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Features

Untangling Uncertainty: A Study of the Discourses Shaping Clinical Ethics Consultation as a Professional Practice

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ABSTRACT

This qualitative social scientific interview study delves into the ways in which professional vision is constructed in clinical ethics consultation (CEC). The data consist of 11 semi-structured interviews that were conducted with clinical ethics consultants currently working in hospitals in one major urban area in the U.S. The interviews were analyzed with the qualitative research method of critical discourse analysis, with a focus on identifying the cultural structures of knowledge that shape CEC as a professional practice. The discourses were first identified as belonging to two higher discourse categories, *order* and *agency.* Order was divided into three lower categories, *emotional, managerial,* and *rational* order, and discourses of agency into the lower categories of *exploration, technique, deliberation,* and *distancing.* An additional discourse of neutral interaction was identified as a bridging discourse, activated to level tensions emerging out of conflicting goals and agencies embedded in CEC practice. This analysis brings out as its main observation that clinical ethics consultants draw on and shift between potentially ideologically conflicting social positions that can create built-in tensions within the professional domain. The study calls attention to these tensions and suggests for the professional group to discuss the possibility of defining priorities between different kinds of order, identified in this study, that shape the CEC domain.

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INTRODUCTION

Clinical ethics consultation (CEC), or healthcare ethics consultation (HCEC), is a fairly new professional practice in the healthcare field, and it can be described as "a service provided by a committee, team, or individual to address the ethical issues involved in a specific, active clinical case."[1] In the U.S., the field is currently under vivid social struggle, as efforts toward formal professionalization[2] have led to debate within the field about the central definitions of the practice.[3] Such a conflicted situation can be identified as the complex social process called the *internal unification* of a profession, which is a typical phase of professionalization.[4]

The goal of this qualitative social scientific study is—by analyzing interview data—to understand the discourses that shape CEC as a professional practice. The theoretical starting point is based on social constructionism, which presumes that central to the organization of a profession is its ability to shape events in the domain of its scrutiny: to give names and meanings to certain objects of knowledge. Based on this meaning making, a profession is able to organize its discourse around certain phenomenal objects and incorporate them into its realm of inquiry and action.[5]

In this study, I explore what CEC practice marks as significant and thereby incorporates into its realm

of inquiry. As the emphasis in this study is put on the exploration of the professional constructions of CEC itself, the individual backgrounds of the interviewees are deliberately not given weight in the analysis. Thus, I start by assuming that despite the fact that people working in the field of CEC come from a variety of backgrounds and often wear more than one hat, there are also shared constructions of what it means to be a clinical ethics consultant: constructions that form the socially circulated—yet also contested—professional vision[6] that shapes and gives meaning to CEC. Professional vision is a useful concept, as it explains why different professions view the same objects or events in different ways, for example, how an archaeologist and a farmer may look at the same patch of dirt and yet see different things.[7] In the same way, I start with the presumption that a certain professional vision of this kind allows a practicing clinical ethics consultant to view everyday hospital life through a specific, meaningful professional lens, to transform the hospital's scattered and scrappy life-world into graspable concepts and tangible action that provide socially constructed meaning, significance, purpose, and legitimation for CEC.

In this article, I refer to CEC as a "professional practice," even though the field is currently officially unacknowledged as a profession. This conceptual choice has been made for the following reasons: as the interviewees were comfortable with the terms *professional* and *profession,* I have chosen not to challenge the concept of professionalism, since, due to the theoretical framework of this study, I approach CEC as a social construction. Thus, it could be said that the use of the term emerges from "bottom up." Moreover, the ongoing endeavor to professionalize the field, in itself, also indicates that, within the field, there is wide movement in which CEC is being constructed as a profession (even though social struggle over the concept no doubt abides). It should also be noted that since I view the professional domain as a social construction arising from the "bottom up," I allow the data to shape what this professional domain encompasses—in other words, I do not limit CEC expertise to cover only definitions of the *consultation* act itself, but to involve all the territory the interviewees have presented to me, including other professional aspirations, such as education and policy writing. It is, however, important to add that by studying CEC as a *professional* practice, I do not intend to adopt any position in the debate on whether the field should be officially acknowledged as a profession or not—taking such a normative stand would go past my domain of inquiry and expertise.

In order to tap into the inner logic of CEC, I analyze interview data to explore the ways in which the domain of practice of CEC is discursively shaped and presented to an outsider listener—to me, a nonclinician social scientist from another country and culture. As the in-depth interview is a personal and intimate encounter that is often used to elicit detailed narratives and stories,[8] it seemed natural that the interviews would allow the ethics consultants to define their professional life and its meanings in their own words. I deliberately chose to study interviews—instead of, for example, official texts or other nonpersonal records—to access the experienced professional life-world in a way that echoed the realities of living in this particular professional domain, with its ups and downs. Additionally, I anticipated my outsider position would enhance the depth of the interviews,[9] as I assumed that the interviewees would explain their profession to me in great detail, since they would not expect me to know the things that their CEC colleagues, for example, would know implicitly. Yet, it should be acknowledged that analyzing the interview data leaves many important aspects of the everyday life of the practice of CEC out of the scope of this study, as the domain of work is not captured "in action," but instead as retrospective narratives. Nevertheless, as professions ultimately only become legitimized by convincing outsiders,[10] it can be argued that *especially* the ways in which a profession represents its domain of expertise to outsiders reflect the main constructions forming the essential "what," "why," and "how" of a profession.

