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# Defining Patient Advocacy for the Context of Clinical Ethics Consultation: A Review of the Literature and Recommendations for Consultants

*Tracy Brazg, Taryn Lindhorst, Denise Dudzinski,  
and Benjamin Wilfond*

## ABSTRACT

The idea of patient advocacy as a function of clinical ethics consultation (CEC) has been debated in the bioethics literature. In particular, opinion is divided as to whether patient advocacy inherently is in conflict with the other duties of the ethics consultant, especially that of impartial mediator. The debate is complicated, however, because patient advocacy is not uniformly conceptualized. This article examines two literatures that are crucial to understanding patient advocacy in the context of bioethical deliberations: the CEC literature and the literature on advocacy in the social work profession. A review of this literature identifies four distinct approaches to patient advocacy that are relevant to CEC: (1) the best interest approach, (2) the patient rights approach, (3) the representational approach, and (4) the empowerment approach. After providing a clearer understanding of the varied meanings of patient advocacy in the context of CEC, we assert that patient advocacy is not inherently inconsistent with the function of the

ethics consultant and the CEC process. Finally, we provide a framework to help consultants determine if they should adopt an advocacy role.

Clinical ethics consultation (CEC) is a service provided in response to questions from patients, families, guardians, caregivers, and clinicians to "resolve uncertainty or conflict regarding value-laden concerns that emerge in health care."<sup>1</sup> The main goal of consultation is to strengthen the quality of care through the identification, analysis, and resolution of ethical questions.<sup>2</sup> In its ideal form, CEC is characterized as promoting a democratic process in which all perspectives are heard and considered.

There are various aspects of the medical encounter that can result in power differentials that affect the ability of patients and their family members to engage as equals with caregivers and clinicians dur-

**Tracy Brazg, MSW, MPH, MA**, is a PhD Candidate at the University of Washington School of Social Work, and is a Clinical Bioethics Fellow at the Treuman Katz Center for Pediatric Bioethics in Seattle. [tbrazg@uw.edu](mailto:tbrazg@uw.edu)

**Taryn Lindhorst, PhD, LCSW**, is the Carol LaMare Associate Professor of Social Work at the University of Washington. [tarynlin@uw.edu](mailto:tarynlin@uw.edu)

**Denise Dudzinski, PhD, MTS**, is a Professor in and Chair of the Department of Bioethics and Humanities at the University of Washington, and is Chief of the University of Washington Medicine Ethics Consultation Service. [dudzin@uw.edu](mailto:dudzin@uw.edu)

**Benjamin S. Wilfond, MD**, is the Director of the Treuman Katz Center for Pediatric Bioethics at the Seattle Children's Research Institute, is Professor in the Department of Pediatrics at the University of Washington School of Medicine, and is an Ethics Consultant at Seattle Children's Hospital. [benjamin.wilfond@seattlechildrens.org](mailto:benjamin.wilfond@seattlechildrens.org)

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ing the CEC process. Some of the sources of these imbalances include the medical knowledge, language, and expertise of the treatment team; the sometimes imperfectly aligned interests of patients and members of the medical team; and the physical and emotional stress of illness.<sup>3</sup> In addition, patients are more likely than healthcare providers to be excluded from the process of CEC.<sup>4</sup> And, when CEC is engaged, a lack of familiarity with the process can place patients at a disadvantage to clinicians who are experienced with the process, and who may have personal or professional relationships with ethics consultants.<sup>5</sup> When ethical conflicts arise, patients may find themselves in especially frightening, stressful, and confusing situations, which can increase the need for patient advocacy.<sup>6</sup> Without attention to balancing the perspectives and power dynamics inherent in ethics consultation, the circumstances described above can lead to prioritizing the perspectives and expertise of the treating clinicians, which implicitly influences consultants' "weighting" of stakeholders' perspectives.

