THE JOURNAL OF CLINICAL ETHICS

The Journal of Clinical Ethics

At the Bedside

What Do We Owe Medical Students and Medical Colleagues Who Are Impaired?

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ABSTRACT

Physicians who are impaired, engage in unprofessional behavior, or violate laws may be barred from further practice. Likewise, medical students may be dismissed from medical school for many infractions, large and small. The welfare of patients and the general public must be our first priority, but when we assess physicians and students who have erred, we should seek to respond as caringly and fairly as possible. This piece will explore how we may do this at all stages of the proceedings physicians and students may encounter. This may include helping them to resume their medical careers if and when this would be sufficiently safe and beneficial for patients.

In this issue of *The Journal of Clinical Ethics,* in "Medical Boards and Fitness to Practice: The Case of Teleka Patrick, MD," Katrina Bramstedt relates the story of Teleka Patrick, a physician who was caught stalking her pastor and later drowned when she drove her car into a lake.[1] Bramstedt uses this case to ask what we should do, as a profession, when clinicians engage in behavior like this. Bramstedt's concern that, above all, we protect patients is longstanding. Its rationale is indisputable: patients are vulnerable and cannot protect themselves. The belief that we should protect patients to the greatest extent possible is widespread and may be increas-

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ing.[2] Still, there is another side—less often formally discussed—that I will present: that we should show impaired students and clinicians the same compassion we insist be shown to patients. This may be warranted in part because pursuing a career in medicine may be almost as important as life itself to them. And this compassion should not be limited to those with such passion, but to all.

The outcome for Teleka Patrick was tragic. For months before her death she heard voices in her head. She believed God directed her to attend a particular medical school so she could be near the man she stalked. She said that she felt she was being tortured by a "demonic power." Perhaps most sadly, just before she died she begged a friend to come to see her as soon as possible, because she felt scared and distraught—but her friend never arrived.[3] Even with subsequent investigations, it is not clear why Patrick didn't seek help. Maybe she feared she would lose her license to practice. Other physicians may not seek help for similar reasons. If this is so, we should want to change how this system functions. Medical facilities have generally done well in caring for clinicians who are mentally ill, so that they can return to practice, if possible. One study reports that many as 70 percent of clinicians who experienced mental health problems returned to practice after five years.[4] Since stalking may be due to mental illness, we should want to help clinicians like Patrick, not deter them from seeking help.

Just prior to her death, Patrick said she knew no one who would come to help her if she asked for help. In this article I will suggest how we can try to prevent this from happening to others, and ways we can respond to students and clinicians who suffer

impairments. I will explore what we can do differently from what Bramstedt suggests for medical students, and what we can do for physicians, like Patrick, who are already in practice. Finally, I will consider how we might continue to offer compassionate contact for students and clinicians, even under circumstances when their outcome is the worst it can be for them, namely being barred from being able to continue to study or practice.

My goal is not to outline specifically what we should do, but instead to initiate a discussion. That said, I suggest that we often abandon these colleagues knowingly or inadvertently, when we should continue to care about them and strive to help them, even though they may have done wrong. I begin by considering how we treat medical students.

HOW TO TREAT MEDICAL STUDENTS?

In this section I address three questions: What should we consider when we interview students prior to admission to medical school, to determine whether they should be admitted? When should students be expelled? What should ethics teachers or other faculty members do when their views regarding expulsion differs from school policy? It is my hope that these examples sufficiently represent other major ethical issues that may arise.

What Criteria, Good and Bad, Should Be Prioritized during Pre-Admission Interviews?

Faculty often interview students for admission to medical school. Alberto Giubilini, Sharyn Milnes, and Julian Savulescu, in "The Medical Ethics Curriculum in Medical Schools: Present and Future," in this issue of *JCE,* stress the importance of this screening.[5] It makes sense to include one-on-one interviews in the admission process. They enable schools to go beyond the stereotypical inferences schools would otherwise use—only words and numbers. What is deemed important during these interviews, as a result, becomes even more important.

An example of what faculty may deem as important during interviews is an approach used by Edmund Pellegrino, MD, an internationally recognized physician and ethical thinker, who died in 2013. Ed was, I should mention, among the first persons who agreed to be on *JCE's* editorial board, almost three decades ago. Others were then eager to join him. When faced with an ethical problem, I would often ask myself what Ed would do. Ideally, we all know such a person. I would often ask his advice, and he didn't ever respond by saying, "I'm sorry, I can't answer, because I am not you." Since I had asked, he knew I wanted his advice. I believe

we should always respond to our colleagues and patients in this way.

When lecturing medical students, Ed would sometimes say that when he interviewed students who were applying to medical school, he would ask them harder and harder questions about medicine until they didn't know the answer. (He would add with a smile that he "usually" knew more medicine than they did.) When a student acknowledged that he or she didn't know the answer, Ed considered this a plus. When a student wouldn't admit he or she knew the answer, it raised doubts, Ed said, regarding the student's integrity. (It is unclear what weight, if any, Ed would place on his doubts when submitting a recommendation for the student's admission to medical school.) He may have shared his approach to interviewing to convey to students the importance of noting and acknowledging when they lacked knowledge. This may be particularly productive now, since the internet provides immediate, up-to-date information.

Ed's practice, in any case, provides an excellent to way to ask what an interviewer can validly infer when interviewing students prior to their admission to medical school. How valid is it, for example, to infer from a student's not saying "I don't know" that the student might offer less as a physician? Is this inference, and others like it, sound enough to suggest that such students are more likely to have significant flaws? Using this specific example, we might ask why a student might not want to say "I don't know." One reason may be that they want so strongly to become doctors, and want to help others to an exceptional degree. Such an exceptional desire may be a positive trait, but it may lead students to not even consider "I don't know" to be an option.[6] This shortsightedness could be a plus or minus. If it is an indication of students' commitment to helping others, interviewers could see it as a plus. If it reflects an underlying, emotionally driven, and habitual disregard for empirical facts and the "truth," an interviewer should see this lapse more negatively, and have greater concern. An interviewer's task is to imagine that a student's behavior may be either, and to seek to place it in context.

Students' hopes to practice medicine may so drive them that, rather than considering saying "I don't know," they will search for any related knowledge they have, even if it is, as it were, only crumbs. Such blindness might reflect the exceptionally good physicians the students might become, as it may be an expression of their exceptional commitment to patients. Of course, this kind of blindness is not limited to clinicians. The clichés that every strength may be a weakness—and *vice versa*—and that every

good character trait may be taken too far, are millennia old, and true of everyone of us.

Even so, it is ironic that a screening question intended to help rule out students who may be the least fit to serve as physicians may actually indicate the students who may be among the best physicians. Of course there are multiple other possibilities. For instance, students know that in this highly competitive academic culture, the greatest rewards and highest recognition often go to those who "know the right answers," whether or not they see their answers in a wider perspective. Deciding who enters and graduates from medical school is fraught with many similar risks, and illustrates how challenging it is to accurately perceive another person's character.

I have met many exceptionally committed students. They often come from a family that includes a child who has special medical needs, such as a younger sibling. Experience with a family member can set students off on this path at an early age.[7] In high school, in their spare time, students may seek out volunteer work with children like their sibling rather than participate in activities more common among their peers, such as social outings or sports. Here's one example. A medical student was a gifted artist, and before entering medical school she spent hours in a children's hospital drawing sick children. They loved it. She noticed how much the children and their families came to trust her, and that they would often share their innermost feelings and fears. When she became a med student, though, she noticed this changed when she wore a "white coat." Children and their families seemed more distant and guarded. She vowed that she would strive, with every patient, to acquire the same trust in a white coat as she had when dressed as an artist. This endeavor has been painful for her because she so often sees herself as failing. Nonetheless, striving to achieve this with each patient and family continues to be warranted, she says.

In their article in this issue of *JCE,* Giubilini and colleagues describe the qualities they believe are the most important for medical students to "demonstrate professionalism: compassion, integrity, respect, responsiveness to patients' needs superseding self-interest, respect for patients' privacy, accountability, and sensitivity to a diverse patient population." If the authors are right, students like the artist may be the ones we most want to become doctors—and, in some cases, they may be the same students who fail "the Pellegrino test." They may be driven by an exceptional capacity to empathize, and so may be the people we would most want to become physicians. Truthfully, the med student/artist would be the physician I would most want for my family, whether she had more medical knowledge than other students or not. Why? First, because of her self-reflective awareness and compassion; even encyclopedic knowledge does not the best clinician make. Second, with sufficient commitment, any student can access up-to-date information on the internet. This may result in better treatment.

Here is an example from my own experience. A physician recommended surgery to his patient because the surgery was the best-known, standard treatment for the patient's condition. Surgery was also the treatment indicated in the most current texts. But the patient was himself a doctor. He looked up his condition on PubMed and read about a cure for his problem using only meds. The patient-doctor emailed the author of the PubMed study, and learned there were doctors in the United States who were familiar with the treatment, and that he had worked with some of them. One of them worked at a medical center near where he lived. He went to this doctor and was cured without surgery. What may have made the difference between the approaches of these two doctors is how they were trained.

Checking for the newest treatment is the kind of practice that Ed Pellegrino would have found so important. Doctors must have sufficient humility to welcome being challenged and to go beyond their training. A clinician who is as committed to patients as the artist/medical student was might be especially inclined to check the internet, as consistent with a high degree of commitment. The identification of this proclivity should be a second priority for faculty who interview students for medical school.

In the next section I will consider the opposite and more vexing side of student evaluation: when faculty must make decisions about dismissing a student from medical school.

When Should We Dismiss Students from
Medical School and When Should We Not?