With these presumptions in mind, I explore the essence of what makes CEC meaningful in the personal accounts collected through interviews. What do consultants "see" through their professional lens? What is constructed as significant from this particular perspective? How does the profession respond to what it marks significant? What kind of demands do these ways of "seeing" set for those working as consultants? Do these demands presume ideological orientations? By exploring such ways of professional construction and conceptualization, I aim to create awareness of the subtle social landscape that produces order and meaning in the professional culture of CEC. I also explore the ways the different discourses position ethicists into social roles with different kinds of implicit expectations.

METHOD

To shift the focus on what lays under the surface, it is important to develop a critical eye toward

what is on the surface. I follow Eliot Freidson's assertion that what a profession declares itself to be should not be treated by social scientists as a fact, but rather as a form of social organization based on a professional claim of expertise.[11] In the case of CEC, it would be naïve for a social scientist to assume that the profession was comprehensively defined by solely claiming that it consists of "identifying and analyzing the nature of value uncertainty or conflict" or "facilitating resolution of conflicts in a respectful atmosphere," as has been suggested.[12] While I do not doubt the sincerity of this goal, it is still clear that many of the implicit complexities of social reality are rendered invisible by these claims. Such implicit elements that construct the order of social life can only be brought into the light by empirical inquiry, as it presents a way to deconstruct the professional mystique that the claim—itself a source of mystique—cannot capture.

The theoretical approach of this study is based on social constructionism.[13] Viewed from the perspective of this theory of knowledge, professions are understood as cultural constructions that are shaped by discursive practice: structures that are created by a dynamic social process in which specific ways of talking and conceptualizing have become culturally hegemonic. Additionally, while from this perspective professions are understood as *created, negotiated,* and *sustained* via such hegemonizing social and cultural practices, they are also viewed as constrained by the same discursive practice, as the possibilities of seeing and acting are controlled by contingent norms of conduct and thought that set the boundaries for the professional sphere of influence and action.[14]

Metaphorically, one could think of the available professional ways of "seeing" as being like paths in a forest: they provide direction and order for taking steps forward—yet, while providing direction, they also constrain walkers to pass only through certain areas of the forest and disregard areas they cannot see. But at the same time, it should be added that acknowledging there are such paths in social reality—paths that both direct and constrain—does not imply that one could not set out into the wild to make one's own path. Professional discourse is not set in stone, but rather in the flux of being constantly socially renegotiated.[15] In this study I delve into exploring what kinds of "paths" of reasoning and action the professional culture of CEC enfolds. This is a topic that requires conscious exploration, as the paths available are typically not explicitly visible to the people involved. They are, in a way, "hidden," by virtue of being so implicit that they rarely become openly questioned or explained—as if they are hiding out in the open.

With these presumptions, I approach the data using the method of critical discourse analysis (CDA). As the "paths"—prevailing discourses—are typically taken for granted and seen as "common sense," making them visible may uncover many enlightening perspectives on the cultural meanings and ideological underpinnings of CEC. Based on this view, discourse analysts presume that in order for embedded discourses to be exposed and made explicit, the use of language in research data must be carefully scrutinized using qualitative analysis techniques.[16] This data reading method is critical in the sense that it aspires to show connections and causes that are typically not transparent to the people involved in the discourse.[17] Thus, critical discourse analysis does not imply "criticism" of the object of the study, but rather is a technique aimed at exposing hidden cultural constructions and tensions. Second, the study is discourse analytic in the sense that it presumes that language not only reflects or represents social practice, but also constructs it. The method, thus, starts from the presumption that language "produces a social reality that we experience as solid and real."[18] It can be argued that if the discourse did not shape meaning and the structure of thought, there would be no shared conception of social reality. Thus, it becomes evident that to understand reality, our experiences, and ourselves, we should make efforts to understand discourse.[19]

In the literature concerning the CDA approach, the exposing of power imbalance and techniques of dominance are often highlighted, and this is often used as a method to unveil racism, misogyny, or other kinds of marginalization in everyday interaction, as well as in media texts and official records.[20] In this study, I take a slightly more cautious approach to the method, as I do not scrutinize techniques of marginalization in my data but, rather, use the method as a way to create awareness of the general structures of knowledge and action that work together to shape the professional domain of CEC. Based on the CDA method, I view the concept of discourse as structural rather than situational, as reflecting widely circulated systems of knowledge rather than the micro reality of what happens between the interviewee and the interviewer. Yet, the method does not imply a top-down view of discourse, but highlights the importance of struggle. People may position themselves either to align with the identified hegemonies or resist them.[21] Viewing discourse as structural—as a social force shaping practice in certain ways as well as contested—al-

lows the researcher to identify the shaping discourses without implying determinism, and thus leaves room for struggle and further discussion. Showing what kinds of ways of thinking are typical also brings attention to other approaches that appear to be shut out of the scope of the field. Bringing attention to what is "known" as common sense within a field also reveals what is "doubted," and may turn attention to what is left entirely invisible. In this study, I focus on identifying the "known knowns" of the field of CEC, and speculate less on the possibilities of what could be. Yet this study also does aim at awakening discussion of both what is and what could be by opening up a perspective on the politics of professional knowing.

