A Brief Reflection on the Experience of Responsibility in Ethics Consultation

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Introduction

Bioethics is well endowed with numerous divisions—policy and practice, academic and clinical, humanities and legal and medical—most of which reflect, in one way or another, core questions of disciplinary expertise and authority. In the field of clinical ethics, such divisions often serve as the underlying source for periodic eruptions in the literature. For instance, there are the debates about whether an "ethicist" is a sort of 'expert' with special knowledge in which it is this knowledge that is to provide the basis for making "moral judgments" about what is right or wrong [7; 15; 17; 19; 21; 26]. Likewise, there are the on-going questions about the proper aim of ethics consultation itself [1; 2; 3; 8; 11; 12; 16], in which debate revolves around whether it is primarily, if not only, to ensure appropriate intellectual structuring of the variety of moral positions and principles that might be pertinent to any specific case or, as Meyers notes, "it is also about understanding how those abstractions reside within a social framework, how psychology and institutional politics motivate ethical conflicts, and how effective communication and mediation are critical to finding resolution to such conflicts" [10: 64]. In view of both the breadth of these debates and the underlying sets of commitments and agendas therein, no one should be surprised when confronted with the accompanying wide spectrum of positions regarding the conduct and content of clinical ethics consultation in the United States and Europe and across the globe.

Among the global spectrum of positions, however, the practical assumption

appears to be that, as a social practice within the same social world as medicine, clinical ethics provides a means to examine, articulate, and respond to those possible meanings most prominently evoked within specific clinical circumstances [4: 27-28; 9: 20; 18: 126-127]. This practice, moreover, involves identifying the problems perceived by those individuals confronted with a clinical decision, and often entails gathering the viewpoints of many different participants included in that decision [23]. The need to gather and consider the viewpoints of different participants can readily be appreciated when one takes into consideration that clinical medicine is hardly ever merely a matter of one physician treating one patient. In fact, clinical practice includes other health professionals (nurses, consultants, social workers, and others); it also is done within certain types of social institutions (hospitals, clinics, partnerships, and the like), which present their own sort of moral complexity and variety. Beyond these, clinical medicine is nowadays conducted within a highly complex network of rules, governmental regulations, professional standards, and the like which, again, present special issues for that practice and its moral assessment [22: 19-20].

The idea, then, is that moral life in clinical practices is not some sort of philosophical dimension beyond or separate from those interactions shared by various participants. To the contrary, moral and normative elements are enmeshed in clinical practices, with the result that "clinical ethics" does not refer to some detachable set of theoretical attitudes or understanding within it. What this means is that recognizing and articulating ethical issues in clinical situations is complex, due in part to the many conceptual and practical commitments embedded in the languages, attitudes, and conventions specific to clinical situations and medical institutions. Ethicists need to be equipped with what Walker calls "a broad cultural and philosophical understanding of morality as living social medium" [20: 137], because the prevalent moral norms in clinical practices, as well as the multiple layers and kinds of relationships between diverse individuals with diverse backgrounds, can and do prompt legitimate concerns about ethics in clinical situations. Moreover, understanding clinical encounters means understanding the concerns of patients and their families, not only the concerns of physicians and other care providers [13].

In view of that complexity, there persists a serious practical concern, one that has received little direct and explicit attention within the field of clinical ethics. This concern arises from the fact that quite often, as part of the process of an ethics consultation, the dominant and "ready-made" meanings prevalent in clinical work must be identified and examined as well as must there be effort to identify and talk about what is morally at stake in, and possibly neglected by, those dominant beliefs—all in order to discover what may be ethically relevant for just those individuals involved in the specific clinical circumstance [24]. Again, Meyers notes that such work can "obviously be a fine balancing act," requiring an ethics consultant to be sufficiently aware of the dominant and normative meanings in clinical settings while not being subject solely to those meanings, and that this balancing is "clearly manageable for the

conscientious person" [10: 80]. Of course, that balancing act raises a persistent issue for those who engage in ethics consultation: how can we discern if we are of help, and who is it we are "helping," since to continue acting in a particular situation is to preserve the presumption that we *are* of help. Can we, in other words, discern whether we are of help while in the middle of a situation? How this concern is addressed, moreover, reflects deep-seated commitments regarding the meaning of responsibility in clinical ethics practice.

§1. Wherein does "help" reside?