In these instances, we should be careful to not make unwarranted assumptions based on inference. Authors who have studied how physicians assess "professionalism" note several common errors. For example, attendings often wrongly judge medical students' professionalism by overemphasizing factors that are related to the specific person, rather than by external factors. This is how people, in general, err when judging another's behavior. The authors call this "the fundamental attribution error."[8]

Hindsight may also compromise our objectivity. There is empirical evidence that when doctors learn of a patient's adverse outcome, they often reason backward—erroneously—that a doctor must have made a mistake.[9] Our negative feelings, and

especially negative countertransference, "distorts clinical moral perception."[10] (*Countertransference* is a therapist's transfer of emotions to a patient, often in reaction to *transference,* which is when a patient redirects feelings for others onto the therapist.) Faculty who are confronted with acts that they consider to be unprofessional may have negative feelings in response. Their feelings, in turn, may darken and impair their ability to see and infer accurately.

A second consideration is consistent with the views of Giubilini and colleagues. The authors recommend that faculty and those who interview students for admission to medical school place relatively greater emphasis on students' having exceptional compassion, rather than on knowledge, as happens now. The gains of having a clinician with exceptional compassion are well-acknowledged.

In her article in this issue of *JCE,* Bramstedt notes that while stalking is not generally considered a crime, it "is clearly unprofessional and a marker of problematic character and fitness, which are under the jurisdiction of medical boards and educational institutions." She raises the question of how far medical schools should go to dismiss students who commit acts that are unprofessional but are not illegal. She states that medical bodies see themselves as having a moral obligation to protect the public, regardless of the law: "There is ample evidence of that the courts use medical codes of ethics to inform legal decisions. Thus, not recognizing professionalism in this same manner is inconsistent and potentially puts the public at risk." As Norman Quist noted, socially constructed behavioral guidelines and expectations may cross over and occupy a place under the rubric of "professional," and even determine how we understand professional behavior.[11]

An alternative view that has been set forth by S.C. Rennie and J.R. Crosby is that some student behaviors are worse than others in ways that warrant qualitatively different consequences.[12] Differences in unprofessional behavior may warrant disparate responses, much as the law does in drawing a distinction between felonies and misdemeanors. Some medical students believe, for example, that the critical distinction in unprofessional behavior is whether a behavior harms another.

Emilie H. Osborn provides an illustrative case.[13] Two first-year medical students had the same take-home paper to write for a final exam. George, who said the paper was "stupid," put off writing to the night before it was due. His friend Ellen had already written her paper and offered to write one for him, and he accepted. The papers were handwritten in the same script, shared identical language and syntax, and George wrote, on the back of the paper he turned in, "Thanks for helping me out, Ellen, have a great summer! George."

The instructor saw this as plagiarism and confronted George and Ellen when they returned from break to begin their second year. "Both [students] flushed, and immediately admitted they had cheated. George . . . blamed only himself. . . . Ellen was very apologetic. . . . Neither of them blamed the course director, the school, or the assignment. They said merely that they had been foolish." The faculty members on a student-faculty committee that reviewed cases of misconduct recommended George and Ellen be dismissed for at least one year. The student members of the committee recommended George and Ellen each have a letter placed in their file and perform some community service, which was accepted as the penalty. Ellen chose to work in a homeless clinic. George chose to conduct research on ethics and on medical students' views regarding his own cheating. When he did, Osborn reports, "The students [in the four class years] were outraged. . . . [S]everal . . . said this was not a crime. . . . Many said they would have done the same thing. . . . A few students said that they felt that this was cheating and supported the faculty's decision."

Osborn reports that the faculty were surprised by the opinions expressed by some students, that the assignment Ellen and George cheated on "wasn't 'real' medicine" like anatomy and physiology (it was a course on health policy), and that "helping each other was more important than being honest with the faculty." This led to a long discussion about whether the school should have an honor code (at that time it did not), and, in his third year, George, with several other students, formed an ethics committee that looked into codes of ethics at various medical schools and developed a statement of principles that is now handed out to the entering class at the school, during its White Coat ceremony. The five principles listed in the code are honesty, confidentiality, respect for others, responsibility, and the expectations of students and faculty.

Even after Ellen and George performed public service and proved to be good students, the letters remained in their files and prevented the receipt of some honors. Osborn writes that the school's response modeled a failure to forgive, and "this lack of forgiveness is puzzling because it seems antithetical to the role of the physician-healer. We forgive our patients their transgressions and agree to help them no matter how much harm they have done to their bodies." Osborn's observation is compelling. It challenges us to think again about our response: that and how we punish, that and how we forgive, the example we set for our students and colleagues.

We may punish students and colleagues who violate professional standards for many reasons. Perhaps the most ominous of these reasons is defensive: that by placing excessive blame on others, we protects ourselves. We may deny the risks and vulnerabilities we face by psychologically projecting wrongdoing onto others.

Osborn's point may be broadened: we should treat students and colleagues as we treat patients. For example, our professional obligation is to treat the patient before us, even if the patient is a serial killer or terrorist. We continue to treat patients who are noncompliant. We treat patients in the order in which they appear before us, not according to their status. Given how we treat patients, which view should medical bodies adopt toward students and colleagues: an automatic response and consequence based on whatever a medical student has done, or a response that takes into account individual factors, such as the context and the student's intentions? In some cases perhaps the best response incorporates both features, just as there are strong societal efforts to not just incarcerate criminal wrongdoers, but to simultaneously help them.

The same sort of question may arise in regard to clinicians who are already in practice, for example, a doctor who is disciplined for a financial crime and serves a jail sentence. When the doctor completes the jail sentence and prepares to resume "normal life," other clinicians may be asked by a medical body or prospective employer whether they would recommend that this doctor resume practice. Clinicians who are asked this question have to decide whether they will vouch for the doctor. Whether the crime committed was financial or was one that harmed another person may make a difference in the recommendation that is requested and given. The principal ethical concern behind our response to students and clinicians who have made these kinds of mistakes is when and how to protect patients from possible harm, to a greater or lesser degree.

Because patients can be especially vulnerable to harm, Bramstedt asserts that, in many cases, we should permanently end students' and clinicians' careers. Key considerations are (1) which behaviors are unlikely to change and, (2) if the behaviors don't change, are they too harmful to patients to be risked? Both of these criteria are met by physicians who knowingly exploit patients' vulnerabilities to further their own ends. Bramstedt writes that, in medical school, infractions that merit dismissal might include engaging in plagiarism, falsification, human or animal abuse, boundary violations, poor reliability and responsibility, lack of self-improvement and adaptability, poor initiative and motivation, negli-

gence, inappropriate use of drugs or alcohol, criminal behavior, and serious matters of moral character.[14] This risk of using this list (or any list, for that matter) is that it may be implemented without nuance or at least without a consideration of any possibly desirable, mitigating factors. An important question is whether, in net effect, the use of a list will lead to a better or worse outcome.

We might pause and focus for a moment on a distinction mentioned previously: some behaviors harm persons and others do not. How should that matter? This might be the first question asked by medical schools and boards of medicine, as well as clinicians, when they assess a colleague's unprofessional conduct. The work left to be done is considerable: to devise caring and compassionate processes for assessment and teaching and at the same time to adequately protect patients.

Using the example Osborn wrote about, Ellen wrote a final paper for George because she was trying to help him. Some medical students thought that although this was cheating, it was done for the right reason, namely, to help another student, and that this was the faculty's ethical code, not theirs. A few students wholly disagreed and thought that cheating, by itself, was grounds for dismissal. How much should students' views matter? On the one hand, they may have a greater understanding than faculty about the "here and now," but, on the other hand, they may not see the real or likely consequences of cheating over the longer run. Ellen may have been responding on the basis of her moral conscience. She may have been putting her concern for George's well-being above her own moral principles. Of course, people who act on this basis may cause great harm. How then should this possibility be taken into account? And, if such a possibly altruistic motivation is taken into account, how should its presence (or absence) be determined? I shall address the procedural concerns this last question raises shortly.

It may be profoundly traumatic for Ellen and George to be interviewed in such determinations. The stakes may be incredibly high, as becoming a doctor may be the dream of a student's life. Osborn writes that the medical students believed, more than the faculty, that helping a fellow student was a higher moral road than adhering to other moral principles. What, if anything, might that imply? For example, are students in general more morally naïve? Or have others lost their capacity for compassion?

Ellen's behavior might indicate that she would become a compassionate and altruistic doctor. This potential could be sharply contrasted with what we might expect of a physician who stalked another person. But both examples raise the question of an

appropriate institutional response: What behaviors, if any, should be forgiven? How might we further support and model compassionate behavior?

In this instance I think of major and minor efforts to improve the care of patients. In psychiatry, a major example would be to seek out a magistrate in the middle of the night for permission to involuntarily hospitalize a patient whom one fears is suicidal—too suicidal to risk leaving alone for the remainder of the night. And going with police and hospital personnel in white coats to bring the patient from home to the hospital. An example of a minor effort is a doctor's effort late at night to find a pharmacy open so she can prescribe sleep meds for a patient who cannot sleep. Another example of a major effort is a dentist who is willing to provide sedation for a child with autism in a parent's car, to provide the dental care the child needs. The dentist may not have the ideal legal protection to do this, but there may be simply no other choice.

Another minor example is a dentist's coming into the office at midnight because a teenager with braces, with two tiny, round, rubber bands in his mouth to help move his teeth swallowed one rubber band and feels it has become stuck in his lower throat. It was not an emergency to remove the rubber band immediately under general anesthesia. It probably would have been resolved when the band was completely swallowed. It was altruistic of the dentist to provide reassurance to this adolescent.

In each of these examples, the doctors did not respond on the basis of deontological policies. Do such examples strengthen the case for medical schools and institutional bodies not to respond automatically to students and doctors on the basis of deontological policies? Should violating principles for altruistic reasons warrant lesser penalties and forgiveness when students or doctors act unequivocally not to harm, but to care? If a caring intention is present and can be reliably confirmed, this kind of response, in principle, could be far-reaching. Perhaps too far, as it might be applied in situations ranging, for example, from patient-favorable coding for insurance to euthanasia.