The data consist of 11 semi-structured interviews that vary between 45 and 100 minutes in length, which were collected in one major urban area (five hospitals in total) in the U.S. in the time period between October 2014 and May 2015. All the interviewees were reached through a central contact person located in a university-based bioethics center. The bioethics center was a natural place to start making connections, as the main purpose of the center is to enhance and sustain inter-hospital connections and communication as to bioethical topics. The interviewees were interviewed in their own offices (n = 5), in general hospital meeting rooms (n = 3), and in general university meeting rooms (n = 3). The backgrounds of the interviewees were physicians (n = 2), nurses (n = 5), other clinical professionals (n = 3), and one lawyer. As the focus of the study is on the inner logic of the statements and not on the interactional order of the situation in which the statements were made, the interviews were transcribed in a way that did not pay close attention to the microstructure of the speech, but rather recorded it in the simplest possible way, with the exception that extended pauses, whispering, laughter, as well as laughing tone were recorded on the transcription. In total, the transcriptions add up to 148 single-spaced pages. To protect the identities of the interviewees, all data samples are anonymized. For the same reason, I have also chosen not to expose the name of the city in which the interviews were made, as CEC is a relatively small profession, and identification might be possible by location.

I approached the data by first making the assumption that some kind of implicit cultural net of silent assumptions exist in it, and that the workings of these implicit orientations can be scrutinized by paying attention to what is present in the data but not said out loud. The first phase of the analytical reading was aimed at developing intuitions in the data: simply reading the data and listening to the audio records in a state of wonder as to what is going to emerge. After this, a more systematic way of reading was adopted, one in which I identified certain themes that appeared to repeat themselves in the data and wrote them down with illustrative data samples. In doing this, I paid attention to the levels of explicit explanation and justification in what was said. As certain statements required less explicit explanations, I paid more attention to questioning what kind of assumptions gave them their unquestionable nature. I also asked what kinds of categories could be actualized, not only in specific examples, but in a variety of different kinds of situations and settings.

The third phase was testing of the categories developed by iterative reading of the data. In this phase the initial categories often needed to be modified or rejected altogether. This testing and redeveloping of the categories illustrates well how the steps of the analysis phase did not simply progress, but often went back and forth between the mentioned phases. This analysis process also shows how categorization emerges out of the data-reading phase in a way that is typical for qualitative research, in which categories of inquiry are not isolated and defined before the data collection, but instead the categorization occurs during the analysis phase of the study.[22] Yet, there are no coherent rules of how such analysis should be made, and, in the end, this depends largely on the imagination of the researcher. In such a process, what is being asked of the data, and how the data are methodologically being approached, makes all the difference in defining what can be found—and even still, not every researcher would come to the same conclusions with the same questions and methods. Eventually, the greatest test to which the analysis can be put lies outside the scope of the researcher; that is, whether or not the findings resonate with the people whom the study addresses.

FINDINGS

The field of CEC as a professional practice was identified as constructed by two higher categories of discourse: order and agency. Order was divided into three lower categories, *emotional, managerial,* and *rational* order, and discourses of agency into the lower categories of *exploration, technique, deliberation,* and *distancing.* An additional discourse of *neutral interaction* was identified as a bridging discourse that was activated to level tensions created by the ambiguity and conflicted goals of other discourses. All of these discourses appear in the data,

yet in different variations. I assume this variation to reflect the heterogeneous backgrounds of the interviewees, as well as the diverse institutional microcultures of the hospitals.

When presenting analysis, I include data samples selected from the interview data. It should be noted that the method of critical discourse analysis does not present any systematic approach to selecting data samples—I have simply chosen them based on my own considerations. The role of quotations is to illustrate how the discourse appears in everyday language, and thus, the quotes demonstrate how the findings of this study are grounded in everyday life. The illustrating data samples also attempt to prompt the imaginations of readers, to identify similar ways of making sense of CEC in their own experiences.

In choosing the quotations, I have paid attention to selecting easily understandable statements that follow the logic of the identified discourses. This is not to claim these exact quotations would be any better than other possible quotations, only that I have chosen them because they illustrate the ways in which the discourses identified here appear in everyday talk. Some of the quoted statements include ellipses to improve their clarity. To offer good examples of the discourses in a nutshell, I have deleted some parts of the quotations—such as repetition, listings of who was present and where, or other details—that do not add essential value to illustrating the inner logic of the discourses I present.

Working Toward Order

The discursive category of order points to the objectives of the professional domain, that is, the questions relating to what is being pursued with CEC. In general, the rationale for CEC was identified in this study as an attempt to create order in the gray areas of healthcare in which uncertainty is unavoidable. These gray areas are the typically invisible links through which the social realities of medical care meets philosophy: How to define what is right? Whose point of view counts? Why? In the interviews, this elusive world of uncertainty represents something that inescapably "bubbles up." I have interpreted these "bubbles" to represent the occasions in which a rupture is suddenly and unexpectedly confronted in the established social order—and when order is ruptured, disorder emerges. Without disorder, the goal of order would remain empty; the realm of CEC becomes meaningful only when disorder bubbles up, for example:

> We don't often even notice the questions of ethics until they're, I'm gonna call it a bump in the road. The bump in the road is about uncertainty, or it's about conflict. [Interviewee 7]

I have identified three kinds of discourses of order to define CEC practice: managerial, emotional, and rational order. These discourses of order respond to different kinds of constructions of disorder.

