

Joseph J. Fins, "On the Lingua Franca of Clinical Ethics," *The Journal of Clinical Ethics* 24, no. 4 (Winter 2013): 323-31.

Clinical Ethics at 25 Years

On the *Lingua Franca* of Clinical Ethics

Joseph J. Fins

ABSTRACT

In this 25-year retrospective on the state of clinical ethics, and the anniversary of the founding of *The Journal of Clinical Ethics*, the author comments on the state of the field. He argues that the language of bioethics, as used in practice, seems dated and out of touch with a clinical reality marked by emerging technologies and the advent of new fields like palliative medicine.

Reflecting on his experiences as a clinician and clinical ethicist, the author worries about the emergence of a shallow bioethics, which is the product of a *lingua franca*. This linguistic amalgam is a weak composite in which concepts are simplified and nuance is overlooked, leading to interpretative errors. The best of ethical reasoning or clinical decision making can be lost in translation. Instead of the well-worn arguments over the relative worth of modes of ethical analysis, like principlism or pragmatism, the author argues that the emphasis should be on the cultivation of the "linguistic" skills necessary for translating any critical method in order to replace the lingua franca of clinical ethics with a more substantial discourse worthy of the complexity of the clinic. Through the emergence of such a shared language, at the interface of the sciences and the humanities, this multidisciplinary field can evolve towards more authentic interdisciplinarity.

Joseph J. Fins, MD, MACP, is the E. William Davis, Jr., MD, Professor of Medical Ethics, Chief of the Division of Medical Ethics, Professor of Medicine, Professor of Public Health, and Professor of Medicine in Psychiatry at Weill Medical College of Cornell University, and is Director of Medical Ethics and an Attending Physician at New York Presbyterian Weill Cornell Medical Center in New York, jfins@med.cornell.edu.

©2013 by *The Journal of Clinical Ethics*. All rights reserved.

Declensions sang on air like a *hosanna*
As, column after stratified column,
Book One of *Elementa Latina*,
Marbled and minatory, rose up in him.
—Seamus Heaney, "Alphabets"

TIME BEFORE HISTORY

Two thousand fourteen is a year of anniversaries, personal, professional, and editorial. Twenty-five years ago I was concluding my residency in internal medicine and starting a stint at the Hastings Center as a visiting fellow. The center had just published its *Guidelines on Care at the End of Life*,¹ and I was beginning to think about clinical ethics, usually with that volume at my side. And for the readership of *The Journal of Clinical Ethics*, 2014 is the twenty-fifth anniversary of its founding.

Silver jubilees are occasions for reflection. Enough time has gone by to gain some perspective, yet the story is too ripe for the disinterested pen of the historian. The moment still belongs to those who helped create the recent past, providing one last chance to get it right, to confront legacies that may have introduced unintended contradictions into our thinking and practices.

It also a time to reflect on the demographics of the practice space. The philosophers and theologians who originally inhabited the space have been augmented, indeed nearly replaced with clinical personnel who are more pragmatic in orientation. New

technologies have challenged old formulations about withholding and withdrawing life-sustaining therapies that were designed for “simpler” times. The broader context of care has also changed. With the burgeoning of the palliative care movement, the clinical ethicist’s niche has become one of co-habitation and, even, peaceful coexistence.

These developments warrant systematic reflection, and I hope to start that process here. I think clinical ethics needs to rethink some long-held “truths” to maintain our relevance and to augment our potential for meaningful contributions in a fast changing clinical context. You may agree or disagree, and on behalf of our editorial board, I invite you, the reader, to join in the conversation. Submit your commentaries to *Clinical Ethics at 25 Years*, a column that we will highlight during this year. Let’s use this milestone to improve on what we have wrought.

The historians will come soon enough.

LANGUAGE OF BIOETHICS

Sometimes, as I walk the wards doing an ethics consult, I feel as if I am speaking an ancient language, like the traveler in modern Europe who only knows Latin. Traveling from Italy to France and on to Spain, the sounds are familiar, but communication is difficult. There is a familiarity to what is heard, but being understood is a different matter. Although the cognates are known, the tense is off. The idiom has become more dynamic and the language of the clinic more specific. Something invariably gets lost in translation.

So too when I talk about clinical ethics to my clinical colleagues. They question settled norms and constructs and seem to misunderstand what we, in clinical ethics, accept as consensus views. Increasingly, much of what we discuss as clinical ethicists seems out of step.