How should Ellen's altruistic intentions to write a paper for George have been weighed against her having cheated? Should other factors be taken into account? Should it matter what the paper was about? Should it matter whether it was about detailed physiological principles essential for all doctors to know, or about, say, ethics? Would taking an exam for a fellow student warrant a different outcome? What if the other student was exhausted after providing exemplary care to a patient who was suffering all alone through the night? The question is where and how to draw boundaries for behavior that we should excuse, forgive, or punish.

When confronted, Ellen and George immediately admitted they had cheated. But what if, when asked, they had lied, to try to protect each other? It is hard to imagine that any medical school would not take additional severe sanctions, such as dismissal, in that circumstance. Otherwise, the school's credibility would be lost. Yet is there another reason students might not want to admit guilt? Perhaps, like students who don't want to admit "I don't know" to Ed Pellegrino, students might fear that if they admit guilt, it will end their medical careers.

As for how we should respond to lying in this instance, we might look to how lying applies in clinical contexts, when doctors lie to benefit patients. Examples abound. For example, psychiatrists "shade" diagnoses so patients with different insurance policies can afford better treatment. The diagnosis "autistic spectrum disorder" has been structured even more generally in the present diagnostic scheme to enable patients with less-severe disorders to better pay for treatment. All of the above acts may be altruistically motivated. Should this matter?

Practically, there may be no way to recognize when students lie about cheating. Beyond this, though, students who are caught cheating may not know whether to deny or to admit wrongdoing. If they admit it, they incriminate themselves. If they lie and are discovered, it may end their medical careers. Students may be placed in situations of irresolvable uncertainty when the stakes are so high, especially if they entered medical school because they are exceptionally altruistic. Students may see the loss of their chosen career as a sort of death. Such stakes are not unique. Another example would be an Olympic athlete who is disqualified from competition in response to some wrongdoing. In the case of Ellen and George, Osborn writes that many students believed "there was a spectrum of cheating that becomes more serious as the stakes get higher. A patient's lab values could be a significant detail in deciding therapy. Writing a paper for a health policy course did not have the same value."

Given this, perhaps it would be appropriate for medical schools to create a "two tier" system that sorts infractions into lesser and greater. If a student's infraction was not in the greater tier of infractions, for which the student could be expelled, a faculty member could say to the student, "It looks to us like you wrote a paper for another student. It's conceivable you didn't, but we must go by what we see. Fortunately, this is not an infraction for which you will be expelled. I'm glad. I want, as you do, for you to be able to go on to become a doctor." The faculty

member could add, "Perhaps you moved to help a fellow student by a concern for others, that could move you to be a compassionate physician. You could prefer to acknowledge that you cheated, if you did, or not. Generally, it's considered to be a higher road ethically to acknowledge being at fault, if that's the case. For this reason, if you are at fault, I hope you acknowledge it. But it's your choice, and there won't be added consequences one way or the other." The faculty member could also say, "We all err. You may have had a good reason to do what you did. You may have wanted your friend to do well enough to graduate. I'm sure you know now you should not do something like this again. It's important to me that we feel at ease with each other, should we meet in the future. Please know that I value you for who you are. What did or did not happen will not diminish this." This approach can be altered when a student's mistake was not intended to help another, but may still convey that an unconditional regard for the student will continue.

These approaches are radical departures from what most of us might do now. They are problematic at the level of policy and the level of practice. Policy-wise, making any such distinction may unavoidably open the door to further exceptions, and, legally, open the door to new litigation. Ethically, a rule-bound solution might be pragmatic and considered morally best, in and of itself, and, all-in-all, might be the most fair and consistent. Still, what might rightly offset this is our need to respond, in the most just way possible, to situations of human weakness and to be able to take into account "good reasons" to a greater extent. Doing so requires a great deal more effort. To respond with continuing, uninterrupted, unconditional regard to those who err may be still more demanding.

Experiencing this kind of unconditional warmth, even after another makes a mistake, may exert an indelible positive impression on students. Giubilini and colleagues note that attending medical school has been documented to have a negative effect on some students, and their moral values may deteriorate during their medical studies.[15] Even for a few students, a profound memory of positive regard after erring might offset other factors, and so prevent this kind of negative effect. That is, compassion modeled by faculty members may go a long way to offset this effect.

Faculty Who Teach Ethics

Faculty who teach ethics may be expected to help identify students who shouldn't become doctors. This is reasonable, but not without peril. I provide an example of why this is so below. Ethics fac-

ulty will want to encourage students to write about topics on which they feel emotionally engaged; otherwise, writing and analyzing a case or topic may merely fulfil a requirement and be, for the most part, unproductive. For students to write about what they really care about, ethics faculty must assure them that what they write is for their instructor's eyes only. Guaranteeing absolute confidentiality may elicit students' heartfelt—or hateful—emotions. When students are assured confidentiality, they may write about what they most care about, often about what has affected them profoundly. For example, some female students express feelings about having an abortion. Some men express shame about being bullied. One essay that stays in my mind was written by a student who expressed shame because, before she began medical school, she provided care for a child with special needs, until the girl was in her late teens. Then the student began to feel "burned out" and ended the relationship. She wrote about how she and the girl would romp through shopping malls, the child in a wheelchair with the student by her side, both waving to passersby, who waved back. The student heard the girl had died, and attended her funeral with great trepidation. But it was fortunate she went, because she learned that the girl and her family did not hate her, as she supposed. Rather, she learned that the family, and the girl, saw her as the brightest light the girl had had in her life.

On the other hand, ethics faculty may feel that they are obligated to report students who express views that are morally problematic. I provide a personal example of this below. If this is the case—that we will report students—we should warn students about this ahead of time. These warnings can be expected to squelch the integrity of students' essays, and violate a core value of teaching as well. Students will most likely write in ways that will keep them wholly safe. In my classes, when a student expresses a view that is problematic, I meet with the student and discuss what was said or written. I take care to indicate, prior to discussing the view, the sound values that may underlie it. I do this in part because I believe it is always possible to find a sound belief behind a troublesome statement. Here's an example of what I am suggesting. A student may feel strongly that it is wrong to make adolescents wait until a certain age to access genetic knowledge that will not benefit. I would tell the student I value his or her concern for adolescents' desires for this knowledge about themselves, and their autonomy.

Validating the other person first is an approach used by most mediators. Having been validated, students, like patients and family members, typically feel more trusting and are more open to adopting a

different moral view—perhaps even a moral view that contradicts their own. But we shouldn't validate others because it may increase the likelihood they will become more open to new ideas. We should do it because, when we look at the ethical bedrock supporting others' moral views, it is likely that some aspect of their view is sound and true, and we can pursue the discussion, as appropriate, from there. After their views are validated, some students, patients, and family members may be able see and accept another's point of view. Some will not. But later, they may become able to accept another's point of view, or at least to soften their own view. There is no way to know. Is there a possible price to pay for taking this approach with students? Yes: we might miss the rare student who should be dismissed. But for that to happen, other faculty also have to miss an indication that the student should be dismissed.

Here is an example. After having read thousands of student essays over the years, only once has a student expressed views that triggered my fear. Late one Friday afternoon, a fellow faculty member approached me and said, "This student should be disenrolled." He had checked with other faculty members, and all agreed. I felt vicarious angst for the student, and dread at the thought of going to the appropriate medical school authorities Monday morning. I said I would read the student's ethics essay.

The student had written that parents should be allowed to kill their children up to the age of 18: "We all know that there are bad kids. Parents already can abort their fetus up to six months. Why not extend this to 18 years? Since we know how some children can turn out, shouldn't we just extend this option of parents being permitted to end the lives of their offspring up until this later age?" (At this point, reader, please ask yourself: How would I respond if I were reading this paper?)

Fortunately, as I read the essay, something seemed familiar about the title: "A Modest Proposal." This was the title of an essay written by Jonathan Swift in 1729, arguing that the poor children could be sold as food to the wealthy, so the children would not be an economic burden.

The student's essay was, as readers may have surmised by now, satire. In writing these essays, students are permitted to address ethical issues in the way they would like, including short stories, drama, and satire, taking into account what these forms, and the humanities more generally, can add to the study of ethics. This student wrote a satire to express his opposition to abortion. I called the faculty member to inform him of this. He thought about it and suggested that I chastise the student in any case, because he had plagiarized the title of Swift's essay.

All inclinations to punish—responses from faculty or colleagues—are worth considering further. The responses may sometimes point to a tendency we all have, but one we must work to see in ourselves: to see in others who have erred, whether faculty, students, or colleagues, what is not there, sometimes a quality or tendency that we may have, but not like, or one we fear.

If a faculty member sees or suspects plagiarism, his or her views on the appropriate response may differ from school policy. If the school favors expulsion and the faculty member favors a lighter penalty, the faculty member may know that if he or she triggers the school policy, the student will probably be dismissed. On one hand, there is a prior, implicit promise to the faculty, school, and students to report a suspicion of cheating. Going against this is the duty to follow one's own values and strong moral views; for example, views based on compassion as embodied and prioritized by the care perspective. There can be profoundly good and bad consequences for following what we, "in our hearts," most believe.

To help focus the discussion, I will return to Ed Pellegrino, and my own guide to moral deliberation: What would Ed do? He often said he was true to his own values—specifically, his spiritual values—first. Another approach might be that of Hannah Arendt, who contributed significantly to philosophy and to how we should regard wrongdoing, or, to use her term, "the banality of evil." She knew the philosopher Martin Heidegger, who, for some time, it is argued, may have supported the Nazis. What enabled some people to resist cooperating with the Nazis, Arendt wrote, was that they asked themselves what would enable them to live most at peace within themselves, and whether they were unwilling " 'to live together with a murderer—themselves.' " She concluded that "living together explicitly with oneself" was "not only the basis for any trustworthy morality," but "at the root of all philosophical thinking."[16] Going one's own way may be the best approach to a problem, but can be risky. Faculty who do not report a student to avoid triggering a dismissal is an example. But it may be, for the reasons aforementioned, a morally acceptable option.