The American Society of Bioethics and Humanities (ASBH) *Core Competencies for Healthcare Ethics Consultation* (here after, the *Core Competencies*) reflects an awareness of the unequal distribution of power and voice related to ethics consultation. The *Core Competencies* calls upon ethics consultants to take the necessary steps to "level the playing field"—that is, to help ensure that all parties involved, especially those who hold less power in the system, have equal opportunity to express their views.<sup>7</sup> The *Core Competencies* do not address how ethics consultants ought to "level the playing field" or what methods could accomplish such ends. Patient advocacy is one response to patients' experiences of vulnerability, and it can be utilized as a tool to improve patients' participation and engagement in their healthcare.<sup>8</sup> There is little agreement about the place of patient advocacy in the CEC process, and the concept has not been adequately defined in the bioethics literature.<sup>9</sup>

To date, the small body of literature devoted to patient advocacy in clinical bioethics comes primarily from the fields of nursing, philosophy, and medicine. Perspectives from social work, a profession predicated on a long-standing, foundational commitment to serving the most vulnerable members of society through case-based and community-based advocacy, are notably missing. Through a cross-disciplinary review of the bioethics and social work literature, this article aims to deepen the understanding of patient advocacy and its relevance to CEC. Implications for practice are discussed, in particu-

lar the roles and responsibilities of the ethics consultant vis-à-vis patient advocacy.

#### FOUR APPROACHES TO PATIENT ADVOCACY

To locate relevant literature in the fields of bioethics and social work, we conducted a literature review spanning 20 years (1993 to 2013), using three major health databases: PubMed, EBSCO, and ProQuest. Search terms included iterations of the following: patient advocacy, advocacy, ethics, professional role, ethics consultation, ethics committees, and ethical decision making. Social workbooks were also reviewed. A total of 23 bioethics articles, 11 social work articles, and five social work textbooks were included. A complete list of all articles and texts utilized is available from the first author. Analysis of the texts was guided by the qualitative method of content analysis, which provides a guide for the systematic classification process of coding and identifying themes or patterns.<sup>10</sup>

Our analysis of the literature identified four approaches to patient advocacy that are relevant to ethical decision making and CEC: (1) the best interest approach, (2) the patient rights approach, (3) the representational approach, and (4) the empowerment approach. These approaches to advocacy are relevant for different types of ethical dilemmas that involve a range of patients, and each entails a distinct perspective on how an advocate might engage with, support, or plead on behalf of a patient. In addition, the approaches to advocacy described in the literature represent a continuum of patients' involvement, thus interacting differently with the call to ensure that all parties "have the equal opportunity to express their views."<sup>11</sup> The brief case descriptions provided in table 1 describe the ways in which ethics consultants can appropriately become involved in various forms of patient advocacy during the CEC process.

#### 1. The Best Interest Approach to Advocacy

The concept of "best interest" holds a particular meaning in bioethics. The best interest standard, a widely relied upon framework for surrogate decision making, is invoked to protect an incompetent person's well-being by having a surrogate determine and make decisions based on the highest net benefit among the available options.<sup>12</sup> It is most commonly applied to situations in which a patient's relevant preferences cannot be known (for example, children, incompetent adults who do not have an advance directive), although this concept can also be applied when a patient has diminished, but not absent, ca-

capacity. When a patient is unable to participate or express a preference (for example, due to age or decisional capacity), a surrogate's understanding of the patient's interests becomes a central element of the ethical deliberation. In these situations, the surrogate acts as a dedicated advocate for the patient, making decisions that are in the patient's best interest.

The best interest approach to advocacy is based on the values and assumptions underlying the well-known best interest standard.<sup>13</sup> For example, in their analysis of patient advocacy, Nelson and Bosek describe the "respect for persons or best interests model" as the model that aims to protect the values held by a patient who is not able to participate in decision making.<sup>14</sup> An advocate in this instance is permitted to act independently to identify, define, and promote a patient's best interest. While the social work literature also describes the concept of best interest advocacy,<sup>15</sup> there tends to be a more critical account of this approach.<sup>16</sup> For example, Moxley and Freddolino state that even when interacting with a patient who has limited mental capacity, it can be beneficial to recognize and legitimize the patient's definitions of his or her own preferences and desires.<sup>17</sup> The stance that patients with limited cognition can participate in decisions surrounding their care may serve as a corrective to the paternalistic tendencies of best interest advocacy.