At least to my ears, the language of clinical ethics has lost its agility, if it ever possessed it. It has become something of an ancient language, one that is read and debated in seminar halls fading from the vernacular of the hospital wards. Why? Because the guiding grammar that informs clinical ethics has become a relic of principlism, a method of moral problem solving that is too nonspecific to provide practical guidance in complex cases. Although an elegant theoretical approach, its applicability to clinical practice has weakened, even as newer editions of Beauchamp and Childress’s venerable text, *Principles of Biomedical Ethics*,² have been modified to become more accessible to clinical audiences.

This should not come as a surprise, as principlism was not intended to be a method of analysis for clinical ethics. Its origins were not in the clinic, but in research ethics, and the “common morality” that informed *The Belmont Report*.³ Yes, we want to foster autonomy, avoid harm, and promote the good, all the while being fair and just. But can we do all that at the same time, given the mix of factors that complicate the clinical context? And if one principle conflicts with the other, which one prevails?⁴

Beauchamp and Childress have written of the balancing and specification of principles as a means to make these judgments. Others like Jonsen, Siegler, and Winslade have taken a strikingly different approach, seeking to reach moral judgments after collecting and analyzing data from the bottom up.⁵ Although DeGrazia has astutely noted that moral reasoning in principlism is not invariably downward but can move from particular cases to general principles under what has been described as a coherence model of ethical justification,⁶ there is no doubt that one is primarily deductive (Beauchamp and Childress) and the other inductive (Jonsen et alia).

The “four topics approach” of Jonsen, Siegler, and Winslade is an evidentiary method that reviews the particulars of medical indications, patient preference, quality of life, and contextual issues before reaching a judgment. It is focused on the details and nuance of each ethical quandary and seeks to reach particularistic judgments drawn from the facts of the case. If principlism is more akin to appellate legal reasoning, the four topics approach resembles what occurs in a trial court, where adherence to due process leads to presentation of evidence necessary for reasoned judgment. Appeals are reserved for incomplete or flawed process or questions for which no true consensus exists.⁷

My own efforts in case analysis have been in the tradition of Jonsen, Siegler, and Winslade⁸ and more proximally, the late John Fletcher,⁹ all of whom can be loosely categorized as being in the American pragmatic tradition. Following their good example, I have spent much of my career trying to operationalize an inductive method of moral reasoning that my colleagues and I called *clinical pragmatism*.¹⁰

Based on Dewey’s theory of inquiry, and like clinical practice itself, clinical pragmatism starts with the recognition of a problem, a problematic situation, to start a process of analysis.¹¹ This process of inquiry collects narrative, clinical, and contextual data to build an “ethics differential diagnosis,” a range of reasonable—yet contingent—hypotheticals to be validated through practice. It is a bottom-up approach that accommodates novelty, detail, and

uncertainty, but leads to principled decision making.

Although I am gratified by those who employ clinical pragmatism in their practices, the dominant school—in the clinic and, *as importantly, in the law*—remains principlism, not these more pragmatic approaches. I believe this has come at a cost, decreasing the avidity for clinical ethics in the clinical sphere, where diagnostic reasoning is itself inductive.

AUTONOMY AT LIFE'S END

If we consider decisions to withhold or withdraw life support, we will quickly see how principlism is out of step with a major focus of clinical ethics and its deliberations. And it is here, at the end of life, when the dominant principle of autonomy, most forcefully expresses itself.

Despite the explosion of new technology and means of life support, the clinical ethicist's discourse still treats resuscitation as if it amounted to basic cardiac life support (BCLS) and an earnest bystander providing cardiopulmonary resuscitation, alternating chest compression with mouth-to-mouth breathing. Despite the veritable arms race of medical technology that is overwhelming intensive care—and requires more specific guidance and nuance—the basic ethical and legal frameworks for these decisions were drawn up decades ago.

And while BCLS has been supplanted by advanced care life support (ACLS), we still talk of “making a patient DNR”¹² and forgoing cardiopulmonary resuscitation. Chest compressions and ambu bags are the least of it. What of the drugs, the devices like pacemakers and extra-corporeal membrane oxygenation (ECMO) that now move us beyond acute resuscitation to efforts that seem like chronic resuscitation?