HOW SHOULD WE ERR WHEN A PRACTICING DOCTOR ENGAGES IN WRONGDOING?

What should we do when a practicing doctor engages in wrongdoing, as Teleka Patrick did? What should we do if it comes to our attention that a doctor has erred? What should we do if we are asked to recommend that a physician be allowed to return to practice after fulfilling whatever penalty was as-

signed? These questions are complex, and involve various subtleties and contradictions that should be taken into account, but we might begin by considering, imagining along a sliding scale, the risks that these doctors might pose to patients.

The Psychopathic Physician

Certainly a clinician could be a psychopath. This would mean essentially that he or she lacks the capacity to feel empathy for anyone, including patients. This disorder is addressed by Fawcett, a psychiatrist who is a leader in this area. He asks, "Are there successful psychopaths . . . that we are unable to study because we can only observe for the most part those who have been incarcerated?" He gives, as an example of "successful psychopaths," corrupt leaders who sell out their constituencies, and answers, "Perhaps there are. . . ."[17] Among this group are those who can behave horrifically to some and kind and loving to others. Underworld figures who care for their own family members are examples.

Heidegger is an example of a professional person who furthered the field of philosophy who had ties with the Nazis.[18] What this may mean is hotly and fiercely contested, but his example may serve to introduce the notion that it may be possible for a physician to serve patients effectively as a doctor, but at the same time be immoral in other spheres. One such physician went "all out" for his patients; for example, he allowed a teenager who tried to end his life to stay in his waiting room during the day, so he would not be alone until he was willing to go home and be on his own. The same doctor was convicted for tax evasion. If we were asked to recommend that he return to practice after he "served time," should we take the nature of the crime into account? The crime was "mild" and didn't harm anyone directly. He did later return to practice and continued to help patients greatly.

Such physicians (as any other person) may be able to change. A surgeon who threw knives in the operating room, for example, got help, and went from being the most reviled physician in the hospital (by a census!) to a doctor who was most beloved. One possible point from all this may be that, rather than allowing our responses to be automatic in these cases, we might better respond based on considerations that are more complex. Our guide might be the psychiatrist Viktor Frankl, who had been interred in a concentration camp during World War Two. He found human kindness in all groups. He advised that we must "not try to simplify matters by saying that these men were angels and these men were devils."[19] This instruction may make choosing what to do more difficult. But it may save us, when making a deter-mination, from arriving at an answer that is too easy, and wrong.

Physicians Who Have Difficulty Understanding Others

Many doctors seem distant. Most medical students can, when asked, rank all those in their class from those who are the warmest to the least warm. Physicians who are the most distant and cold may be brilliant and the sharpest of clinicians. They may have traits like people with autistic spectrum disorder, and, as a result, have more difficulty understanding patients who don't "work" they way they do. They may cause harm. They may also be wizards with a scalpel and have the best surgical outcomes. For instance, one patient told her doctor that she had had a one-night stand. He shouted, "You what?!" She never went back to see him again. Another patient who had a terminal illness told her physician that she feared dying. His reply: "We all die." Same result. A doctor who sought to be empathic to a mother who had just given birth to a baby with Down's syndrome said, "I'm so sorry." The mother still hates him, decades later.

These doctors can learn to do better. There may, though, be limits to how far they can go. This possible limitation was best expressed by Jay Carter, a person with full-blown autism spectrum disorder, also known as Asperger's syndrome, in an article he wrote for *JCE* a decade ago.[20] Carter's psychiatrist asked for Carter's consent to write up his "case," although it was later apparent that he did not realistically anticipate what this would involve. When Carter read the published case, he was at a loss: "As I began to read the article, I responded with horror and dismay . . . my situation was far worse than I could have imagined . . . there was . . . a terrible Catch-22 in all of this. Since I had Asperger's syndrome, which limits my ability to perceive social cues, perhaps what [the psychiatrist] had written was true and, worse yet, I was incapable of realizing it. I was blind to my own blindness!"

This depicts the type of limitations some physicians have: they are blind to their own blindness. Realizing this may help us to not set too high a threshold for those we should accept and value as doctors. This may be useful when a physician behaves in a way that appears most insensitive. A harsh response may fail to take into account the doctor's mix of strengths and limitations. Counseling, not punishment, may be the optimal response.

Doctors Who Are Altruists

I remember during psychiatric training that a patient began crying in a group session. A psychiat-

ric resident got up, walked over to the patient, and gave her a hug. Nonsexual. He was severely reprimanded. Bramstedt speaks of clinicians who have trouble with boundaries. Altruists may have more trouble with boundaries than others. A social worker I know offered, for example, to take a patient home with her. I believe the patient would have responded very well to this. The social worker was strongly reprimanded for offering. One doctor didn't bring his child in for care because he wished to respect the values of his wife, who was opposed to most Western medicine. He almost lost his license. Still another doctor prescribed valium for his son when he was in college, because he was very anxious about exams. The doctor could have lost his license. He was called before his medical board—and I don't know the result. These clinicians cared, perhaps too much. These examples remind us how we should be wary of seeing such wrongdoings as more simple than they are. They raise the question of when such behaviors should be actionable and when they are excusable. The answers should never be easy. These examples remind us that even doctors who are caring may err, and they may or may not repeat their errors. To echo Frankl, we should not respond automatically and unthinkingly, as a reflex.[21]

HOW SHOULD WE TREAT STUDENTS AND CLINICIANS WHEN WE ASSESS THEM?

When discussing students and doctors whom we might want to bar from practicing medicine, I note a very important aspiration: to be able, during and after assessment, to have the best possible continuing relationship.[22] How might this be possible? I will address this topic in three sections.

1. When Possible, Resolve Issues to Limit Harm

As discussed above, when a medical body determines a student's or clinician's outcome, it may choose to go either of two ways: (1) treat all infractions in essentially the same way, or (2) consider an infraction as falling into one of two groups: (a) more serious, similar to a legal felony, or (b) less serious and not requiring disbarment, similar to a legal misdemeanor. If the medical body adopts the second way, and the infraction is less serious, an assessor may want to consider other values in deciding what to do. The interests of third parties may, for example, be so profound that they should warrant priority. Here is an example. A clinician committed a minor infraction that did not affect a patient or other person. (The nature of the infraction isn't important to the discussion.) A nurse working with him noted the error and shared it with a colleague. Her col-

league felt he should report the error, but the nurse greatly opposed it. She had meant only to share that the error had occurred, she said, not to have her colleague act on it. She planned to work with the man who had erred over the next several years, and she feared that if he was reported, he would know that she had reported the error, and that would destroy their working relationship, which was very important to her. Further and perhaps most importantly, this was an error that wouldn't recur. Her colleague decided to accept her request. They both thought, in fact, after discussing it, that this was by far the best way to proceed.

This case illustrates that if the unprofessional conduct is minor, and another person's best interests might be profoundly at stake, especially if the wrong won't be repeated, or is extremely unlikely to be repeated, it may be ethically preferable, or at least acceptable, to not report. Such conduct may not always require remediation. Assessors who believe that every such instance must be remediated and engage in all-or-none solutions should at least consider that this approach may create some exceptionally painful problems.

2. What Should an Assessor Say, Prior to Determining an Outcome?

Assessment sessions may be painful for all parties involved. Richard Holloway, a dean of students at a large private medical college, writes that "the specter of the dismissal hearing is among the most dreaded of our responsibilities." Part of the problem, he says, is that an "advocate is supposed to be the students' advocate on the one hand, the institution's on the other hand, and perhaps crusader for the good of society on the third. . . ." He continues, "It is hard to maintain a demeanor of dispassion when so much is on the line for the student. . . ."[23] Under these circumstances, assessors should be compassionate, to the greatest extent possible, to the person being assessed. It may not matter to the person who is being assessed, relative to the other stakes they face. Assessors should indicate that they care about the person being assessed because he or she is a fellow person, and deserves nothing less.

When forensic psychiatrists evaluate an alleged criminal for competency to stand trial or for insanity, they tell the alleged criminal that they are working for the state. They may go the extra mile, being morally conscientious, and repeat this warning when they sense that the person being assessed may be about to incriminate him- or herself, in spite of the warning. The person being examined may develop too much non-self-serving trust. Or they may have been acclimated to trust clinicians. Consequently,

psychiatrists may purposefully choose to be distant to reduce the risk of eliciting too much trust. They may not do this to be two-faced; they may do it kindly, to not engage the person they are assessing while simultaneously acquiring information about the person that may work greatly against her or him.

Warning the person being assessed may, paradoxically, have the opposite effect. Telling a person who is being assessed not to trust the interviewer may mean to the person being interviewed that he or she *can* trust the interviewer. When interviewing or assessing a student or colleague, a better way to warn may be to directly express discomfort, by saying: "I want you to know how badly I feel having to do what I am doing now. I don't know anything like your pain. But please know, regardless of the outcome, my caring for you as a colleague will continue." To do this is uncommon. It may, to those interviewed, seem wholly too much. Still, it is a start.

For example, when faculty met with Ellen, the medical student who wrote a final paper for her friend George, they could have explicitly expressed their respect and unconditional regard for her during their meeting. Perhaps they did.

3. Being There, Even if One Can Offer Nothing More

In many cases, students and doctors who have engaged in wrongdoing will be excluded from practicing medicine. Even in these situations, however, those who know the students and clinicians can arrange to be with them, as by sitting with them during the hearing and meeting with them afterwards. We can emotionally at least be there.

