is so pointing to normative standards, but that would be less than helpful. Instead, a good teacher would demonstrate the right "feel" that is achieved with a finely honed tool by comparing the cutting of both tools on various types of wood. In that way, the novice would learn the lesson of the necessity and practical utility of having a properly sharpened tool.

What implications does this line of argument have for the controversies over clinical ethics and ethics consultation? If clinical ethics is a dynamic practical pursuit, then the question of method in clinical ethics is less about decision making using normative concepts or principles authoritatively imposed on patient care, but rather a more complex set of activities. Thus, understanding the nature of ethics consultation is a prerequisite for addressing the controversies surrounding this field of activity and for assessing the adequacy of the various criticisms that have been leveled against clinical ethics.

Note

1. Potter, Van Rensellar, *Bioethics: Bridge to the Future*. New York: Prentice-Hall, 1971.
2. Sass Hans-Martin. "Fritz Jahr's 1927 concept of bioethics." *Kennedy Inst Ethics J* 2007; 17(4):279-295.
3. Toulmin, Stephen E. "How Medicine Saved The Life of Ethics." *Perspectives in Biology and Medicine* 25, no. 4 (1982): 736–749.
4. Kuczewski, Mark G., "Ethics Committees and Case Consultation: Theory and Practice." G. Khushf, ed. *Handbook of Bioethics*. Dordrecht: Kluwer Academic Publishers, Inc., 2004, pp. 315-334.

5. Rothman, David J., *Strangers at the bedside: a history of how law and bioethics transformed medical decision making*, New York, Basic Books, 1991
6. I have argued that this is the wrong way to frame the question, because it begs the question by presupposing that the involvement of the ethics consultant potentially overrides patient autonomy. See, Agich, George J. "Why Should Anyone Listen to Ethics Consultants?" In H. Tristram Engelhardt, Jr., ed. *The Philosophy of Medicine*. Dordrecht, Holland and Boston: Kluwer Academic Publishers, 2000, pp. 117-137.
7. American Society for Bioethics and Humanities. *Core competencies for healthcare ethics consultation*. Report of the American Society for Bioethics and Humanities 1998;1-48.
8. A paper by Stella Reiter-Theil ["Dealing with the Normative Dimension in Clinical Ethics Consultation." *Cambridge Quarterly of Healthcare Ethics* 2009, in press] is helpful in understanding this point. She argues that the normative element in ethics consultation has been misunderstood. She offers view of normativity as a pervasive dimension of ethics consultation and shows how the normative element in ethics consultation is actually quite complex. Rather than entering "all at once," she shows that the normative element functions in a graded fashion according to a hierarchical typology and argues that escalation up the scale of normative of the towards the authoritative imposition of outcome is actually quite rare.
9. Walker, Margaret Urban, "Keeping Moral Space Open: New Images of Ethics Consulting." *Hastings Center Report* 1993;23(2):33-40.
10. American Society for Bioethics and Humanities. *Core competencies for healthcare ethics consultation*. The Report of the American Society for Bioethics and Humanities 1998;1-48. Paradoxically, this characterization has itself come under criticism by those who insist that a stronger decision-making or advice-giving model of ethics consultation better captures the exercise of ethical expertise that the well-trained—read in here your favorite discipline—consultant brings. Ironically, such claims seem intended to elevate one discipline over another in what is essentially a multidisciplinary field. In my judgment, they do not offer much evidence about what ethics consultation actually involves and, correlatively, what skills and knowledge well-trained ethics consultant should possess. Instead, they seem to support what critics see both as unjustified claims to professional power and status, which creates the potential for abuse. This



paradoxical situation is a bit beyond the scope for my exploration in this paper, even if it is not beyond explanation. I leave it to sociologists and social psychologists to attempt to explain what drives the continued promotion of professional status by some individuals and disciplines. The relevant point for this paper is that the controversy does raise an important question about the underlying assumptions about the nature of clinical ethics and the activities that legitimately comprise ethics consultation.

11. Agich George J. The question of method in ethics consultation. *American Journal of Bioethics* 2001;1(4):31-41.
12. Some thinkers have advocated casuistry as a remedy to this approach that is often associated with a theoretical or principle oriented approach. Surprising to some, casuistry, at least in its most common forms, does not usually address the ongoing or concrete circumstances of a case. It takes the case as presented or given considers the case over and against other paradigm cases and renders a judgment regarding the ethical probity or appropriateness of a course of action based on the consideration of this case, against others. The case, as I have argued elsewhere, is treated primarily as a given and the casuist is typically not an agent involved practically in the case as such, but rather functions as an adviser or coach outside the field of action or play. To use developed the sports metaphor, one could say that the function that I am trying to describe would be satisfied by one who not only in gauges in the game on the field, but does so as a coach, and, at the same time, is a commentator and analyst addressing the play-by-play and action as it proceeds. This analogy helps us to realize the difficult and complex nature of the phenomena that I am describing.
13. Agich George J."Authority in ethics consultation." *J Law Med Ethics* 1995;23(3):273-283; Casarett DJ, Daskal F, Lantos J. The authority of the clinical ethicist. *Hastings Cent Rep* 1998;28(6):6-11.

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