The DNR framework seems to be at the end of its tether for most of the resuscitation decisions we consider, like an attenuated Newtonian mechanics encountering high velocity physics. The analogic thinking only gets you so far, and concepts like being DNR on ECMO boggle the mind. Yes, I suppose that means one would not attempt chest compressions on a patient attached to the bypass machine, but what good would even the most earnest pumping do when the ECMO failed to perfuse and ventilate? Yet many incrementally approach a withdrawal of ECMO by taking the seemingly “intermediate” step of writing a DNR order, which logically should also mean that the ECMO be turned off, as it *is a resuscitative act*.

My point is not to solve the ECMO quandary here—my colleagues and I have recently written about that conundrum¹³—instead it is to point out the need to think about our actions in the clinic in a different way, not so bound up with questions of resuscitation, a physiological refuge that had a patina of scientific neutrality when it was introduced, because it was so binary. One either did CPR or not. Now it's not so simple, and pretending it is lends false reassurance to those who must make complex decisions.

More problematic is the centrality of the DNR discussion. While that was appropriately the center of conversation when we needed to advance the permissibility of the negative right to be left alone, that right is now well ensconced in practice and the law. That has been a notable success of bioethics. But that victory obscures the fact that, in complex cases, the decision is not simply one to forgo care, but to make other affirmative choices, such as those for palliation. The DNR question, so dominant as it remains, distorts the clinical transaction at the bedside and ultimately truncates choices for other care options. As I have written, it is not a comprehensive plan for end-of-life care, but “simply a plan for the last fifteen minutes of a patient's life.”¹⁴

We need to expand and deepen the conversation beyond the mechanics of a DNR form. If we still agree with the importance of choice—and we must—these choices need to be more available and informed. Surrogates will need better explanations of what is being proposed, and we, the clinicians, need to be clearer about what we are doing, ambiguity and all. And perhaps most importantly, the choices have to be real and, I would daresay, *guided*.

In a desire to satisfy a mistaken notion of both autonomy and patient rights, we have allowed families to demand—and receive—care that is futile, if not overwhelming disproportionate, often misrepresenting what clinicians might do as effective when it is not. It is much like the “slow code” of old, in which “show” efforts at resuscitation were performed to satisfy a family's desire for a “full code.” Those actions were dishonorable, a breach of physician integrity that misrepresented faux resuscitation as efficacious, when it was known to be ineffective.

Providing ineffective and burdensome care at the behest of surrogates to patients who are no longer able voice a preference seems to me something just short of a slow code. Even though clinicians are revulsed by what they are sometimes called upon to do, and know it will be burdensome and ineffective, they feel obliged to offer “everything,” in case

they be accused of misusing their power and breaching the sacrosanct autonomy of the surrogate. In the past 25 years, this deference has undergone a transformation, from hearing surrogates' preferences to being bound by them. I think that we need to restore some semblance of shared decision making so as to avoid such distortions in care decisions.

FUTILITY

So much of what happens in clinical ethics centers around disagreements about appropriate care. The most common variation on this theme is the prototypic futility dispute in which patients' families (they usually occur after the patient has lost capacity) demand care of uncertain or marginal benefit, that clinicians hope to avoid. The plot line is familiar to readers of this journal. . . . Families assert their autonomy and demand care that has no clear benefit, or is, at best, highly disproportionate in its risk versus benefit ratio. Practitioners believe they have explained the hopelessness of the situation,¹⁵ but have actually failed in communicating the direness of the situation with rhetoric that is often obscured by medical jargon.¹⁶ The outcome: Despite the futility or marginal utility or the burden associated with the treatment, care is provided because the value placed on choice allows for some unbelievably bad ones.

When families make such demands, they generally win, drawing authority from the prizing of autonomy and self-determination over other goods and laws that were meant to protect patients and families from the value judgments of clinicians, but that now prevent those same physicians from protecting their patients from disproportionate harms from burdensome treatments without foreseeable benefit. Add to this mix the willingness of many physicians to take a path of least resistance and go along with that extra round of chemotherapy, lest they be the victim of reprisal by malpractice litigation—a phantom that seldom occurs.

When a clinical ethicist encounters this all-too-familiar dynamic, he or she is trained to respect patients' and families' preferences, and to help clinicians educate families about possible outcomes and realistic goals of care, endeavors that work when addressing families who possess a requisite degree of rationality and calm, but those are not the families who generate futility disputes and demand ever more care. For those families, the conventional approach is wholly inadequate, placing clinicians in the position of providing care that they can only describe as inhumane.