An incident that Frankl reported is helpful in this regard. He relates that a patient who was bent on committing suicide called him at 3 a.m. He talked with her for 30 minutes, until she said she would not take her life. But when the patient saw him later, she told him that it was not his arguments against taking her life that had convinced her. The only reason she decided not to commit suicide was that, rather than getting angry at her for calling and disturbing him in the middle of the night, Frankl patiently listened to her for half an hour. A world in which this can happen, she concluded, must be a world worth living in.[24]

Assessors may ask and invite the student or clinician to meet with them after the assessment, regardless of the outcome, to convey their sincerity by stating that they want to continue to be colleagues, if that is what the student or clinician would want.[25] Holloway, the dean of students who spoke about feeling dread, describes a meeting with Lana Tremont, a medical student whom he and others on the faculty were assessing regarding dismissal. Dur-

ing the meeting, he says, "Neither of us could talk freely as we had often done when [Tremont] visited my office in the past."[26] The student had not been prepared for the science required in medical school, and had repeated her first year, yet continued to struggle. During the assessment interview, Tremont's attorney revealed that she had a learning disability that she had never disclosed. Holloway writes, "I kept my head down in shame, avoiding eye contact." Tremont was not dismissed. Holloway writes that after the assessment, "I called her home at night so that she could avoid a sleepless night."

The importance of supporting a student or clinician who is at risk of losing a career, or who has lost a career, cannot be overstated. When possible, faculty members who are not assessors should go as far as they can to offer support. They can offer to sit with the person who is waiting to be assessed, join the person afterwards, and keep in contact after that, if the person wants. Doing this may be like keeping in contact with a patient's family after a patient has died. After all, the assessment may result in a kind of death. We could say, "I would like to remain with you during the interview and after it. If you wish, please take me up on it, and we can leave the interview area and maybe sit and talk together over coffee or tea. We can continue to talk even after that, if you'd like." Showing this kind of concern and care is a priority with our patients. With our colleagues, perhaps we can do even better?

CONCLUSION

I propose a different approach than Bramstedt suggests, not because it is right or better, but because it should also be on the table. When interviewing students who have erred, faculty might not make speculative assumptions, but rather look for signs that suggest exceptional compassion. Wrongs might be seen as existing in two categories, better and worse, and faculty can avoid placing students in a bind in which they may incriminate themselves in wrongdoing when they don't know which answer may deprive them of a future they deeply want. Faculty may want to follow their own conscience in these situations. When a wrongdoer is a clinician already in practice, the assessment of the physician should be complex.

Finally, assessments should be conducted compassionately, regardless of what a person has done. This can include finding ways to avoid harm, when reasonable; telling the person prior to an interview that we care and offering to be with the student or colleague during the interview and afterwards, if the person wants this.

Holloway, the dean who assessed the student who had a learning disability, provides a follow up. The student later said, " 'I've changed and there's a lot I understand now that I didn't. . . .' " Holloway writes, "Tears filled my eyes. . . . There is nothing that could replicate the feeling of a Lana Tremont or of me as I continued to stand, reflecting on her extraordinary grace and dignity. . . . I hope she knows I will be forever grateful."[27]

NOTES

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2. P. Jesilow and J. Ohlander, "The Impact of Tort Reforms on the Sanctioning of Physicians by State Licensing Boards," *Journal of Empirical Legal Studies* 7, no. 1 (March 2010): 117-40.

3. Patrick graduated from medical school with a medical degree and a doctorate in chemistry and "had her pick of medical residencies." J. Mack, "Teleka Patrick Case; 6 Things We Know and Questions Still Unanswered," 10 April 2014, *http://www.mlive.com/news/kalamazoo/index.ssf/2014/04/teleka patrick_case_4_things_w.html.* See also J. Mack, "Teleka Patrick Tweeted about 'Demon,' Frustrations with Unrequited Love Just before Disappearance," 7 January 2014, *http://www.mlive.com/news/kalamazoo/index.ssf/2014/01/teleka Patrick tweeted about_d.html.*

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13. E. Osborn, "Punishment: A Story for Medical Educators," *Academic Medicine* 75, no. 3 (March 2000): 241-4.

14. A similar list is presented in S. Brockbank, T.J. David, and L. Patel, "Unprofessional Behaviour in Medical Students: A Questionnaire-Based Plot Study Comparing Perceptions of the Public with Medical Students and Doctors," *Medical Teacher* 33 (2011): e501-8, e503.

15. J. Patenaude, T. Nivonsenga, and D. Fafard, "Changes in Students' Moral Development during Medical School: A Cohort Study," *Canadian Medical Association Journal* 168, no. 7 (1 April 2003): 840-4.

16. D. May, *Hannah Arendt* (Harmondsworth, Middlesex, U.K: Penguin Books, 1986), 112-3. See also, H. Arendt, *Eichmann in Jerusalem* (New York: Viking, 1963).

17. J. Fawcett, "Expanding our Understanding of Antisocial Personality Disorder and Psychopathy," *Psychiatric Annals* 45, no. 4 (April 2015): 160.

18. Heidegger had "one big idea that should have been of use in resisting totalitarianism," which was "to take up a self that you didn't know you had." S. Bakewell, *At the Existentialist Café* (New York: Other Press, 2016), 78-9. When Heidegger's notebooks were published in 2014, "they provided yet more confirmation of something already known: Heidegger was a Nazi, at least for a while, and not out of convenience but by conviction," 80.

19. V.E. Frankl, *Man's Search for Meaning* (New York: Washington Square Press, 1970), 136.

20. J. Carter, "Looking in to a Distorted Mirror," *The Journal of Clinical Ethics* 14, no. 1-2 (Summer 2003): 95-100, 97.

21. V.E. Frankl, *The Will to Meaning* (New York: New American Library, 1968), 8.

22. R.L. Holloway, "Reflections: Lana," *Families, Systems, & Health* 24, no. 2 (2006): 213-7.

23. Ibid.

24. Frankl, *The Will to Meaning,* see note 21 above.

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Features

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

Salla Saxén

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 re-

spected 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. More-

over, 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

ACKNOWLEDGMENTS

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.

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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.

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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.

How Can Clinical Ethics Committees Take on Organizational Ethics? Some Practical Suggestions

James E. Sabin

ABSTRACT

Although leaders in the field of ethics have for many years pointed to the crucial role that organizations play in shaping healthcare ethics, organizational ethics remains a relatively undeveloped area of ethics activity. Clinical ethics committees are an important source of potential expertise, but new skills will be required. Clinical ethics committees seeking to extend their purview to organizational issues will have to respond to three challenges—how to gain sanction and support for addressing controversial and sensitive issues, how to develop an acceptable process, and how to make a difference on the ground. The article presents practical suggestions for how clinical ethics committees meet these challenges.

INTRODUCTION

The ethical quality of medical care depends as much on the ethics of organizations as the ethics of individuals. For better and worse, the culture and policies of hospitals, group practices, insurers, and other health system organizations shape individual clinician-patient relationships. We can't have ethical healthcare without ethical organizations!

Calling for attention to organizational ethics isn't new. In a seminal 1982 article, Goodpaster and Matthews argued that corporations have moral as well as legal and financial responsibilities.[1] Closer to healthcare, in 1990, Cohen[2] and Boyle[3] asked clinical ethics committees to extend their purview to organizations and public policies. In a similar vein, Reiser challenged healthcare organizations to "look critically at how professed institutional values can best be realized in day-to-day interactions within the institution and with the wider community."[4] A study of clinical ethics consultation at Seattle Children's Hospital found that 96 percent of the consults included at least one organizational issue![5] And, many ethics consultants would agree with the Canadian ethicist who told an interviewer, "most clinical consults are actually organizational ethics issues or have an organizational ethics piece."[6] But despite 25 years of encouragement, healthcare organizational ethics continues to be an underdeveloped field.

Where will the expertise needed for addressing complex organizational issues come from? A key source for strengthening the ethics of health organizations will be the clinical ethics committees that have been so well developed at hospitals and other health facilities. But a survey of ethics committees found that organizational issues are the consultations the committees have the least success with.[7] To contribute more effectively to the ethical quality of organizations, clinical ethics committees must develop new skills.

My aim in this article is to offer practical guidance for how ethics committees and consultants can begin to put their toes into organizational waters.

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ENHANCING THE CLINICAL ETHICS COMMITTEE'S CAPACITY FOR ORGANIZATIONAL ETHICS

The suggestions that follow draw on reports from clinical ethics programs that have been active in organizational ethics, my own 16-year experience directing an organizational ethics program at a health plan, and opportunities to consult to clinical ethics programs about developing organizational ethics capacity. Although most of my comments are directed to ethics *committees* that are moving to include organizational ethics in their purview, the principles apply just as well to individual ethics *consultants.*

Leaders of hospitals, large group practices, accountable care organizations, and other health entities have not been clamoring for organizational ethics programs. Before an ethics committee takes on organizational ethics it should ask itself: Why haven't the leaders been asking us to do it? In my experience, three legitimate leadership concerns and a common misunderstanding of the word "ethics" must be addressed before trying to add organizational ethics to a clinical ethics committee.

First, leaders believe that top management and the board of directors have the ultimate responsibility to oversee how organizations deal with values and to promote ethical conduct. They're right. But in clinical ethics, the fact that the attending physician has ultimate responsibility for conducting care in an ethical manner doesn't mean that ethics consultation may not be useful in complex clinical situations. CEOs (chief executive officers) can generally understand that just as perspectives from finance, human resources, law, and other areas are vital for effective leadership, ethics can contribute in a similar manner. I've found it useful at Harvard Pilgrim Health Care to define the ethics program as providing "decision support"—a familiar managerial concept—to leadership and the board. Leaders will only back organizational ethics activities if they see the activities as supplementing and supporting—but not supplanting—their ultimate responsibility in relation to values.