In clinical ethics practice, in order for an ethics consultant to actually help others become more aware of their own moral views, that consultant needs to pay close attention to the actual, clinical circumstances of the situation, how what is perceived as a "problem" has come about, and how the specific circumstances are understood by those individuals whose situation it is.[23] Otherwise, precisely those factors of the clinical situation which both create problems and suggest possible resolutions could be missed.

For example, consider the following statement: "By helping to identify what needs specific notice and attention within the gradually unfolding moral perspectives of the primary decision-makers in a particular situation, ethics consultants attempt to pick out key options, and points of decision, and subsequently attempt to help others to envision the options and outcomes in the light of those others' own concerns and values." Questions immediately arise regarding the ways clinical practitioners might consider, even evaluate, that claim. Does "helping to identify what needs specific notice and attention" make any sense in those actual clinical conversations in which clinicians find themselves? Perhaps. Or, is it more likely that these statements point to other commitments, like those moments when clinicians, by quietly listening, try to figure out a way to continue the conversation with someone facing a difficult situation or choice? Possibly.

By asking things this way, it may seem that typical understandings concerning what can be generally said about ethics consultation is being implicitly endorsed. However, the actual sense of meaning is rather being directed to everyday occurrences, because it is under the general influence of precisely these kinds of question that clinical ethicists conduct conversations. Ethicists work to discover what is most worthwhile, including personal values, religious values, symbolic values, and emotional values. In that way, ethics consultants attempt to enable the other participants *to find* out, first, what their deepest values are; and second, whether these values can be sustained in the aftermath of decisions [25]. Especially for a family and their intimate advisors, as well as for the physicians, nurses, and others participating in a clinical situation, the focus of these conversations is aimed at the patient's possible futures that are directly affected by each of their actions [22: 56].

There is also this: regardless of how sincerely an ethics consultant may wish to "help" someone, it's not only that he or she may, in that very act, 'cause harm', but even more

the point is that in the middle of those activities involved— when actually talking, listening, questioning, responding, and so on—an ethics consultant is likely as not to be *unable* to tell whether he or she is "helping" or "harming", and furthermore, may never be able to determine the actual extent to which one has done the one or the other.

Clearly, these matters are keenly complicated, multi-faceted, and resistant to simple solutions. For example, simply complying with a person's wish, for instance, their explicit desire to have a ventilator removed, no matter how earnestly expressed, does not necessarily guarantee that in performing the action for which they wish, we will then be 'helping', since we must acknowledge that this person may not know 'what's good for him'.

Equally to the point, perhaps, is that even in the real time, so to speak, of engaging in the conversations and interactions which typically characterize ethics consultation, just how will those leading ethics consultation tell whether *what* they are identifying in others' statements about ethics, meaning, religion, values, and so on, is merely a momentary adherence, or perhaps a kind of posing, putting a "good face" forward, or to the contrary, expressive of deeply held, enduring and unquestionable values and projects, and thus, necessary to understand in order to establish what might be beneficial or harmful to all those other persons involved in the ethics consultation? Moreover, does it matter, actually, just where an ethics consultant's own appraisals come to rest along that range or spectrum of possible responses? And, *if* it *does* matter, in what ways—and by what methods—could or should ethics consultants identify and ascertain the evidence to support claims to benefit or harm?

§2. The import of "clinical" in "clinical ethics"

There are many reasons why the above problematics matters, particularly the general sense of that commitment to discover what is at stake for all involved in ethics consultation—including the "consultant." This sense of commitment informs important features of ethical significance when engaged in the activities of ethics consultation.

Furthermore, from that basis of working to discover the ethical significance of each situation for its own sake, if an ethics consultant participates in clinical deliberations and actions, it seems likewise clear that those activities continually provide occasions for reflection on the ethics consultant's own reasoning and actions. The combined questions of whether, how, and when the ethics consultant engages in such reflection thus create one of the central ethical issues confronting that consultant – "ethical" since to decide and then engage in reflection typically assumes that such reflection is beneficial.

If ethics consultation is to remain faithful to those moral features found in the complex layering of contexts, values, decisions, and persons found in each clinical encounter—by which the role of ethics consultation purports to be both directed and concerned—then the ethics consultant must explicitly explore what is implicit in those acid contingencies of time and circumstance that etch the reality of illness, grief, and mourning

upon the experiences of almost all involved with clinical life. That is, not only must the ethicist reflectively participate in the actual circumstances, but where necessary for clarity and understanding, she or he should initiate discussion of the clinical questions and uncertainties at hand.