While such a perspective can be chalked up to the idiosyncratic sentiments of particular practitioners, this constellation of feelings has occurred too often and too widely to be ascribable to outlier sentiment. Instead, this outcome is reflective of a system of interactions, of discourse, that fails to protect patients from harm and asks clinicians to provide disproportionate care.

Why would an ethical framework allow this to occur? First, because principlism has been so misunderstood in the clinic as simply the primacy of autonomy, an unnuanced acceptance of self-determination, a "the customer is always right" attitude, that pertains to commerce, but not to the professions. This deference to patient autonomy has distanced physicians from their own professionalism and their ability to be self-regulating. Where there should be a corpus of professional knowledge and norms, there is a reluctance to partake of judgment, lest this use of the physician's power be equated with paternalism. So physicians abdicate and do what they perceive they must do, without questioning the family's prerogative to direct care or reflecting upon their judgment. They avoid these essential "second looks" or gut-checks, lest they violate the sanctity of patient autonomy.

The language of bioethics, at least as practiced in the clinic and written in state law and federal mandates like the Patient Self-Determination Act,¹⁷ have too often taken physicians' discretion off the table in futility disputes too. We have come to believe that all such exertions are paternalistic. But as Howard Brody has argued for the ages in his wonderful *Healer's Power*, the practice of medicine is impossible without the exertion of power, of judgment and discretion.¹⁸

A case in point involved a patient with a terminal malignancy. She had an open sternal wound. Her family demanded resuscitation, and no one dared write a do-not-resuscitate order because, under prevailing state law, a DNR order cannot be written over the objection of a surrogate (the patient lacked capacity). The DNR law's deference to the family circle precluded a formal DNR order that could have protected the patient from cardiac rupture from the shearing forces of a displaced sternum being compressed.

Here, Hippocratic ethics called for the patient's protection from harm, and so the physician and clinical ethicist met with the family and told them that, in the event of a cardiopulmonary arrest, the patient would not receive chest compressions. She would continue to be ventilated by her tracheostomy and receive medications if indicated, but no chest com-

pressions. They did not ask for permission to be relieved of an obligation to perform chest compressions because *it was neither indicated nor safe, and they were willing to make that call*. They invoked their medical knowledge and the power of their medical licensure to make this determination. And when the family asked for *open* cardiac massage, they responded that it was not appropriate and not current practice under these circumstances—in an obtunded, elderly patient with metastatic disease.

Now some readers might view actions taken in this case as an abuse of authority by the doctor and clinical ethicist (who also happened to be a physician). I would argue in their defense that they acted ethically, protecting the patient from harm and appropriately exercising power, overcoming barriers intrinsic to clinical ethics and the law that made this exertion of professionalism difficult.

NOT SO FAST

Even as I read the words I have just written, I wish it were that simple. If all our ills could be cured by a tempering of the family's desires with a dose of professionalism, we could be in the clear. But it is not that simple, because what passes for professionalism too often reeks of ideology, a self-satisfied sense of righteousness that is neither critical nor reflective.

I worry too that a call for a resurgent physician voice could create an opening for a new sort of paternalism, flying under the progressive flag of a second wave of palliative care. What do I mean by that? Well, I am concerned that palliative care—as a construct and a practice—has become too prescriptive and ideological, advancing a proscribed way to die. It has morphed from a prizing of patient choice and a means to maximize the quality of one's remaining days, to a decision to withhold or withdraw care.

I view these trends as antithetical to the origins of palliative care as means of providing comfort and relief, an evolving tradition dating back to the Irish Sisters of Charity who opened Our Lady's Hospice in Dublin in 1879. According to an account by Dame Cicely Saunders, the founder of the modern palliative care movement, the sole focus of the Sisters of Charity was the care of the dying.¹⁹ Describing their hospice, it has been said that the Sisters of Charity observed, "It is not a hospital, for no one comes here expecting to be cured. Nor is it a home for incurables, as the patients do not look forward to spending years in the place. It is simply a 'hospice' where those who are received have very soon to die, and who know not where to lay their weary heads."²⁰

That phrase, "weary heads," lingers with me since I read it over a decade ago, embodying the empathy, the compassionate care that so informed the palliative care movement as it marched through the 1990s fighting for legitimacy in clinical circles and fighting off those who more narrowly sought to use it to advance the case for physician-assisted suicide.²¹ As advanced by its most thoughtful proponents, palliative care originated from a patient/family-centered stance that focused on relief of distress and closure, as well as an appreciation that patients and families came to decisions in their own way, in their own time. Each patient's trajectory would be unique, and the key to formulating a smooth glide path to a peaceful death was to help the patient to articulate goals of care. Decisions to withhold or withdraw care were never goals, in that framework. They were the means, meant to be derivative of a prior articulation of goals, desires, and aspirations, some of which could be satisfied in other ways.