Second, in some organizations, leaders fear that an organizational ethics program could become a bully pulpit for malcontents. This is a real danger. I've seen it happen. Ethics is a very emotional subject. Any of the major stakeholders in a health system can use the banner of "ethics" to label their perspective as the primary truth and to excoriate those who hold other views as "unethical." Administrators are often leery about being bashed by unhappy

physicians. As with clinical ethics, organizational ethics requires a climate of respectful attention to competing perspectives and thoughtful deliberation about differences.

Third, leaders want their organizations to be "nimble" and "fast moving" in the volatile healthcare arena. If they see organizational ethics as a bureaucratic impediment—a "must approve" version of a papal seal of approval—they will not support developing a program.

Finally, the word "ethics" can itself be an impediment. When colleagues and I were doing field work on organizational ethics,[8] we were startled by how commonly organizational leaders took "ethics" to mean finger-pointing and scolding. When seen in that light, organizational ethics was regarded as a threat, not a resource. When we asked leaders about "ethical issues" in their organizations, we often drew a blank. But when we asked questions like, "What keeps you awake at night?" "What are the toughest questions you have to deal with?" and "What groups inside and outside of your organization hold different values about what you should do?" we got into deep and probing conversations about issues like how to deal with expensive medications and whether it was acceptable not to offer low-value treatments. If leaders understand that "organizational ethics" means deliberations of this kind, not haranguing, they will be more likely to support the development of a program.

There is a saying in the organizational ethics world: "If the CEO is not also 'Chief Ethics Officer,' don't waste your time trying to do organizational ethics." The CEO doesn't have to be an active participant in the program (although it helps if she or he is), but moral and material support from the top is an absolute precondition for success.

Once the CEO gives the go-ahead for the clinical ethics committee to add an organizational focus, there are four key developmental steps for the committee to follow.

1. Educate the committee about the organization's administrative functions. The starting point for clinical ethics consultation is understanding the facts of the situations that are being addressed. Likewise with organizational ethics. To work with organizational issues, the committee must be able to consider a wide range of facts in the spheres of finance, law, human resources, marketing, the political environment, and more. For most committees this will require new learning.[9]

2. Cultivate links to administrative leadership. Contributing to the ethics of an organization is only partly an intellectual task. To be effective, ethics

committees require relationships. A good way to start is to ask administrative leaders how an organizational ethics process could contribute to the organization and what they see as potential risks. To be seen as having a legitimate role in relation to administrative functions, an ethics committee needs supporters who can open doors for it and vouch for its value. Developing the requisite relationships isn't a "once for always" process—relationships must be nurtured over time. I meet one-to-one with C-suite leaders at least annually and depend on informal "face time" encounters as well.

3. Broaden membership in accord with the expanded purview. Even if a clinical ethics committee has had membership from the administration, working with organizational issues will require a wider range of participants. The guiding principles for establishing membership are to ensure that perspectives from all of the key stakeholders are represented and to include participants whose presence enhances trust in the process.[10] As an example, the health plan committee that I chair includes employers who provide insurance through the health plan, clinicians who practice in the health plan network, consumers who are insured through the health plan, and public policy leaders. The fact that the CEO and senior leaders have brought issues to the committee builds trust in the ethics process.

4. Start slowly and apply a try-it-fix-it approach. "Hit the ground walking" is a good maxim for starting a new ethics function. Those who have participated on a new clinical ethics committee have observed how much start up effort is required, even for an ethics activity that is understood and generally well accepted in the hospital world. For organizational ethics, which is much less understood and established than clinical ethics, having the committee spend time educating itself, developing relationships, and piloting the consultation process before it launches "for real" will be time well spent.

A skeptic could plausibly claim that if a clinical ethics committee follows my recommendations to "cultivate links to administrative leadership" and "broaden membership," it will turn itself into a fig leaf that would allow administrative wolves to pose as benevolent sheep by cloaking their actions with a patina of ethics. This is a real risk. In response to this concern, Spencer and colleagues recommend, "the organizational ethics program should be administratively located as an advisor to (and possibly an occasional decision maker for) the governing board," to assure that there will "be no undue influence by any particular department of the organization."[11] This is a viable proposal, but, in my experience, boards have preferred to make the CEO responsible for the ethical conduct and culture of the organization. If an ethics committee chair told me she/he feared administration would use the committee as a "cover," I would advise the committee to not to take on an organizational ethics role until the climate was more propitious. Ethics committees do not have superhuman power. An organizational ethics committee would not have prevented the Enron fiasco!

No matter where organizational ethics is administratively located, the relationship between ethics and compliance is a crucial question to address. Ideally, leaders will see ethics and compliance as a two-pronged approach to promoting the integrity of the organization,[12] with the *ethics* component emphasizing ideals and principles, and the *compliance* component emphasizing meeting legal and regulatory expectations.[13] Concerns around risk management assure that leaders will give compliance strong organizational support. Allying ethics with compliance under the banner of integrity can be a prudent tactical step for an ethics committee to take.

DEVELOPING A METHODOLOGY FOR DOING ORGANIZATIONAL ETHICS

Although there is no single methodology for doing organizational ethics, three approaches offer practical guidance. To highlight their distinctive strengths, I describe the approaches in an oversimplified manner (Weberian "ideal types"). The actual programs draw on all of the elements that I use these individual programs to exemplify (see table 1).

1. Organizational ethics via quality improvement. In the past decade the Veterans Health Administration (VHA), which provides healthcare to

TABLE 1. Three approaches to organizational ethics

Approach to organizational ethics	Example	Distinctive strength
Organizational ethics via quality improvement	VA IntegratedEthics	Strong connection between ethics, QI, practical action
Organizational ethics via support of misson	Multiple faith-based systems	Strongly motivating for staff and constituents
Organizational ethics via stakeholder analysis	Harvard Pilgrim Health Care	Cultivates a wider moral community

nearly six million patients, has implemented "preventive ethics" as part of a managerially sophisticated approach to organizational ethics (Integrated Ethics), at all of the VHA's 153 medical centers and 21 regional networks.[14] Preventive ethics committees aim to improve ethics quality in a measurable manner by identifying, prioritizing, and addressing gaps in the quality of ethics quality on a systems level.[15] The distinctive strength of the Integrated Ethics program lies in using well-honed quality improvement tools to move from individual case analysis to systemic changes.[16]

2. Organizational ethics via support for mission. One in six patients in the U.S. is cared for in a Roman Catholic hospital, and Catholic ethicists have developed an especially clear approach to organizational ethics that treats the organization as a "moral actor" that should be guided by its mission.[17] Typically, a "mission committee" or "mission officer" is charged with ensuring that the organization "walks the talk" with regard to its mission. The distinctive strength of the mission-centered approach developed by faith-based systems is its capacity to strengthen staff motivation and morale and to elicit trust among constituents.[18]

3. Organizational ethics via stakeholder analysis. The Harvard Pilgrim Health Care Ethics Advisory Group applies a stakeholder-based approach[19] to ethics by creating an ethics process with vigorous voices from consumers, careproviders, employers, staff, and leaders from the policy community.[20] The group enters into dialogue with health plan leaders who seek consultation. The distinctive strength of the stakeholder-based approach derives from using deliberative dialogue about real-time controversial issues to cultivate a wider moral community.

HOW CAN ORGANIZATIONAL ETHICS MAKE A DIFFERENCE?

The most useful question when considering a new activity is often two words—"So what?" What value can be hoped for from a clinical ethics committee adding an organizational focus? In business terms, what is the potential ROI (return on investment)?

The business literature emphasizes the importance of "brand." If an enterprise is seen as honest, reliable, and caring, it's likelier to succeed. An ethics committee that strengthens the degree to which the organization truly manifests these values—and is recognized for doing this—will be creating a meaningful ROI and is likely to receive support from organizational leaders.[21]

As an example of making a difference that is valued by the organization, in 2012 Harvard Pilgrim Health Care, the not-for-profit regional health plan for which I chair the Ethics Advisory Group, received complaints about excluding coverage for gender affirmation services like surgery and hormones for transgender persons. (At the time, it was common for health insurers to exclude these services.) The CEO asked the corporate medical director to bring the question of coverage to the Ethics Advisory Group. Several transgender advocates participated in the meeting. The group concluded that although public and private insurance cannot cover every potentially valuable health service, there was no ethical rationale for excluding gender affirmation services from consideration. It recommended that these services be allowed to compete for coverage on equal footing with other medical and surgical interventions. Leaders accepted the recommendation, and in subsequent years the organization initiated coverage for gender affirmation services.[22] The decision was welcomed by employees, members, and the wider community. The Human Rights Campaign, the largest LGBT civil rights advocacy group in the U.S., included Harvard Pilgrim on its list of employers that meet 100 percent of its advocacy standards.[23] The CEO has said that the ethics program "is part of who we are."

CONCLUSIONS

Clinical ethics committees that seek to extend their purview to organizational issues must address three challenges: how to gain sanction and support for addressing controversial and sensitive issues, how to develop an acceptable process, and how to make a difference on the ground.

Organizations are likeliest to welcome committees that recognize and support the role of the CEO and other leaders in setting the moral direction for the organization. Taking this stance is consistent with the role that clinical ethics committees take as consultative bodies to the responsible clinicians (in managerial terms, providing "decision support"). Whatever the clinical ethics committee recommends, ultimate decision-making authority rests with the attending physician and the patient/family. Clinical ethics committees should approach organizational issues in the same way. Defining their organizational ethics role as providing decision support to leaders by examining issues "through the lens of ethics" is likely to help.