Thus, one implication here is that, in these clinical situations, it is not only what physicians experience, what nurses go through, or even the legitimate focus on what patients and their families experience. What becomes equally fascinating and significant are the experiences the ethics consultant goes through. It would seem peculiar, if during a process of consultation an ethics consultant would encounter such significant and sensitive matters—such as what makes life worthwhile—and not undergo some real, actual contact with those crucial, human questions at the same time.

In that context, it may be helpful to consider that throughout his writings on clinical ethics, Richard Zaner's stance is that to be concerned about ethics in clinical situations means to recognize the unavoidable necessity of undergoing the disquiet and hardship of self-reflection and deliberation about what one believes is most precious, most hoped for, and most worthwhile in life. To come into clinical circumstances as an ethics consultant, he says, "is not only to be a reminder of that need for deliberation about deeply serious issues, but it is also to serve as an affirmation of that need and the significance of those issues and the profound feelings they evoke" [25: 147].

Quite often an ethics consultant becomes involved with a conversational exploration of matters that frequently prove "very difficult to get to and discuss, much less to figure out what course of action seems most congruent with their respective beliefs" [25: 148]. The real need is to find ways to talk about "this core of what is held to be most worthwhile as fully and fairly as circumstances permit" [25: 26-27]. On the part of the ethics consultant there thus needs to be a "concerted, focused effort to hear and, perhaps, even help" give to these other individuals "their needed moral voice and [the] courage to hear themselves in their own telling, as they are encouraged to probe ever more deeply into their own lives and circumstances and, ultimately, to take responsibility for what must be done and lived with" [24: 272].

Here the ethicist also encounters tensions that relate directly to ethical concerns about respect and harm. An ethicist is confronted with these considerations about respect and harm especially in regard to those persons he is trying to help. It is precisely in this context that core questions about responsibility occur for the individual ethicist him- or herself, as well as in his or her relationship with those others. Returning to Meyer's idea about "balancing," the whole thrust of such observations it to make clear this crucial implication: being responsible pertains to how the particular individual serving as "ethics consultant" understands not only roles and prevalent expectations, but his or her reflective self-understanding *while actually consulting* (that is, what the consultant really does and says while talking, listening,

questioning, and responding—as well as where, when, why, with whom, for what reason, and so on). The point here is that frequently within institutions there are persistent confusions about the *role of ethics consultation* within an institution and the general *expectations for the actual ethics consultant* who might fulfill that role in particular circumstances.

§3. Institutional roles, individual activities

In order to help others faced with both the limits of their present circumstances and with the necessity of making at times agonizing decisions implicated in those actual circumstances, it seems evident that the ethics consultant should be an actual, if only partial and temporary, participant in that situation. In that role as ethics consultant, therefore, ethics consultants experience the complexities of clinical situations and learn by interacting with them—especially by sensitive listening and alert observations. Such learning, moreover, is fostered by the efforts of trying to identify and possibly revise certain presumptions and activities, all the while reflectively considering whether or not, and how, the situations change in those interactions. But what of ethics consultation within an institution? Does that *explanation* of what ethics consultants do legitimate the institutional role? Much of what has been suggested so far hinges on the distinction that must be made here between *role* responsibilities and *being responsible* in the activity of ethics consultation.

First, as a responsible participant, even if only a partial and temporary participant in the actual clinical situation, the ethics consultant must be able to account for his or her own substantive commitments as one component for being responsive to concerns that arise in that actual clinical situation. Responsibility, then, in the practice of clinical ethics consultation, is always generated in that moral scope of the consultant's activities. However, when administrative bodies establish goals for an ethics consultation service, independent of what the consultant thinks of those goals, the consultant, by adopting the *role of ethics consultant* within the institution, nevertheless acquires a different sort of *accountability* regarding those goals. As a result, confusions can readily occur in the overlap of meaning in the characterizations of ethics consultation: at times the term, "ethics consultation," refers to the *role* of ethics consultation (both regarding its *line of authority* and its *function* within an institution), while at other times, "ethics consultation" refers to *the activities* actually pursued while acting under the aegis of that *institutional role*.

This kind of overlap and dual meaning can, and frequently does, create persistent sorts of confusions and tensions between the *role of ethics consultation* for the institution and the *role of the consultant* as an proponent of the associated institutional goals. Of course, precisely here a key normative issue arises, because the expectations held by the consultant about the moral scope of his or her activities may indeed be much different from those general expectations directed toward the consultant by those with whom she or he interacts.