In the intervening decade, much has changed. In too many cases, a clinician's angst about an impending death and sense of causality, or even responsibility, for a patient's demise has been replaced by the consolation that those who withhold or withdraw life-sustaining therapies are acting in a progressive fashion, invariably in the right, acceding to the patient's or the family's wishes. And, if that is wanting, then making decisions based on the superior judgment on such matters, that comes with medical practice. There is a certainty to these decisions replacing the ambiguity of clinical intentions and the moral angst that used to be felt. In short, this ideological belief in palliation and palliative care in a prescriptive way to die has taken some of the gravitas out of dying.

No longer just about securing a right to die, practices and beliefs have morphed so that a timely death has become proper and prescriptive. When patients don't die as expected, or on time, one hears house staff using the phrase "failure to die"—an echo on the earlier geriatrician's "failure to thrive"—to describe terminally ill patients who linger and refuse to die. A failure to die. . . . *We used to call that survival*. Now that is being seen as a failure, a strange twist since Wanzer wrote of death as a medical failure back in 1989.²² That essay is also celebrating its jubilee, but so much has changed. From death as failure, to failure to die: Everyone is in such a hurry.

OF GOOD INTENTIONS

In cases both personal and professional, as a family member and a doctor, I have seen this rush to

judgment in which clinicians jump to a palliative care recommendation even before a diagnosis or prognosis was clear and before relationships were made with patient and family. These doctors were not disinterested nor motivated by malintent. They earnestly believed that what they were doing was right, and was what they had been trained to do in their courses in medical ethics and palliative care. They had good intentions, even as their presumed beneficence had unintended consequences.

A memorable case in point came to our ethics consultation service. A patient with endocarditis secondary to intravenous drug abuse was hospitalized in the intensive care unit, with a spinal cord abscess involving c3-c5. She had septic embolic to her head and lungs, compromising both her level of arousal and her respiration. Because of cervical cord compression at the roots of the phrenic nerves, the patient had lost ventilatory drive and was ventilated.

Because the patient was unconscious and in critical condition, her father consented to a DNR order. A few weeks later, the patient regained consciousness. Essentially locked-in because of her spinal cord lesion, she began to communicate with her eyes. Her doctors called for an ethics consult because she indicated she wanted to have her endotracheal tube removed and to die.

I was the consultant on call, and was asked by the patient's unit doctors to see her and validate this request so that they could honor her wishes and allow a dignified death.

When I met the patient, she was alert and clearly able to signal yes and no with her eyes. After some preliminary questions to ensure that she could follow instructions and answer consistently, and some additional neutral queries, I asked her if she wanted to die, as I had been told. She answered, No.

I confirmed that this was her answer and continued to ask about her endotracheal tube. "Do you want the tube out?"

Yes, she responded with her eyes.

"You would like the tube out?"

Yes, again with her eyes.

"You know that if I take the tube out you could die?"

Yes, she said looking straight at me.

"So you still want it out?"

Yes.

"So you want to die?"

No, she responded.

I repeated this sequence several times and in different ways, and came to the conclusion that she wanted the tube out, she understood that taking it out would cause her to die, and that she did not

want to die. There was an inconsistency here, and I felt obliged to search for an explanation. After all, all the patient could do was to respond to my requests. She could not generate her own questions.

"So, let me summarize. You don't want to die, but you want the tube out? Correct?"

Yes.

And then, my hypothesis: "Does the tube hurt you?"

The question was met with a massive swooshing, downward gaze of her eyes, and even something of a grimace, which I translated as an emphatic *Yes*.

"So," I suggested, "You want the tube out because it hurts?"

Another expressive, *Yes*.

Adopting a palliative stance, I suggested that if she wanted to live, then we would need to keep the tube in until it was safe to take it out, or place a tracheostomy tube that would be more comfortable. That option was not possible because she was on a significant amount of pressure support, so the procedure could not be done safely.