With regard to process, there is no one-size-fits-all model that can be taken off the shelf. Organiza-

tional ethics activities must fit the organization's structure and culture. In Catholic healthcare, the mission committee can draw on official guidance—ultimately seen as emanating from God—such as the *Educational and Religious Directives for Catholic Health Care Services.*[24] In the VHA system, the IntegratedEthics® program draws on the strong military tradition of establishing standardized procedures, planning carefully for logistical support, and evincing loyalty to comrades and colleagues. And at Harvard Pilgrim Health Care, the Ethics Advisory Group brings together the health plan's multiple constituents, consistent with the way U.S. health plans work at the interface of patients, careproviders, commercial and public purchasers of insurance, regulators, and others.

The ultimate aim and justification for organizational ethics activities is to make an ethically meaningful difference in how an organization functions. Unless that happens, the activity will be merely academic, and likely to lead to frustration. The effort to make a difference requires managerial skill on the part of the clinical ethics committee, strong relationships with organizational leaders, and practical understanding of what kinds of outputs will be valued and used by the organization.

As clinical ethics committees venture into dealing with organizational issues, it will be important to collect, share, and learn from their experience. Doing that was crucial for the development of clinical ethics. In the next decade we can hope for something similar for organizational ethics.

NOTES

1. K.E. Goodpaster and J.B. Matthews, "Can a Corporation Have a Conscience?" *Harvard Business Review* (January/February 1982): *https://hbr.org/1982/01/can-a-corporation-have-a-conscience.*

2. C.B. Cohen, "Ethics Committees as Corporate and Public Policy Advocates," *Hastings Center Report* 20, no. 5 (September-October 1990): 36-7.

3. P. Boyle, "Business Ethics in Ethics Committees?" *Hastings Center Report* 20, no. 5 (September-October, 1990): 37-8.

4. S.J. Reiser, "The Ethical Life of Health Care Organizations," *Hastings Center Report* 24, no. 5 (1994): 28-35.

5. D.J. Opel et al., "Characterisation of Organizational Issues in Paediatric Ethics Consultation: A Qualitative Study," *Journal of Medical Ethics* 35 (2009): 477-82.

6. D.S. Silva et al., "Clinical Ethicists' Perspectives on Organisational Ethics in Healthcare Organizations," *Journal of Medical Ethics* 34 (2007): 320-3.

7. G. McGee et al., "Successes and Failures of Hospital Ethics Committees: A National Survey of Ethics Committee Chairs," *Cambridge Quarterly of Healthcare Ethics* 11 (2002): 87-93.

8. S.P. Pearson, J.E. Sabin, and E.J. Emanuel, *No Margin, No Mission: Health Care Organizations and the Quest for Ethical Excellence* (New York: Oxford University Press, 2003).

9. L.J. Weber, "Taking on Organizational Ethics," *Health Progress* 78 (May-June 1997): 20-3, 32.

10. M. Rorty, "Getting the Different Voices in the Same Room," *American Journal of Bioethics* 9, no. 4 (2009): 39-41.

11. E.M. Spencer, A.E. Mills, M.V. Rorty, and P.H. Werhane, *Organization Ethics in Health Care* (New York: Oxford University Press, 2000), 158.

12. J.A. Gallagher and J. Goodstein, "Fulfilling Institutional Responsibilities in Health Care: Organizational Ethics and the Role of Mission Discernment," *Business Ethics Quarterly* 12 (2002): 433-50; L.S. Paine, "Managing for Organizational Integrity," *Harvard Business Review* (March-April, 1994), *https://hbr.org/1994/03/managing-for-organizational-integrity.*

13. W.A. Nelson, "Comparing Ethics and Compliance Programs," Healthcare Executive 27, no. 4 (2012): 46, 48-9.

14. E. Fox, M.M. Bottrell, and K.A. Berkowitz, "Integrated Ethics: An Innovative Program to Improve Ethics in Health Care," *Public Sector Innovation Journal* 15, no. 2 (2010): 1-38.

15. M.B. Foglia et al., "Preventive Ethics: Addressing Ethics Quality Gaps on a Systems Level," *Joint Commission Journal on Quality and Patient Safety* 38, no. 3 (2012): 103-11.

16. W.A. Nelson et al., "Preventing Ethics Conflicts and Improving Healthcare Quality Through System Redesign," *Quality and Safety in Health Care* 19 (2010): 526-30.

17. D. Ozar, "Finding a Voice: Like Individuals, Organizations are Moral Speakers and Actors," *Health Progress* 87 no. 6 (2006):24-7.

18. C. Bayley and J. Busacker, "Beyond Brand: The Essential Quality of Catholic Health Care," *Health Progress* 96 no. 6 (2015): 45-7.

19. D. Ozar et al., *Organizational Ethics in Health Care: Toward a Model for Ethical Decision Making by Provider Organizations* (Chicago, Ill.: American Medical Association Institute for Ethics, 2000).

20. J.E. Sabin and D. Cochran, "Confronting Trade-Offs in Health Care: Harvard Pilgrim Health Care's Organizational Ethics Program," *Health Affairs* 26 (2007): 1129-34.

21. L.S. Paine, *Value Shift: Why Companies Must Merge Social and Financial Imperatives to Achieve Superior Performance* (New York: McGraw-Hill, 2003).

22. The consultation report from the meeting is available on request. Write to *Jim_Sabin@harvardpilgrim.org.*

23. LGBT is an acronym for lesbian, gay, bisexual, and transgender.

Human Rights Campaign, "Corporate Equality Index," 2015, *http://www.hrc.org/resources/corporate-equality-index-2015-statements-from-employers-that-rated-100-perc.*

24. United States Conference of Catholic Bishops, "Educational and Religious Directives for Catholic Health Care Services," 2009, *http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.*

What Is Everyday Ethics? A Review and a Proposal for an Integrative Concept

Natalie Zizzo, Emily Bell, and Eric Racine

ABSTRACT

"Everyday ethics" is a term that has been used in the clinical and ethics literature for decades to designate normatively important and pervasive issues in healthcare. In spite of its importance, the term has not been reviewed and analyzed carefully. We undertook a literature review to understand how the term has been employed and defined, finding that it is often contrasted to "dramatic ethics." We identified the core attributes most commonly associated with everyday ethics. We then propose an integrative model of everyday ethics that builds on the contribution of different ethical theories. This model proposes that the function of everyday ethics is to serve as an integrative concept that (1) helps to detect current blind spots in bioethics (that is, shifts the focus from dramatic ethics) and (2) mobilizes moral agents to address these shortcomings of ethical insight. This novel integrative model has theoretical, methodological, practical, and pedagogical implications, which we explore. Because of the pivotal role that moral experience plays in this integrative model, the model could help to bridge empirical ethics research with more conceptual and normative work.

INTRODUCTION

The emergence of bioethics is often tied to various scandals and challenges in biomedicine, including those related to research (for example, experiments on institutionalized children), and those related to tough dilemmas in clinical practice (for example, determination of brain death and withdrawal of life support). These were, for the most part, issues that had a dramatic public profile. It is also true that bioethics was triggered by non-dramatic, everyday ethics issues, such as a culture of increasingly impersonal care (for example, large hospitals, specialization of medicine) and the need to recognize and respect individuals' rights in daily care. As a result of these events, many changes have been brought to healthcare and biomedicine over the past 50 years. At the same time, there is a sense that bioethics has focused on the more dramatic ethical issues, while the issues faced in daily life by health-

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care practitioners, patients, and caregivers—"everyday ethics"—are not well considered and reflected in the agenda of bioethics. For the purpose of this article we consider everyday ethics to encompass issues that occur regularly within healthcare, but that are perhaps under-discussed in light of their regularity or overlooked because they are perceived as ordinary and unimportant from an ethical standpoint. A failure to recognize the important ethical dimension of these everyday issues, however, ignores ethical theories that can aid in the consideration of these issues, and may have lasting effects (for example, influence how individuals interact in the healthcare system).

The call for greater attention to everyday ethics has profound philosophical roots, notably in philosophical pragmatism, which called for more attention to everyday moral experience, starting in the early twentieth century, and later in feminist philosophy.[1] Dewey, for example, repeatedly stressed the need to capture everyday moral experience and bring back philosophy (and philosophical ethics) to the study of real-world problems.[2] Accordingly, he repeatedly critiqued essentialism and what he described as the "philosophical fallacy," that is, the fallacy of neglecting context in philosophical thinking to the profit of unbounded universalism.[3] In the last decades, numerous critiques of bioethics stemming from different theoretical perspectives have pointed to bioethics' lack of connection with everyday ethics. Contemporary scholarship stemming from the tradition of clinical ethics,[4] feminist ethics,[5] pragmatism,[6] and narrative ethics[7] have all, in different ways, called for greater attention to everyday ethics, a term that has been in use explicitly in bioethics since at least the 1980s. Perhaps most notably, in 1990, Kane and Caplan published a landmark anthology, titled *Everyday Ethics: Resolving Ethical Dilemmas in Nursing Home Life,* that considered ethical dilemmas in nursing home care.[8] Since Kane and Caplan's book, the application of the term has since expanded and been applied in many other contexts, and it is important to recognize that the call for a return to everyday concerns in medical ethics has a long[9] and rich history.[10] Nonetheless, the concept of everyday ethics remains, to our knowledge, somewhat undefined, is often left unnamed by authors, and is missing integration with normative theoretical frameworks.

In this article, we examine more in depth the concept of everyday ethics. To accomplish this, we review the current literature that references everyday ethics and identify the core features and functions of this concept. We then reflect on the normative function of everyday ethics. We propose an integrative model of everyday ethics, which serves the purpose of drawing attention to a particular set of issues that are understudied in academic research and remain overlooked or unrecognized as ethical issues. We examine how different normative theories account for aspects of everyday ethics that, when viewed through an integrated lens, draw the eye to important but under-appreciated issues in bioethics. The implications (theoretical, methodological, practical, and pedagogical) of this integrative concept are illustrated and discussed.