Attention to paternalism is relevant to the goals of CEC, which aims to facilitate the resolution of conflicts in a respectful atmosphere with attention to the rights, interests, and responsibilities of all involved parties.<sup>18</sup> Nonetheless, there are certainly circumstances when vulnerable and voiceless patients can benefit from a best interest advocate during the CEC process. In fact, we argue that ethics consultants sometimes act as best interest advocates for vulnerable and voiceless patients—for example, when a parent refuses lifesaving treatment for a child who has a good chance of recovery. In analyzing the benefits and burdens of each potential decision, a consultant may be called upon to promote, defend, and advocate a position that prioritizes the child's best interest.

## 2. The Patients' Rights Approach

A number of bioethics and social work texts appeal to rights in the discussion of patient advocacy. In the social work literature, a patients' rights approach to advocacy rests on the idea of citizenship—that, regardless of one's capacity, all people should be accorded rights and treated as equals.<sup>19</sup> Wilks described a "rights based approach" to advocacy, in which an advocate ensures that the

basic human rights of the patient are promoted and defended.<sup>20</sup> In the bioethics literature, the idea of rights is more often accompanied by the commitment to protect patients' rights.<sup>21</sup> Using the terms "promote," "defend," and "protect," both bodies of literature suggest that patients' rights advocacy is employed when rights have been breached, and an advocate may be needed to draw attention to and ameliorate the breach.

We distinguish the differences between the best interest and patients' rights approaches to patient advocacy. Rights are considered to be the claims of an individual, while interests are more closely tied to making decisions that advantage or advance the life of an individual. Rights and interests are sometimes connected. Protecting a patient's rights is often in the best interest of the patient, so, in some circumstances, either or both approaches to advocacy could be applied. In other instances it is the patient's rights that must be the focus, regardless of whether a decision will advance the life of an individual or be to the individual's advantage. For example, in a situation when a surrogate attempts to override a patient's previously stated preference for withdrawal of life-sustaining therapy, a patients' rights approach to advocacy ensures that the patient does not lose her or his rights as an autonomous individual, despite the loss of the ability to participate in decision making.

## 3. The Representational Approach

Most articles across both bodies of literature suggest definitions of advocacy that are relevant to patients who have the capacity to advocate for themselves, but who are without sufficient power or influence to do so effectively. When patients are able to articulate their treatment preferences/perspectives, the representational approach suggests that it is the advocate's role to ensure that patients' wishes and interests are represented to those who most need to hear them. Implied in this description of advocacy is the understanding that prior to representing, supporting, or pursuing patients' interests, advocates must gather information directly from patients about their wishes or preferences. This is different from the approaches to advocacy described above (best interest and patients' rights), which give advocates the power to determine, on behalf of patients, what ought to be advocated.

Descriptions of the representational approach to advocacy are similar across the two bodies of literature, although the social work literature places more emphasis on the relationship between the autonomous patient and the advocate as central to the rep-

representational approach. For example, Schneider and Lester—who describe an advocate as someone who represents a client—are explicit that advocacy involves a relationship with an individual patient.<sup>22</sup> Wilks describes a “person-centered approach” to advocacy, which places the relationship between the advocate and the service user at the center of the advocacy process, ensuring that patients are involved in decision-making processes that call for advocacy.<sup>23</sup> With the relationship between the advocate and the patient as central, representational advocacy in ethically complex situations includes presenting a client’s point of view; acting as a liaison between patients, their families, and the medical team; ensuring that relevant information from the patient is not ignored; supporting the patient’s autonomy or right to make decisions; and providing support for the patient who may feel alienated from the institution.<sup>24</sup>