Managerial order. A modern hospital is a complex institution that has to be managed socially and economically—otherwise it will not function. A clinical ethics consultant is typically hired by the hospital and held accountable for CEC. Therefore it is only natural that at least part of the CEC work is shaped by demands or aspirations to participate in managing the life in the hospital. For example, the avoidance of lawsuits, with the help of CEC, in order to benefit the hospital is mentioned frequently in the interview data. From this point of view, CEC becomes legitimized and meaningful by serving the managerial order of the hospital. It functions as a mechanism to ease conflicts that may be at risk of becoming detrimental to the hospital organization:

> Ethicists can really help to try to listen to each party but then find a solution that's towards the middle that all parties can live with. [. . .] Ultimately when it's not possible, and you have an intractable dispute, that's often when it goes into the legal realm. So that's, that's obviously what we want to avoid. [Interviewee 11]

In this data sample, the "ethics realm" and the "legal realm" appear as if placed on a continuum that is defined by the troublesomeness of the dispute. Avoiding conflicts that lead to the legal realm is presented as something that it is "obvious" to want to avoid. The ethicist is, thus, implicitly positioned as an agent who can level disputes as a way of keeping the hospital organization out of legal trouble. In the following sample, ethics consultation also appears as something that can be considered useful in and by itself for the potential legal process:

> A lot of times when they [physicians and nurses] are feeling worried about being sued they consult, because they wanna have an ethical note in the record. [Interviewee 3]

In this data sample, ethics consultation is represented as a "note in the record," which implies that CEC can have strategic significance that cannot be reduced simply to the results of a consultation—and that this strategic piece of influence fits the interests of defending hospital staff, should they be sued. In such subtle ways, the ethics consultant is positioned into playing a strategic role in sustain-

ing the managerial order of the hospital organization.

Emotional order. In the interviews, many descriptions emerged in which the role of the ethics consultant was defined as that of supporting healthcare staff in ways that could loosely be placed under the category of "emotional." Based on these descriptions, I have identified the discourse of emotional order, by which I refer to the ethics consultant's role in the management of the emotional landscape of the hospital. For example, CEC is repeatedly defined as a pursuit to ease distress, in which the consultant is positioned as a competent agent to achieve this end:

> I feel a strong desire to assist the doctors and the nurses because they do experience a lot of distress about some of these cases [. . .] I feel a desire to help them cope with that so they can continue doing the amazing work that they do and not get overcome with feelings of, just, um, discouragement or moral distress. [. . .] When we do our rounds and are checking with them, it sort of gives them an opportunity to express their, their feelings and kind of vent about, cases where they feel very conflicted. [Interviewee 11]

In this discourse, the emotional realm of hospital working life is produced as a potential source of disorder—even so much that without the ethicists, the healthcare providers are portrayed as possibly not capable of continuing to do their work. Thus, interventions—such as ethics rounds—to restore function and order in the emotional landscape enter the agenda of the clinical ethicist. This points to the implicit assumption that the healthcare work domain is not "only work" in a detached rational sense, but rather involves deep psychological absorption and emotional commitment on the part of the healthcare providers. Emotional life crosses the lines between "work selves" and "private selves." The role of the ethicist in this order is to act as a mediator, a "vent" through which the emotions can come out safely without disrupting the social balance and order of hospital work life. This discourse thus positions the ethicist as a resource of staff support. At the same time, it should be noted that while an ethicist could potentially also be presented as an agent of alleviating patients' distress in the same way, this goal did, interestingly, not appear very clearly in my data. As a consequence, this role may potentially position ethicists into a role with understandable, built-in tensions if they are implicitly expected to solely support the staff in disputes with patients when difficult decisions are being made.

Rational order. In the discourse I have named rational order, the ethics consultant is represented as having the ability to provide rational models to support and sustain best ethical practices in everyday hospital life. In this discourse, identifying ethically problematic areas, as well transforming them into rational systematic policies, methods, and actions, appears on the agenda of the ethics consultant. This approach presupposes that social life in the hospital conceals many unanswered and difficult ethical questions; the ethics consultant is positioned to be on an exploration to expose such challenges as well as to offer intelligible solutions and education concerning them:

> I would say that we do a lot more preventive ethics work, with our educational seminars, through identifying very common types of issues [. . .]. So we do a lot of education, we have lately been working on developing [. . .] our ethics resources [. . .] sort of quick-and-dirty ways to, to think about, those kinds of things. [Interviewee 1]

With the same logic of presenting ethicists as agents of rational thinking, they are defined as "ethics translators," persons who can interpret vague feelings and qualms and convert them into the intellectual language of ethics. Through this translation work, such ambiguous experiences become reframed, and thus, ordered by rational thought. This rational language offers a solid ground to face and deconstruct issues in the gray areas where uncertainty, ambiguous emotions, and conflicts abide:

> It can be a pretty simple case but you can pinpoint two or three ethical issues, you kind of see that light bulb go on where they'll go, oh wow, I never thought of it like that. [. . .] You can see people go, oh so that's what the ethics concern is. They know something is not right, but they, they might not know to label it as an ethical concern. [Interviewee 4]