So the patient and I agreed to a number of things, now that her goals were clear. First, we would rescind her DNR order, as she wanted to live. Second, she would be put under general anesthesia for a week, to seek if her lungs would heal, making tracheostomy placement possible. If that became an eventuality, we would waken her and obtain her consent for this. On the other hand, if her condition worsened and she would not be able to come off the tracheostomy tube, she directed us to reinstitute the DNR order and perform a terminal extubation.

She was placed under general anesthesia and continued to receive treatment for her systemic endocarditis, and emerged a week later as a candidate for tracheostomy placement. This was done, and she eventually went to rehabilitation.

A fortuitous outcome, but whatever had occurred, it is important to return to how the case was too easily framed as a right-to-die case, and how that changed. Over the course of 40 minutes of "discussion" with this patient, a "routine" withdrawal of care—presented by the patient's medical team with much self-satisfaction—had become something quite different. Through our conversation, we clarified that the patient never wanted a withdrawal of life support and did not desire death. Her request to have her tube removed, too easily interpreted as a euphemism like "pulling the plug," was actually a call for pain relief in a patient who had become voiceless due to her paralysis and intubation.

The desire to provide this patient a dignified death also suffered from a lack of credible eviden-

tiary information about the patient's prognosis. Her fate was presumed by the treating team to be far worse than her actual prognosis. After additional consultation, it was estimated that she had a 50 percent chance of independent respiration after the abscess was drained and treated with antibiotics. Why the "treating" team so quickly saw the patient's situation as terminal can only be surmised. We might speculate that it might have been related to prejudicial views towards her substance abuse and her "self-inflicted" illness, or due to cognitive bias, stemming from a framing effect engendered from an abscess overlying the critical roots of the phrenic nerve. Whatever the explanation, the forces of nihilism were working upon this case in a manner that distorted decision making to the point of almost sacrificing a patient's life.

SHALLOW BIOETHICS

When a preacher makes a point of criticizing a patriarch or the Deity, he or she is said to be "preaching against the text." It is an awkward place for a theologian, and equally so for a bioethicist. And so it seems that the case of the patient with metastatic cancer and the open sternal wound and the patient with the endocarditis are at odds with each other. In the first, I urge the doctors to clearly demarcate the limits of care. In the second, I critique the physicians who wanted to withdraw life-sustaining therapy. How are these two cases to be reconciled, with broader lessons drawn for clinical practice?

Although the first case urged less treatment and the second care urged more, it is the depth of the care, not the ultimate direction, that link these two cases together. Each case suffers from the same deficit, namely a failure to engage the patient and family more fully in dialogue and negotiation. They also suffer from a knowledge deficit that stems from such superficial engagement. In the first case, it was professionals ceding what they knew about the dangers of resuscitation. In the second, it was not knowing what was not known: neither the patient's true preference nor her prognosis.

Regrettably, these errors occurred under the guise of a *shallow bioethics*, true to neither principism nor pragmatic approaches. It was sloppy, incomplete, and inattentive to both details of the cases and to the prevailing ethical principles that should govern practice. In the first, it was deference to autonomy at the expense of other ethical values and a corpus of medical knowledge that is the purview of clinicians. This embrace of autonomy, unrestrained by other principles or medical facts, was fundamen-

tally a breach of professionalism, precluding more thoughtful responses about the risks of resuscitation.

In the second case, it was the enthusiastic endorsement of what seemed like an autonomous choice without subjecting that false belief to more scrutiny. It was an example of how an ideological embrace of what one believes is right can erode the contingency and skepticism necessary for safe clinical practice.

DISCOURSE IN TRANSLATION

When I began this essay, I suggested that the clinical ethicist was like the traveler who spoke an ancient language and was no longer understood, suggesting that he or she needed to brush up on modern Romance languages to gain entry to the conversation. But a close reading of the cases presented here suggest that I was wrong, and that it is the other way around. It was the intervention of a clinical ethicist that prevented iatrogenesis, either from a decision to attempt resuscitation when it was dangerous, or to forego it when in fact it was indicated and desired.

The trouble is that these errors were occurring under a *lingua franca* of clinical ethics. The *Oxford English Dictionary* defines *lingua franca* as "any mixed jargon used for intercourse between people speaking different languages."²³ And that is the case of clinical ethics in the clinic. The "professionals" in clinical ethics are coming from a background in the humanities and social sciences, as well as clinical practice. In contrast, their interlocutors have been acculturated in the language of science, which is more quantitative and reductionistic. They are indeed speaking different languages, placing them at a distance.