The representational approach fits with the non-controversial advocacy role that ethics consultants sometimes play. It is appropriately employed in the following two situations: (1) when patients are able to express their “side of the story” but are not included in the process of ethical deliberation, or (2) when patients are present during an ethics consultation, but have difficulty expressing their “side of the story,” due to a language barrier, limited literacy, lack of verbal skill, severity of illness, lack of education, or other factors. In such instances, it is reasonable for an ethics consultant to translate and represent the patient’s interests in language and context familiar to clinicians—to step in as a patient advocate who works to ensure that the patient’s interest/story is given the attention it deserves during the deliberative process. In fact, representing views in ethics consultation is a core responsibility of consultants that is stated in the *ASBH Core Competencies*—consultants are required to “represent the views of the involved parties to others” and “enable involved parties to communicate effectively and be heard by other parties.”<sup>25</sup> While we do not dispute that a consultant’s role is to help represent all sides, when patients have difficulty voicing their perspective, a consultant ought to act as a representational advocate on behalf of patients so that an essential perspective is not demoted or eclipsed.

### **The Empowerment Approach**

The *ASBH Core Competencies* also require that “fair, inclusive, and transparent discussion take place that empowers the voices of all stakeholders.”<sup>26</sup> Empowerment is enabling people to speak for themselves so that they may play a part in the

construction of their own lives and destinies.<sup>27</sup> Given the intent to hear from all sides of a conflict, empowering stakeholders to speak for themselves might be considered the preferred approach in CEC. Only one bioethics text, however, which was written from the standpoint of feminist ethics, mentions the empowerment of patients as a possible element of patient advocacy in CEC.<sup>28</sup> In contrast, empowerment is a central element in social work practice and the profession’s understanding of patient advocacy. To this point, the National Association of Social Workers describes 20 standards for social work practice in healthcare settings. “Empowerment and advocacy” are combined in one standard, indicating the two concepts are connected and rely on each other.<sup>29</sup>

The empowerment approach to advocacy aims to increase a patient’s sense of agency in her or his life and to help a patient feel more confident and able to express choices.<sup>30</sup> Advocating through the empowerment approach might involve encouraging patients to ask their own questions<sup>31</sup> or taking a more active role in giving suggestions, coaching, and sharing information.<sup>32</sup> Practicing empowerment does not require that a patient have full decisional capacity.

An empowerment approach to patient advocacy in CEC is appropriate when patients are able to speak “their side of the story” but do not feel comfortable doing so. Examples of such circumstances may include an adolescent whose parents have made health decisions for him throughout his life; or a woman who is not allowed to express her desires by other members of her family. In such circumstances of empowerment, advocacy could mean encouraging the adolescent to share his preferences for treatment, or providing space for the woman who is silenced by her family to speak about her preferences, interests, and values. The approach requires advocates to support and encourage patients who are involved in ethics consultations to ask questions and participate fully. Regardless of the tactic for empowerment, patients, and their expertise and agency, are the center of the empowerment approach to advocacy. By helping patients to speak for themselves whenever possible, patients’ perspectives can be central to the CEC process.

### **RECOMMENDATIONS FOR THE PRACTICE OF CEC**

Along with better articulating the four approaches to patient advocacy in CEC, we describe the practical implications of patient advocacy for ethics consultants. Below are three recommendations for consultants.