As "ethics translators," ethics consultants appear as knowledgeable and practical professionals with the capacity to untangle the social and emotional knots bubbling out of everyday interaction. Thus, consultants are not distant experts available only for resolving ethically complex patient cases or in their ivory tower writing policy recommendations, but rather grass-root-level intermediators who can identify difficult and contentious issues in everyday life and then bring them to a higher level of abstraction, in which recreating order becomes possible by developing and utilizing systematic eluci-

dations and solutions. This role then positions ethicists between the practical and the abstract. An implicit assumption defining this role appears to be a characteristic enlightenment narrative. Turning ambiguous everyday life into rational concepts can "give light" and help in the ordering of everyday action—while the alternative is darkness:

> So that there can be standards, so that there's not relativism, so that we use the literature to tell us, you know, what, what does this look like, or else we are sort of, just feeling in the dark. [Interviewee 1]

Professional Agency

If order refers to what CEC as a professional practice aims to accomplish, agency correspondingly refers to the types of discourse that shape the means of how order can be pursued. I have identified four discourses of professional agency: technique, exploration, deliberation, and distancing.

Working by technique. The discourse of agency as a technique is best defined by the metaphor of a tool box. It points to practical elements that can be taught and learned as well as transferred from one situation to another. Such practical tools are, for example, understanding ethical principles as well as the cultural and legal contexts, and the tools of managing communicational interaction by the mastering of mediation and facilitation skills:

> If you think of ethics consultation as having a tool kit, then, mediation is the huge wrench, and those skills can be learned through mediation programs. [Interviewee 7]

The discourse of technique creates agency and offers professional legitimation for CEC, based on the mastery of needed skills. As a consequence, technique binds clinical ethical reasoning into an expert territory, where learnt conceptual reasoning and skills pave the way for CEC practice:

> So I'd say that I bring, personally, having trained, in multiple ways, that I, I'm balancing three different strains of thought. One is the principles, autonomy, beneficence, nonmaleficence and, and justice and fairness of thinking about a process. The second is virtues, taking up virtues and vices and realizing that, conflict can bring out the worst of people, um, but it can also inspire people to bring out their best. [. . .] And then the um, part of that also is, I'd say, part of that psycho-social-spiritual model, because we recognize that there are, deep social needs, and spiritual needs, that might need to be attended. [Interviewee 9]

In this data sample, the ethicist portrays expertise as flowing out of balancing abstract strains of thought that require specific ethics training. In this discourse, both the ability to provide ethics consultation, as well as the right to merit legitimation for it, are located in what seems like a relatively fixed range of technical requirements for the consultant to master.

CEC as exploration. Unlike the technique of agency, the technique of exploration starts from a presumption that not all problems can be solved with the available technical solutions and models. Thus, when viewing the role of the ethics consultant within the discourse of exploration, reality appears to be more complex than was implied by the technique of agency. Rather than leaning only on technical skills, the world is explored with an open mind, which can lead to unexpected discoveries. This exploration starts from the assumption that ethicists set out to find out something they do not yet know. The discourse of ethicists as explorers abandons the idea that ethicists can have answers and solutions ready in their tool box at a given time, or that those could be taught or mastered in an impervious sort of way. Exploration thus emphasizes that solutions must be actively sought, and creates discursive space for real uncertainty, which the technique may render invisible by presuming that consultants can grasp any difficult situation by using their tool box:

> The case that haunts me. . . . [. . .] That was a case that I talked to about with people in London, who had been working with *déjà-vu* patients.[23] They also ended up, they said they hadn't had real success either, but we did try some of the directions that they had talked about. [Interviewee 8]

Exploration can also be invoked by the notion of "keeping moral spaces open":[24]

> I just go up in the unit and I say, are you ethically quiet, versus medically quiet. [. . .] It's just a very neutral, nonjudgmental way of saying, are there any ethical issues in the horizon that you wanna talk about. [Interviewee 8]

> Something like ethics rounds certainly are not a requirement but I find them to be a very valuable resource, in quotes "keeping moral spaces open" and really engaging clinicians right at the frontlines where they're taking care of patients um, to um, support, um, their rational processes, um, of emotionally charged situations. [Interviewee 9]

In these examples, the ethics consultant explores with the caregivers what their potential concerns are, in order to establish a communicative climate in which the emotional and ethical domains of healthcare have room to be acknowledged. The latter example also shows how the categories of rational and emotional order are overlapping in the effort of offering constructing support for the healthcare staff.

Deliberation. In the agency discourse I call deliberation, the field of CEC becomes occupied not only by ethicists themselves, but a group of deliberators who aim to collectively construct and share decisions, as well as solutions. In this discourse, the agency to define the meanings and the limits of what is ethical is diversified, and the work of the ethicist is brought under collective scrutiny:

> Whenever we do an ethics consult and write a report, afterwards they [the ethics committee] have access to the report, and we have an open meeting where they've read the report ahead of time and they're able to ask questions about the process that we used, or um the reasoning that we used, or why we, why we didn't do a certain thing, so it's really an opportunity that holds us accountable as ethicists. [Interviewee 11]

The discourse of deliberation brings the scope of the CEC from the individual domain into the sphere of the collective. While the agencies of technique and exploration presuppose ethicists as individually competent professionals, capable of conducting worthy practice, the discourse of deliberation presupposes that CEC work is, by nature, political, or at least vulnerable to individual biases. This presupposition creates an orientation toward deliberation as a form of checks and balances for evaluating ethicists' work. Yet, tensions may rise in defining the borders of the individual and collective domains of practice: how to define the borderlines between what kinds of decisions or actions ought to be deliberated, and, on the other hand, when to rely on ethicists' individual expertise?