In light of this kind of distinction, another relevant issue is revealed: if the propriety of the present standards for clinical routines and forms of practice—including now ethics consultation—is asserted without examining the beliefs, attitudes, choices, preferences, and tastes that purportedly ground such standards, then ethics consultation risks becoming another way to manage the detrimental symptoms of these ready-made meanings. Furthermore, in that context the liability related to concerns about authority—or even expertise—is not so much that ethics consultants consciously impose their values on patients, but that their normative judgments made in the role of "ethics consultant" may well become so taken for granted that these likewise become taken merely as ready-made rules to follow in an institutionally standardized role for ethics consultation.

For example, pursuing and engaging in clinical conversations of the sort entailed here, as a disciplined practice, raises a point of ethical significance: to pursue and engage in such conversations, one must adopt a perspective that values the experience of the others and sees the need to give an account of the others' experience in decision making. Beliefs regarding human uniqueness, quality of life, respect for persons, privacy, and the moral fabric of society can all come into play. And, for most of people it is not easy to look into their own basic sense of "worth" that has become challenged by the potential outcomes of illness, injury, disability and dying. Clinical inquiry into these matters illustrates the sensitive character of ethical investigation into suppressed meanings — whether these are denied or consciously hidden — into sublimated limitations to communication, and even failures in understanding. What can result raises a key point of ethical significance: such inquiry—the activity of attempting to uncover and identify the assumptions and values expressed in the situation—*may not* be valued by the others.

The complex, clinical form of this question is as follows: Is it more harmful or beneficial to identify and articulate crucial factors inherent to the core meanings and values voiced by a particular individual, crucial factors that the ethics consultant can see have remained unspoken, and possibly unacknowledged, and perhaps unimagined [5]? What if those others—as is the tendency of many—would rather not examine themselves in that focus of tormented choices, the despairing commitments and the furtive allegiances in their very own lives now generated in their very own lives by the conspiracy of circumstances?

§4. The experience of being responsible

As a result of these kinds of questions, an ethics consultant must be quite skilled in making judgments about both the timing and the content of the questions he or she pursues, so as to account for clinical tendencies, prejudices, and power relations already present in the situation—including those brought about by the ethics consultant's involvement, which may include that consultant's own pre-judgments. At the layer of institutional expectations and discussions, raising questions about the cultural, social, economic, political, and moral

assumptions that underlie the clinical relationships in the institution is one primary means of uncovering such biases. But this presents additional complications, because in raising such questions about these relationships—relationships that perhaps contribute to the specific problem that prompts a request for ethics consultation in the first place—the ethics consultant may appear naive in the taken for granted ways and routines of the institution.

The significance of this point is that the ethics consultant, as the person "who has to place in question nearly everything that seems to be unquestionable to the members of the approached group," is likely to be considered a stranger [6; 14: 96], which might raise doubts about loyalty and whether such an individual can be trusted with what are considered important and delicate interests embedded in both the political and clinical economies of an institution. And yet, precisely by not taking for granted such assumptions and interests, the ethics consultant may find and describe different features of relationships present in the situation, as a way to bring into sharper focus issues that may require additional explanation and action.

Furthermore, in those activities, clinical ethics consultants attempt to locate the continually shifting balance among the aims, goals, desires, hopes, illusions, and so on, of the many individuals contributing to the complex relationships that compose clinical situations. In that ever-changing balance the ethicist attempts to make explicit what is most deeply cherished and worthwhile for those individuals, with the intention that it may inform what they are willing to live with in the aftermath of their decisions.

The second and more extensive point is this: if ethics consultants *do not* articulate and rigorously examine—that is, if they do not *hold up for inspection* and *test*— such influential pre-suppositions, crucial factors, core meanings, values and beliefs, and so on, including his or her own, then what is left of "ethics" and responsibility?

An ethics consultant, then, when going into a situation, needs both to anticipate multiple frames of reference, including his or her own, and to be prepared to explore, actively, the alternative notions that arise, notions and attitudes that may be divergent from those anticipated. As well, each consultant must pay careful attention to the characteristics of his or her own choices and the way in which those choices place that individual in a network of concerns that she or he is participating in and learning about.