**TABLE 1.** Four approaches to patient advocacy for CEC

Approach and citations	Role of patient advocate/role of patient	Examples of appropriate patient advocacy by ethics consultants
<p><b>Best interest:</b> Aims to protect the interests held by a patient who is not able to participate in decision making.<sup>1</sup></p>	<p>Advocate is permitted to act independently of patient to identify, define, and promote what the advocate believes is in the best interest of the patient.</p>	<p>Case Example: A parent refuses life saving treatment for a child with a good chance of full recovery</p>
<p><b>Patients' rights:</b> Ensures that the patient's rights are recognized and protected.<sup>2</sup></p>	<p>Patient is not a participant in the CEC.</p> <p>Advocate permitted to act independently of patient because patient may be unable to express their own preferences (e.g., substituted judgment) or unable to recognize that their rights are being threatened.</p> <p>Patient may or may not be a participant in the CEC.</p>	<p>In analyzing benefits and burdens of each potential decision, a consultant may be called upon to promote, defend and advocate a position that prioritizes a child's best interest.</p> <p>Case Example: A surrogate attempts to override a patient's previously explicitly stated preference for withdrawal of life-sustaining therapy.</p> <p>Consultants can act as patient rights advocates by appealing to autonomy-based moral frameworks. This approach ensures that patients do not lose their rights as autonomous individuals, despite their loss of the ability to participate in decision making.</p>
<p><b>Representational approach:</b> Ensures that the patient's (and/or their surrogate's) wishes and interests are represented to those who most need to hear about them.<sup>3</sup></p>	<p>Relationship between patient and advocate is at the center of the advocacy process. The advocate:</p> <ul style="list-style-type: none"> <li>• represents the patient's point of view to the team</li> <li>• acts as a liaison between patients and the medical team</li> <li>• supports patients' autonomy or their right to make their own decisions</li> <li>• provides support for patients who may feel alienated from the institution</li> </ul> <p>Patient may or may not be a participant in the CEC.</p>	<p>Case Example: Interpersonal conflict between a patient and the medical team result in difficulties with medical decision-making. The medical team considers the patient "difficult" and the patient experiences difficulty voicing her perspective.</p>
<p><b>Empowerment approach:</b> Enables people to speak for themselves so that they may play a part in the construction of their own lives and destinies; aims to increase a patient's sense of power and agency.<sup>5</sup></p>	<p>Places the patient at the center of the advocacy process. The advocate:</p> <ul style="list-style-type: none"> <li>• encourages patients to ask their own questions</li> <li>• gives suggestions, shares necessary information</li> </ul> <p>Patient is able and encouraged to participate in the CEC.</p>	<p>Representing views in ethics consultation is a core responsibility stated in the ASBH <i>Core Competencies</i>—consultants are required to "represent the views of the involved parties to other" and "enable involved parties to communicate effectively and be heard by other parties."<sup>4</sup> While the role is to help represent all "sides", it is the patient who is having difficulty voicing their perspective, the consultant can (and ought to) act as a representational advocate on behalf of the patient during the consultation process.</p> <p>It is always appropriate for consultants to empower all parties to participate in the deliberative process. Given the power differentials that exist between patients and clinicians, it is often the patient who could use empowerment. However, empowerment-based advocacy can also be used to elicit unspoken voices on the medical team (e.g., residents, social workers, nurses, chaplains, etc.)</p>
<p>The ASBH <i>Core Competencies</i> require that "fair, inclusive and transparent discussion takes place that empowers the voices of all stakeholders."<sup>6</sup></p>		