The result is that although there appears to be communication between practitioners and clinical ethicists, when we interact we actually each speak a second language in which neither of us are fluent. This *lingua franca* is a weak composite that neither captures the best of our ethical reasoning nor the excellence of sophisticated clinical decision making. This amalgam can lead to a shallow bioethics on the part of practitioners—and, as ominously—an equally thin notion of clinical practice amongst those clinical ethicists who are not otherwise trained in medicine or the health professions. This divide has been deepened by medicine's embrace of "evidence-based" practice, an approach that tolerates only certain kinds of evidence and dismisses that which is not falsifiable.²⁴ In this cognitive frame, numbers can easily become confused with values.

This is a dangerous mix. Each side, through the aegis of a shared lingua franca, sees a lack of depth in the discourse of the other, which can lead one unfamiliar with the richness of the other's "text" to be dismissive, and even disrespectful. These views are not the fault of what is actually there, but the shallowness of what is actually accessible through translation of a primary language's richness through a rickety vehicle like a lingua franca. So when we communicate in this shared language, neither side is at its best, each struggling to simplify and decrease complexity and nuance, to be understood across a linguistic—and here a conceptual—divide.

THE WAY FORWARD

While there may be deficits in our theories of bioethics—after all, nothing is without its flaws—I have come to appreciate that the challenge for clinical ethics *in practice* is more about how these theories are communicated, or rather miscommunicated and misrepresented, by those whose fluency is lacking both in the expression and reception of a complex text.

Our focus therefore should be less on theoretical disputations about the virtues of one method over the other. An analogy would be to ask who is the greater novelist, Hemingway or Woolf, when the audience can not speak English and no suitable translation is available. In that case, as in debating the merits of principlism versus pragmatism, the more pressing need is to build the language skills necessary for appreciating *any* method.

This will require enhanced—and more effective—training in clinical ethics, that integrates ethical reasoning early in the medical, nursing, and allied health curricula, so that students and trainees receive what amounts to a *bilingual* education. As they learn, for example, about the Krebs Cycle and the gluconeogenesis of starvation, they might also learn about the ethics of patients who voluntarily decide to stop eating and drinking at life's end. This integrated approach will build the incremental fluency necessary to address complex problems in all their dimensions, and help the learner grasp both the significance of the science and the ethical significance of a patient's request.

Those who come to clinical ethics from earlier work in the arts, humanities, and social sciences will have a reciprocal need to become familiar with the clinical context within which they hope to contribute. This can be accomplished through masters or fellowship programs. Nothing short of a robust exposure and meaningful immersion in the clinical

space—and the language of the clinic—will be adequate to equip these individuals with the "linguistic" skills to share their critical insights from non-science domains with a clinical audience.

An early first step in bringing such standards to clinical ethics is an effort by the Quality Attestation Presidential Task Force of the American Society for Bioethics & Humanities (ASBH) that I have led as president of the ASBH, ably joined by Eric Kodish of the Cleveland Clinic.²⁵ This initiative has sought to begin a quality assurance process for those who would do clinical ethics consultation and to set minimal standards for the competency of those who practice this activity. We hope this model will have derivative educational benefits for healthcare professionals, as well as ethics consultants.

TOWARDS INTERDISCIPLINARITY

As daunting as the aforementioned challenges may appear, they are good problems to have. The need to replace our shared lingua franca of clinical ethics with something more substantial, a proper language more able to convey nuance and complexity and engender serious study, is a reflection of our collective evolution from a multidisciplinary field to a discipline that is truly becoming interdisciplinary. In the former case, people from multiple disciplines speak to each other in translation. In the later, multiple disciplines cross boundaries to coalesce using a common focus and a shared language. Seen in this light, the past 25 years have been extraordinarily formative, not only in the maturation of clinical ethics, but for its potential of transformation the language of the clinical transaction itself.²⁶

DEDICATION

This article is dedicated to the memory of John C. Fletcher.

MASKING OF THE CASES

The identities of the persons in the cases described in this article have been masked by changing nonclinical details of the cases.

NOTES

S. Heaney, "Alphabets," in *Opened Ground: Selected Poems 1966-1996* (New York: Farrar Strauss and Giroux, 1998).

1. Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Bloomington: Indiana University Press, 1987).

2. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, 1st ed. (New York: Oxford University Press, 1979). The seventh edition was published in 2012.
3. J.H. Evans, *The History and Future of Medical Ethics: A Sociological View* (New York: Oxford University Press, 2012); National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington D.C.: Government Printing Office, 1978; DHEW Publication No. (OS) 78-0014).
4. J.J. Fins, "A Review of *The History and Future of Medical Ethics: A Sociological View* by John H. Evans, New York: Oxford University Press, 2012," *American Journal of Bioethics* 6, no. 13 (2013): 58-9.
5. A.R. Jonsen, M. Siegler, and W.J. Winslade, *Clinical Ethics* (New York: Macmillan, 1982).
6. D. DeGrazia, "Common morality, coherence and the Principles of Biomedical Ethics," *Kennedy Institute of Ethics Journal* 13, no. 3 (2003): 219-30.
7. J.J. Fins, F.G. Miller, and M.D. Bacchetta, "Clinical Pragmatism: Bridging Theory and Practice," *Kennedy Institute of Ethics Journal* 8, no. 1 (1998): 39-44.
8. Jonsen, Siegler, and Winslade, see note 5 above.
9. F.G. Miller, J.J. Fins, and M.D. Bacchetta, "Clinical Pragmatism: John Dewey and Clinical Ethics," in *Frontiers in Bioethics: Essays Dedicated to John C. Fletcher*, ed. F.G. Miller (Hagerstown, Md.: University Publishing Group, 2000).
10. J.J. Fins and M.D. Bacchetta, "Framing the Physician-Assisted Suicide and Voluntary Active Euthanasia Debate: The Role of Deontology, Consequentialism, and Clinical Pragmatism," *Journal of the American Geriatrics Society* 43, no. 5 (1995): 563-8.
11. J.J. Fins, M.D. Bacchetta, and F.G. Miller, "Clinical Pragmatism: A Method of Moral Problem Solving," *Kennedy Institute of Ethics Journal* 17, no. 2 (1997): 129-45.
12. That is, writing a do-not-resuscitate (DNR) order.
13. E. Meltzer, N. Ivascu, and J.J. Fins, "ECMO and DNR: A Paradox Worth Explaining," *The Journal of Clinical Ethics* 25, no. 1 (Spring 2014, in press).
14. J.J. Fins, *A Palliative Ethic of Care* (Sudbury, Mass.: Jones and Bartlett, 2006), 121.
15. M.Z. Solomon, "How physicians talk about futility: making words mean too many things," *Journal of Law, Medicine & Ethics* 21, no. 2 (1993): 231-7.
16. J.J. Fins and M.Z. Solomon, "Communication in Intensive Care Settings: The Challenge of Futility Disputes," *Critical Care Medicine* 29, supp. (2001): N10-5.
17. Omnibus Budget Reconciliation Act of 1990. Pub. L. No. 101-508.
18. H. Brody, *The Healer's Power* (New Haven, Conn.: Yale University Press, 1992).
19. C. Saunders, "The evolution of hospices," *Free Inquiry* (Winter 1991/1992): 19-23.
20. G. Goldin, *Work of Mercy* (Richmond Hill, Ont.: Associated Medical Services and Boston Mills Press, 1994), 270.
21. J.J. Fins, "Death and Dying in the 1990s: Intima-
- tions of Reality and Immortality," *Generations: Journal of the American Society on Aging* 23, no. 1 (1999): 81-6.
22. S.H. Wanzer et al., "The physician's responsibility toward hopelessly ill patients: A second look," *New England Journal of Medicine* 320, no. 13 (1989): 844-9.
23. *The Shorter Oxford English Dictionary* (Oxford, U.K.: Clarendon Press, Oxford University Press, 1987).
24. J.J. Fins, B. Pohl, and D. Doukas, "In Praise of the Humanities in Academic Medicine: Values, Metrics and Ethics in Uncertain Times," *Cambridge Quarterly of Health Care Ethics* 22 (2013): 355-64.
25. E. Kodish and J.J. Fins et al. on behalf of the ASBH Quality Attestation Presidential Task Force, "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics & Humanities," *Hastings Center Report* (in press).
26. J.A. Baroness, "The clinical transaction: Themes and descants," *Perspectives in Biology and Medicine* 27, no. 1 (1983): 25-38.