Distancing. The agency discourse that I call distancing refers to the construction of a strategic outsider position as an operational method that is available to ethics consultants. For ethics consultants, there is a potential to position oneself as detached from ongoing social interactions and silent normative frameworks. In distancing, ethics consultants are depicted as those who are wise enough to know what is "really going on," fully aware of the underlying implications present in a situation, and respected enough by others to express that knowledge.[25] This outsider position offers discursive space for ethics consultants that other participants are assumed to lack; for example, in the following example, distancing allows the ethicist to break and reframe the social order in a situation by "stating the obvious":

> One thing that I find helpful is to go ahead and state the obvious. Because, and I think of it as transparent communication, so when everyone's thinking . . . well, this person just doesn't value the other person's idea, that needs to be out on the table. So I will frequently be the person that says you know, maybe I am instigating here, but are you trying to say that you don't respect their beliefs. [Interviewee 4]

In this example, the interviewee implicitly positions the ethicist as an outsider who is not constrained by the social order of the situation in which "the obvious" cannot be stated by others who are entangled in the interaction. Distancing from this social framework grants the ethicist the discursive space to state the obvious. This reframes the situation by enhancing transparency in the attitudes and social positions of the participants.

The strategic positioning of an ethicist as an outsider interventionist can also create social order in and by itself, as the following example demonstrates:

> And the other thing is when they have meetings, they . . . will kind of bark at each other, but the minute you have a, a sort of a neutral person coming in, everybody behaves themselves. It's just like a family. [Interviewee 8]

Distancing can thus serve as a valuable strategy for interventions both by explicitly intervening in the interaction order (first example) and implicitly by virtue of being an outsider (second example), as it offers ways to reframe social situations. Both implicitly and explicitly positioning oneself as an outsider thus holds functional potential for the ethicist to use positioning as a way of untangling conflict and reframing communication.

Neutral Interaction as a Bridging Discourse

The discourses identified in this study deconstruct the social constructions shaping CEC as a professional practice in order to make sense of the different discursive positions available for ethicists in their professional role. These positions assume different expectations: depending on whether ethicists position themselves as a strategic piece of sustaining managerial order, an emotional resource for staff,

or an agent of "giving light" through processes of rationalizing everyday events, the goals they will pursue will likely be different. Furthermore, expertise and deliberation as starting points for agency hold different ideological foundations: while deliberation places moral understanding under the collective domain, the technique presumes that specific education can provide a legitimate base for CEC. Depending on the many aspects of the case at hand, these goals and presumptions embedded in the professional discursive landscape may present conflicting implications. How do ethicists navigate between different goals and agencies? What kinds of goals and means should they prioritize, in what situations, and why? Asking such questions explicitly renders the built-in tensions between the different goals of the professional domain visible.

I have identified the discourse of neutral interaction as a bridging discourse that has the potential to alleviate tensions that arise when ethicists need to navigate between the different kinds of order and agency. In the following example, tension can be detected between the agency through which the ethicist appears as an individual expert, and the collective agency of deliberation. This tension in expectations is soothed by the claim that CEC is merely a neutral, consensus building process:

> I think our service is very widely accepted here, but one reason may be that we, we don't walk into the situation and say, well we're the experts we'll just tell you what to do, you know it's a more of a consensus building process. [Interviewee 10]

In this example, entering a situation and claiming expertise is portrayed as clearly negative. The neutral process of consensus building legitimizes the ethicist's entrance into a situation as acceptable by describing the intervention of the ethicist in terms of pure *interaction,* however, it renders the *moral-political domain* of the ethicist's work invisible. It also leaves unanswered whether "ethics" implies "consensus." Yet what this discourse clearly does do is position ethics consultants as experts in enhancing interactions:

> So, when I ask for a cardiac consult, I get a cardiologist who will evaluate like, the patient's heart function and tell me what I should do about it. [. . .] That's not how ethics consultation works. The expertise isn't in the answer, really, the expertise is in the process. [Interviewee 7]

In my data, the enhancement of interaction repeatedly appears as a justifiable and defensible product of CEC, whereas the concept of "ethics expertise" is seen as questionable. My understanding is that if the implicit moral-political domain in which ethicists operate cannot be explicitly discussed and brought to light in the same way as the interactional domain, this indicates that an invisible struggle regarding the definition, limits, and legitimization of CEC underlies my data in silent ways. Moreover, built-in tensions between the domains of order that the professional discourse constructs as significant can be alleviated by claiming neutral interaction. When only neutral interaction is at stake, ethics consultants do not have to face difficult questions as to whether they prioritize working as a strategic piece toward avoiding lawsuits (managerial order), as emotional support persons for staff (emotional order), or in pursuit of finding and entrenching the best ethical practices grounded in conscious exploration and rational reasoning (rational order). It also strategically leaves open the difficult and politically charged question of whose agents ethicists are:[26] whether they work in the interest of patients, the staff, or the hospital institution in general. Additionally, the discourse of neutral interaction eliminates markers of hierarchy and power asymmetry, which may have invisible consequences. Arguably, as overt markers of hierarchy become less evident, covert markers of power asymmetry may become more potent by making power asymmetry more subtle, rather than disappearing.[27]