TABLE 1., continued

NOTES

1. A. Fiester, "Mediation and Advocacy," *American Journal of Bioethics* 12, no. 8 (2012): 10-1; R.L. Pierce, "A Place for Ethics? A Place for Advocacy?" *American Journal of Bioethics* 12, no. 8 (2012): 17-8; K. Spence, "Ethical Advocacy Based on Caring: A Model for Neonatal and Paediatric Nurses," *Journal of Paediatric Child Health* 47, no. 9 (September 2011): 642-5; L. Monterosso et al., "The role of the neonatal intensive care nurse in decision-making: Advocacy, involvement in ethical decisions and communication," *International Journal of Nursing Practice* 11, no. 3 (2005): 108-17; K. Nelson and M.S. Bosek, "The Case of Ms. M: Should an Ethics Consultant Serve as a Patient Advocate?" *JONA's Healthcare Law, Ethics and Regulation* 5, no. 4 (December 2003): 77-81; L.K. Stell, "Clinical ethics and patient advocacy," *North Carolina Medical Journal* 70, no. 2 (2009): 131-5; W.L. Allen and R.E. Moseley, "Will the Last Health Care Professional to Forgo Patient Advocacy Please Call an Ethics Consultant?" *American Journal of Bioethics* 12, no. 8 (2012): 19-20; N. Bateman, *Advocacy Skills for Health and Social Care Professionals* (London, U.K.: J. Kingsley, 2000). J.A. Erlen, "Who Speaks for the Vulnerable?" *Orthopedic Nursing* 25, no. 2 (March-April 2006): 133-6; J. Boylan and J. Dalrymple, "Advocacy, Social Justice and Children's Rights," *Practice* 23, no. 1 (February 2011): 19-30; P.P. Freddolino, D.P. Moxley, and C.A. Hyduk, "A differential model of advocacy in social work practice," *Families in Society: The Journal of Contemporary Social Services* 85, no. 1 (2004): 119-28; D.P. Moxley and P.P. Freddolino, "Client-driven advocacy and psychiatric disability: A model for social work practice," *Journal of Sociology and Social Welfare* 21, no. 2 (1994): 91-108; T. Wilks, *Advocacy and Social Work Practice* (New York: McGraw Hill Open University Press, 2012).

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3. P. Norrie, "Ethical decision-making in intensive care: Are nurses suitable patient advocates?" *Intensive Critical Care Nursing* 13, no. 3 (1997): 167-169; Nelson and Bosek, "The Case of Ms. M.," see note 1 above; Spence, "Ethical Advocacy Based on Caring," see note 1 above; J.P. Spike, "Do Clinical Ethics Consultants Have a Fiduciary Responsibility to the Patient?" *American Journal of Bioethics* 12, no. 8 (2012): 13-5; S. Sherwin and F. Baylis, "The Feminist Health Care Ethics Consultant as Architect and Advocate," *Public Affairs Quarterly* 17, no. 2 (April 2003): 141-58; J. Zimelman, "Point and counterpoint: Should incompetent patients (and their families) be provided professional advocates for an HEC concurrent case review? YES," *HEC Forum* 6, no. 3 (1994): 170-2; K. Schroeter, "Ethics in perioperative practice—Patient advocacy," *Association of Operating Room Nurses Journal* 75, no. 5 (2002): 941-4, 949; Erlen, "Who Speaks for the Vulnerable?," see note 1 above; L.M. Rasmussen, "Advocacy Through a Prism: A Response to Commentaries on 'Patient Advocacy in Clinical Ethics Consultation,'" *American Journal of Bioethics* 12, no. 8 (2012): W1-3.; Stell, "Clinical ethics and patient advocacy," see note 1 above.

4. American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, Ill.: ASBH, 2011), 25.

5. Erlen, "Who Speaks for the Vulnerable?," see note 1 above; Nelson and Bosek, "The Case of Ms. M.," see note 1 above.

6. ASBH *Core Competencies*, see note 4 above, p. 9.

**Recommendation 1: Become Attuned to How Power Differentials Impact CEC**

Consultants are expected to understand how power differentials between patients, families, and clinicians can influence the representation or presentation of patient's interests, rights, and perspectives.<sup>33</sup> This requires reflexive practice and a willingness to become critically self-aware. For example, consultants must pay attention to issues arising from differences based on race, social class, education, degree of illness, and other factors that may inhibit a patient's ability or willingness to participate in the process of ethical deliberation. In addition, consultants must be acutely aware of whose voices and perspectives are (and are not) represented in the ethical deliberation process. When moving through the process of gathering information and facts about a case, consultants ought to ask themselves three questions:

1. Whose perspective is not present in this conversation?
2. Why is it not present?
3. Should it be?

These three questions function to recognize disparities in power and voice at the onset of an ethics consultation.