And finally, the ethics consultant must distinguish the achievement-orientation associated with fulfilling responsibility within a role from being responsible. For the former will always be couched within the complex frames of institutionalization and professionalism—important factors, to be sure, but factors inherently concerned with standardization and boundaries reflective of given norms. Being responsible, on the other hand, reflects a more open-ended character in which the basis for choosing is, in the moment of choosing, partial and incomplete, even while propelling one into the next moment.

References

1. Aulisio MP. Ethics consultation: is it enough to mean well? HEC Forum. 1999;11(3):208-217.
2. Aulisio MP, Arnold RM, Youngner SJ. Health care ethics consultation: nature, goals, and competencies. A position paper from the Society for Health and Human Values-Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation. Ann Intern Med. 2000 Jul 4;133(1):59-69.
3. Agich GJ. What kind of doing is clinical ethics? Theor Med. 2005;26(1):7-24.
4. Baylis FE. A profile of the health care ethics consultant. In: Baylis FE (ed). *The Health Care Ethics Consultant*. Totowa, NJ: Humana Press, 1994.
5. Bliton MJ, Finder SG. Strange, but not stranger: the peculiar visage of philosophy in clinical ethics consultation. Human Stud. 1999;22(1):69-97.
6. Churchill LR. The ethicist in professional education. Hast Cent Report. 1978 Dec;8(6):13-15
7. Cowley C. A new rejection of moral expertise. Med Health Care Philos. 2005;8(3):273-9.
8. Dudzinski DM. The practice of a clinical ethics consultant. Public Aff Q. 2003 Apr;17(2):121-39.
9. La Puma J, Schniedermayer D. *Ethics Consultation: A Practical Guide*. Boston: Jones and Bartlett, 1994.
10. Meyers C. *A Practical Guide To Clinical Ethics Consulting: Expertise, Ethos and Power*. Lanham, MD: Rowan & Littlefield Publishers, Inc, 2007.
11. Rubin SB, Zoloth L. Clinical ethics and the road less taken: mapping the future by tracking the past. J Law Med Ethics. 2004 Summer;32(2):218-225.
12. Reiter-Theil S. The Freiburg approach to ethics consultation: process, outcome and competencies. J Med Ethics. 2001 Apr;27 Suppl 1:i21-3.
13. Reiter-Theil S. Balancing the perspectives: the patient's role in clinical ethics consultation. Med Health Care Philos. 2003;6(3):247-254.
14. Schutz A. The stranger: an essay in social psychology. In: *Collected Papers II: Studies in Social Theory*. The Hague: Martinus Nijhoff, 1964.
15. Scofield GR. Speaking of ethical expertise... Kennedy Inst Ethics J. 2008 Dec;18(4):369-84; discussion 385-92.
16. Smith ML, Weise KL. The goals of ethics consultation: rejecting the role of "ethics police". Am J Bioeth. 2007 Feb;7(2):42-4
17. Steinkamp NL, Gordijn B, ten Have HA. Debating ethical expertise. Kennedy Inst Ethics J. 2008 Jun;18(2):173-92.
18. Ten Have H. The hyperreality of clinical ethics: a unitary theory and hermeneutics. Theor Med. 1994 June;15(2):113-131.
19. Varelius J. Is ethical expertise possible? Med Health Care Philos. 2008 Jun;11(2):127-32.
20. Walker MU. Keeping moral space open: new images of ethics consulting. In: *Moral Contexts*. Lanham, MD: Rowman & Littlefield Publishers, Inc, 2003.
21. Yoder SD. The nature of ethical expertise. Hastings Cent Rep. 1998 Nov-Dec;28(6):11-19.

22. Zaner RM. *Ethics and the Clinical Encounter*. Englewood Cliffs, NJ: Prentice Hall, 1988.

23. Zaner RM. Experience and moral life: a phenomenological approach to bioethics. In: DuBose ER, Hamel RP, O'Connell LJ (eds). *A Matter of Principles?* Valley Forge, PA: Trinity Press International, 1994.

24. Zaner RM. Listening or telling? Thoughts on responsibility in clinical ethics consultation. Theor Med. 1996;17(3):255-77.

25. Zaner RM. *Troubled Voices: Stories of Ethics and Illness*. Cleveland, OH: Pilgrim Press, 1993.

26. Zoloth-Dorfman L, Rubin SB. Navigators and captains: expertise in clinical ethics consultation. Theor Med. 1997 Dec;18(4):421-32.

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