DISCUSSION

This study describes the ways in which clinical ethics consultants play a part in sustaining different kinds of conceptions of order by taking on an intricate array of social positions in their hospital work field. These positions contain different kinds of meanings and expectations, as well as different agencies, placing ethicists into potentially conflicting and ambiguous social roles. Through the analytical deconstruction made in this study, some of the built-in and silent tension points created by these intersecting demands have been made visible. Such tension points are built-in because they lie in-between the ideologies that the different discourses represent, such as in tensions between individual versus collective forms of agency, or the different conceptions of order. In some of the tension points, the discourse of neutral interaction can be invoked to defend and legitimize CEC practice: by claiming CEC practice is simply about neutral communication, the built-in tensions as well as the pressures created by outside demands can be alleviated. By

this perception I do not mean to claim that CEC was not about neutral communication by nature, as the data show no proof to make such an argument. Rather, I merely bring out the observation that neutral communication, as a discursive strategy, can serve as a bridge between the inner tensions that emerge from the ambiguous positions that ethicists take on, as well as from the social realities of the struggle in which they navigate. It should also be noted that it is possible that this bridging effect may hide some tension points from further scrutiny.

As a consequence of the analysis made, the question arises as to what is the first and foremost aspiration defining the practice of CEC—should ethicists put the most weight on enhancing managerial, emotional, or rational order in their work? In this study, I have not made interpretations of the hierarchy of the different levels of order—yet, clearly, in reality, ethics consultants must move flexibly between these conceptions of order, and likely, sometimes channel their energy into helping to recreate one kind of order and overlook another. While I do not make normative statements about what kind of order would be most preferred, I hope that the categorization made in this study can potentially help to conceptualize the choices that ethics consultants confront in their daily working life as they move between different professional aspirations—making the potentially conflicting demands and positions observable and concrete. Creating collective awareness and reflection about the ways in which ethicists navigate between different goals and agencies can also pave the way for the group, as a profession, to define clear normative statements about what kind of order would be regarded as highest in priority, should the varying orders clash.

Given that for practical reasons the interviews were made in only one urban area, it should be acknowledged as a limitation of this study that the data may reflect a local culture, and it is likely that the results would not be the same elsewhere. Yet I do not hold this limitation to be a restriction of a study of this kind, in which the purpose of identifying some discursive practices that construct the professional vision—not all of them—is to serve a larger goal: the stirring up of imagination that gives fuel to further reflection and discussion by bringing explicit attention to the discursive nature of the professional domain. For this same reason, I do not view the relatively small data sample as an obstacle, but rather as an opportunity to offer the researcher the possibility to read the data more closely. Hence I believe the interpretation of this data makes up in idiographic depth what it may lack in volume. Moreover, the 11 interviews show clear repetition of the central themes and ideas that I have identified in my interpretation, which points to data saturation.

When considering the limitations of this study, it should be noted that while this study has demonstrated that the field of CEC conceals a multifaceted canvas of available constructions of order and agency, it does not reveal in what ways these agencies and conceptions of order are actually experienced in ethics consultants' everyday work. Interview data do not reach the ways in which this practice is situated, and the data do not answer in what ways the categories I have listed in this study may directly or indirectly connect to everyday practice.[28] Additionally, the discourses identified in this study naturally do not reflect all of the possible ways of reasoning and understanding surrounding the professional culture of CEC. Rather, the study delves into analyzing those ways that are most clearly represented in limited data. For example, as the perspectives of patients do not appear in the data, I was not able to analyze the practice of CEC in this regard. Moreover, as I have deliberately chosen to study CEC as a professional practice, rather than, for example, as a lay movement,[29] implicit limits have been set as to what can be discovered. Yet, what this study does offer is the development of a systematic categorization of some of the ways that knowledge and perception are framed by discourses of order and agency in the practice of CEC. This categorization can provide a framework that can help CEC professionals, as well as the professional group at large, to reflect on their daily professional experiences, methods and aspirations, while identifying possible points of built-in tension. This categorization can also offer baseline conceptualizations that are potentially useful for the kind of ethnographic research that could further capture the implicit realities of everyday working life—only research of this kind could ultimately expose the ways in which the categories I have identified are translated into action.

To summarize, my perception is that the field of CEC could best be characterized by the notions of fluidity and struggle. A clinical ethics consultant must adapt to be able to fluidity move between the different categories of order, as well as to adapt to different models of agency situationally. Struggle, on the other hand, is the lifeblood of CEC, as it is a field that provides guidance for difficult situations of conflict and other social ruptures. Further, CEC not only faces struggle on the outside, but also on the inside, as its meanings and methods are under constant negotiation. Thus, clinical ethics consult-

ants must learn to live with uncertainty and fluidity in many overlapping ways. While the idea that the social world consists of many areas in which struggle, competing values, and intersecting ideologies abide should come as no surprise to ethics consultants, it is a question of its own whether the field is able to tolerate such pluralism in its own ranks—a question that, at least implicitly, is currently being confronted within the professionalization debate. My hope is only that, in this dispute, CEC professionals exercise endurance in tolerating the struggle, fluidity, and uncertainties they already confront in their daily work.