**Recommendation 2: Triage the Need for Patient Advocacy**

A primary role and responsibility of an ethics consultant is to ensure that patients (or their perspectives) are included in the deliberative process. Thus, recognizing the need for advocacy is already a central responsibility of the ethics consultant in some cases, and we should help consultants discern when advocacy is called for and who should provide it. Below is a list of questions that ethics consultants and healthcare providers involved in CEC can ask to help determine whether a patient is more likely to experience vulnerability, powerlessness, and the inability to participate in a democratic process of ethical deliberation:

1. Are the patient and the medical team in conflict?
2. Is the patient alone and without familial/community support or representation?
3. Does the patient have difficulties communicating preferences, because of limited proficiency in English, cultural differences, of limited cognition, or other factors?
4. Is the patient a member of a socially marginalized group or medically disenfranchised (that is, low socio-economic status, limited access to

resources, member of a historically oppressed racial or ethnic minority)?

If the answer to any of these questions is “yes,” another question should follow: Does the patient have a person who is dedicated to ensuring that the patient’s interests, rights, values, and preferences are presented and understood during ethical deliberation? If the patient already has a dedicated patient advocate in place (for example, a family member, a nurse, or a social worker who is explicitly involved to represent the patient), then the duty to ensure the patient’s voice is included is often fulfilled. If, however, there is no dedicated person who can be named as a patient advocate, or when a patient’s advocate seems to be at odds with the patient’s best interest, it will be important to designate an advocate to ensure that the process takes into account the patient’s perspective, preferences, interests, and rights.

### **Recommendation 3: Take Responsibility to Ensure the Patient’s Perspective is Articulated and Considered**

If no dedicated patient advocate is available, and the consultant recognizes that the patient’s perspective is under-represented or under-appreciated, the consultant ought to ensure that the patient’s perspective is articulated and considered in full. First and foremost, this requires seeking out another patient advocate who can step into the role, and inviting this person to participate in the CEC. For example, is there a family member who can be included in the deliberative process? A nurse who has stayed out of the conflict between the patient and the medical team? A social worker or patient navigator who has a close relationship with the patient or family? If no patient advocate is available, it is within the role and responsibility of the ethics consultant to adopt one of the four approaches to patient advocacy outlined in this article. In such circumstances, consultants need to state openly why they have assumed the role of advocate, and that they will no longer will be participating as a neutral facilitator.

### **CONCLUSION**

One outcome of CEC is to help address power imbalances of various kinds. For CEC to adequately achieve this goal, ethics consultants need to better articulate the tools that they have available to facilitate a “level playing field.” Patient advocacy, if better understood for the particular circumstances of CEC, is a tool that may result in better representation when power differentials affect whose views

are heard and how communication between conflicting parties occurs.

By delineating four approaches to patient advocacy, we have demonstrated that some of the standard roles and responsibilities of ethics consultants can be understood as patient advocacy. And while the ASBH *Core Competencies* do not explicitly discuss consultant’s roles vis-à-vis patient advocacy, our interpretation of the *Core Competencies* suggest that the role is not wholly incompatible with that of an ethics consultant. While patient advocacy is certainly not the primary function of an ethics consultant, it is sometimes an appropriate and even necessary role that helps to ensure a more just deliberative process.

### **NOTES**

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5. Dubler and Liebman, *Bioethics Mediation*, see note 3 above.

6. G.J. Annas, *The Rights of Patients: The Authoritative ACLU Guide to the Rights of Patients* (New York: New York University Press, 2004).

7. ASBH, *Core Competencies*, see note 1 above, p. 15.

8. Annas, *The Rights of Patients*, see note 6 above; N. Bateman, *Advocacy Skills for Health and Social Care Professionals* (London, U.K.: J. Kingsley, 2000); J.A. Erlen, “Who Speaks for the Vulnerable?” *Orthopedic Nursing* 25, no. 2 (March-April 2006): 133-6.

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