HUMAN RESEARCH INFORMATION

This article is part of a doctoral thesis that explores different ways of dealing with ethically sensitive issues in healthcare environments, with a central focus on the Finnish healthcare system. The thesis, as a whole, was evaluated by the University of Eastern Finland Committee Research Ethics in June 2014.

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CONFLICTS OF INTEREST

The author has no conflicts of interest to report.

NOTES

1. J.A. Tulsky and E. Fox, "Evaluating Ethics Consultation: Framing the Questions," *The Journal of Clinical Ethics* 7, no. 2 (Summer 1996): 109-15, 112.

2. Regarding the professionalization efforts by the American Society for Bioethics and Humanities, see K. Kipnis, "The Certified Ethics Consultant," *HEC Forum* 21, no. 30 (2009): 249-61.

3. The debate is briefly acknowledged in A.J. Tarzian, "A Code of Ethics for Healthcare Ethics Consultants: Journey to the Present and Implications of the Field," *American Journal of Bioethics* 15, no. 5 (2015): 38-51, 38.

4. "Conflict and struggle around who shall be included or excluded mark the process of internal unification of a profession." L.M. Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley, Calif.: University of California Press, 1971), xii.

5. C. Goodwin, "Professional vision," *American Anthropologist* 96, no. 3 (1994): 606-33, 628.

6. Ibid., 606.

7. Ibid.

8. B. Dicicco-Bloom and B.F. Crabtree, "The qualitative research interview," *Medical Education* 40, no. 4 (2006): 314-21, 317.

9. C. Tinker and N. Armstrong, "From the Outside Looking In: How an Awareness of Difference Can Benefit the Qualitative Research Process," *Qualitative Report* 13, no. 1 (2008): 53-60.

10. E. Freidson, *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (Chicago: University of Chicago Press, 1986).

11. E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, 2nd ed. (Chicago,: University of Chicago Press, 1988).

12. American Society for Bioethics and Humanities, *Core Competencies for Healthcare Ethics Consultation,* 2nd ed. (Glenview, Ill.: ASBH, 2011), 3.

13. Social constructionism is a theory of knowledge in social sciences that presupposes that everything that passes for knowledge in society is constituted through social processes in which certain ways of knowing become understood as "common sense." The empirical research in this tradition presumes that the established ways of conceptualizing the truth can be uncovered and brought under critical scrutiny through qualitative inquiry. See P. Berger and T. Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (New York: Penguin Books, 1966); see also V. Burr, *Social Constructionism* (Abingdon-on-Thames, U.K.: Routledge, 1995).

14. About how discourse shapes professions and their legitimation, see S. Sarangi and C. Roberts, "The Dynamics of Interactional and Institutional Order in Work-Related Settings," in *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management* Settings (Berlin: Mouton de Gryter, 1999), 1-57.

15. A dialectical perspective to discourse presumes that while discourses have structural ideological influence, they are also always under struggle, and thus, hegemonic knowledge structures manifest only a temporary, partial, and contradictory fixity. N. Fairclough, *Discourse and Social Change* (Cambridge, U.K.: Polity Press, 1992), 66.

16. Ibid.; N. Fairclough, *Language and Power,* 2nd ed. (Harlow, U.K.: Longman, 2001); J. Blommaert and C. Bulcaen, "Critical Discourse Analysis," *Annual Review of Anthropology* 29 (2000): 447-66.

17. Fairclough, *Discourse and Social Change,* see note 15 above, p. 9.

18. N. Phillips and C. Hardy, *Discourse Analysis: Investigating Processes of Social Construction* (Thousand Oaks, Calif.: Sage, 2002), 2.

19. Ibid.

20. Fairclough, *Language and Power,* see note 16 above; T.A. Van Dijk, *Prejudice in Discourse* (Amsterdam: John Benjamins, 1984).

21. Fairclough, *Discourse and Social Change,* see note

15 above, p. 9.

22. G. McCracken, *The Long Interview* (London: Sage, 1988), 16-7.

23. The interviewee refers to a patient who post-operationally developed a nonstop feeling of *déjà-vu*—whatever he did or saw, he always felt that he had experienced it before. The feeling drove the patient crazy, and as morphine seemed to be the only way to quiet his symptoms, difficult ethical questions arose.

24. Quoting M.U. Walker, "Keeping Moral Space Open: New Images of Ethics Consulting," *Hastings Center Report* 23, no. 2 (1993): 33-40.

25. Compare to similar observation in professional engineering culture made by G. Kunda, *Engineering Culture: Control and Commitment in a High-Tech Corporation* (Philadelphia: Temple University Press, 1992), 178.

26. About the ambiguity in defining whose agent the clinical ethics consultant is, see S. Latham, "Professionalization of Clinical Ethics Consultation: Defining down the Code," *American Journal of Bioethics* 15, no. 5 (2015): 54-6.

27. About subtle power asymmetry in institutional discourse, see Fairclough, *Discourse and Social Change,* see note 15 above, pp. 202-4.

28. See S. Sarangi, "The Conditions and Consequences of Professional Discourse Studies," *Journal of Applied Linguistics* 2, no. 3 (2005): 371-94.

29. About clinical ethics consultation as a lay movement, for example, see D. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991); and A. Dzur, *Democratic Professionalism: Citizen Participation and the Reconstruction of Professional Ethics* (University Park, Pa.: Penn State University Press, 2008): 207-43.