WHAT IS EVERYDAY ETHICS?

In order to better understand how everyday ethics has been characterized in the academic literature, we performed a literature review using PubMed and ProQuest MEDLINE, using the terms "everyday ethic*". This search yielded a total of 88 results (excluding duplicates); 27 of these were excluded because they had no abstract and were inaccessible, while 61 results were included and analyzed. (Two had abstracts, but full versions were inaccessible; 59 results were fully accessible.) We reviewed the abstracts of all included results, as well as the abstracts of articles that were relevant to the bioethics/clinical context (for example, articles that discussed everyday ethics in the context of delivery of care were carefully examined, while articles that discussed everyday ethics in the context of information technology were not fully read).

Defining Everyday Ethics

To operationalize a term, it is important that it has a coherent and consistent definition. When it comes to describing what is meant by everyday ethics, only one-third (33 percent) of the articles gave a description or definition of the term. Nearly half of the articles (41 percent) used the term only in the title or abstract. This scarcity of definitions seems to indicate that everyday ethics is thought to be an implicitly understood concept. When descriptions of everyday ethics were given, however, they were inconsistent and varied depending on the context. For example, in the nursing literature, many of the definitions were, not surprisingly, focused on the experience of the nurse: " 'Everyday ethics' involves those usual encounters that nurses have with patients, their families, and other health providers, […] [it] centers on who the professional nurse is and how the nurse interacts with and relates to others in the health care environment."[11] Comparatively, other descriptions highlighted everyday ethics as charac-

TABLE 1. Illustrative published descriptions and definitions of everyday ethics

- "Everyday conflicts that have ethical implications—what we call 'situated ethics.' "[1]
- "Ethical questions that arise on a day-to-day basis."[2]
- "Situations involving values, virtues, obligations, ethical principles (such as respect for persons) or manifestations of these principles (such as truth-telling and confidentiality), as well as conflicts between any of these, although conflict [is] not required. In addition, [. . .] matters relating to professionalism and associated responsibilities [are included]."[3]
- "The day-to-day clinical activities that constitute a moral territory lying outside of formal ethics guidelines."[4]
- "The small decisions about the content and order of daily life in nursing homes[5] and other health and social service settings."[6]
- " 'Ordinary' issues of daily living."[7]
- "Ethics with a small e, 'the moral what-to-do questions [. . .] that require [. . .] to evaluate and choose between alternatives'[8] on an everyday basis, while in the field. [. . .] it is not the Ethics with a capital E of Ethics Committees or Ethics Councils."[9]
- " 'Housekeeping issues,' [...] the everyday routine issues that constitutes a major part of the health care work performed by nurses and often ignored and invisible in ethical dogma."[10]
- "Everyday ethics involves human values and beliefs about how we should live and interact with one another on a daily basis."[11]

NOTES

1. S. Van der Dam et al., " 'Here's My Dilemma': Moral Case Deliberation as a Platform for Discussing Everyday Ethics in Elderly Care," *Health Care Analysis* 20, no. 3 (2012): 250-67.

2. J.A. Carrese et al., "Everyday ethics in internal medicine resident clinic: An opportunity to teach," *Medical Education* 45, no. 7 (2011): 712-21.

3. V. Loblay, "Everyday ethics: Ultrasound and Sex-Determination in Australia," *Indian Journal of Medical Ethics* 6, no. 4 (2007): 188-93.

4. A.L. Caplan, "The Morality of the Mundane: Ethical Issues Arising in the Daily Lives of Nursing Home Residents," in *Everyday Ethics: Resolving Dilemmas in Nursing Home Life,* ed. R.A. Kane and A.L. Caplan (New York: Springer, 1990).

5. C.M. Messikomer, and C.C. Cirka, "Managing Everyday Ethics in Assisted Living: A Research-Based Case Analysis for the Classroom," *Gerontology and Geriatrics Education* 28, no. 4 (2008): 71-93.

6. B.A. Powers, "Ethnographic Analysis of Everyday Ethics in the Care of Nursing Home Residents with Dementia: A Taxonomy," *Nursing Research* 50, no. 6 (2001): 332-9.

7. Nuffield Council on Bioethics, *Medical Profiling and Online Medicine: The Ethics of 'Personalised Healthcare' in a Consumer Age* (London: Nuffield Council on Bioethics, 2010).

8. V. Lichtner, "The Everyday Ethics of Field Work Research with Vulnerable Patients," *Studies in Health Technology and Informatics* 205 (2013): 813-7.

9. S. Öresland et al., "Home-Based Nursing: An Endless Journey," *Nursing Ethics* 18, no. 3 (2011): 408-17.

10. B.A. Powers, "Everyday Ethics of Dementia Care in Nursing Homes: A Definition and Taxonomy," *American Journal of Alzheimer's Disease and Other Dementias* 15, no. 3 (2000): 143-51.

11. E. Balka, and M. Tolar, "Everyday Ethical Dilemmas Arising with Electronic Record Use in Primary Care," *Studies in Health Technology and Informatics* 169 (2010): 285-9.

terized by "multi-perspectiveness."[12] There was recognition of the importance of different views in identifying and resolving everyday ethical issues.[13] The importance placed on multiple perspectives is perhaps best exemplified by the various studies that investigated not only the views on everyday ethics of healthcare practitioners, including physicians, nurses, and other allied healthcare professionals, but of patients, family members, and caregivers.[14]

Some authors characterized everyday ethics based on its frequency, and others emphasized its ordinariness (for example, "ordinary ethics-related issues commonly faced").[15] An emphasis on the ordinary likely stems from Caplan's original conception of everyday ethics, wherein he states, "Ethics concerns not only questions of life and death but how one ought to live with and interact with others on a daily basis. The ethics of the ordinary is just as much part of health care ethics as the ethics of the extraordinary."[16] Although some descriptions overlapped, there was no single, consistent definition of everyday ethics (see table 1). Despite these inconsistencies and variable definitions, everyday ethics seems to be operationalized as a set of ethical issues that occur regularly, arise often in healthcare interactions, and are frequently overlooked.

Defining Everyday Ethics by Comparisons

In many of the retrieved articles, everyday ethics was more often described in terms of what it is not. For example, everyday ethical issues were often contrasted to ethical issues that are viewed or analyzed as dilemmas.[17] Some authors regarded everyday ethics as overlooked by principle-based or procedural theories,[18] and viewed everyday ethical issues as better analyzed using contextual forms of ethics.[19] Perhaps most commonly, everyday ethics was contrasted to what has been alternately termed "dramatic,"[20] "high-intensity,"[21] "sensational,"[22] or "tragic"[23] ethics. In this article, we adopt the term "dramatic ethics" to refer to this type of ethics, although we do not mean to imply any normative judgments in our distinction of these two sets of ethical issues.[24]

Within the retrieved literature, dramatic ethics was often described as rendering everyday ethics invisible,[25] causing it to be overlooked[26] and overshadowed.[27] Dramatic ethics is seen as having a higher media and public

profile, and correspondingly as retaining the focus of bioethics.[28] Despite the multiple comparisons of everyday ethics to dramatic ethics, the term dramatic ethics itself was poorly characterized. Our review suggests that dramatic ethics is often associated with acute care, and tends to focus on high-technology, often invasive or life-threatening interventions, and advances in research. Comparatively, everyday ethics is seen as aligning more closely with regular, practical clinical ethical issues, reflecting "real-life" problems faced by patients or careproviders. Notably, dramatic ethical issues were perceived as challenging and important, but also as less common and as not reflecting the actual experience of most patients and healthcare providers.[29] In contrast, everyday ethics was described as "subtle and pervasive,"[30] and was seen as a feature in the experiences of the many.[31] We highlight the differences between everyday and dramatic ethics, derived from the literature and our own reflections, in table 2.

Common Contexts of Everyday Ethics Discussions

Interestingly, everyday ethics seemed to be widely discussed in two contexts. The first is nursing (47 percent of included sample), for whom issues such as those related to consent for minor procedures[32] and dealing with problematic patients[33] were discussed. The second most highly discussed context was the ethics training of healthcare professionals (25 percent). Many articles in this context discussed similar issues (for example, issues related to consent, confidentiality, and managing therapeutic relationships,[34]) as they relate to the experience and education of trainees, as well as challenges that relate specifically to being a trainee (for example, balancing obligations as a learner and as a healthcare provider,[35] managing the limits of one's compe-

tence[36]). Meanwhile, a smaller subset of the literature focused on the experiences of patients and their families (13 percent; for example, issues related to navigating the healthcare system, asserting one's autonomy and being sufficiently informed, and issues with access to care[37]). An even smaller subset looked at everyday ethical issues for health researchers (4 percent; for example, issues related to collecting data from participants in developing countries).[38]

Many authors called for the use of everyday ethical issues in the ethics training of clinicians.[39] The focus on everyday ethics in ethics education may be a result of efforts to utilize the ethical issues that practitioners are most likely to encounter in the provision of care as teaching tools (that is, those that are frequent and familiar).[40] In this case, everyday ethics is described as more reflective of the actual experiences of careproviders[41] and may serve as a bridge between bioethics and clinical practice.

The multiple contexts in which everyday ethics was discussed illuminate an important point: many individual stakeholders are touched by everyday ethics. As a result, a consideration of *whose* everyday experience it is that is examined factors into descriptions of everyday ethics. Everyday ethical issues can involve any of the above parties, but the particular ethical challenge or concern may vary, depending on whose perspective is taken. At the same time, it is important to note that different stakeholders may experience the same everyday ethical issues (for example, issues related to access to care), but in different ways.

Professionalism, Relationships, and Everyday Ethics

Finally, the importance of everyday ethics to professionalism and the common obligations of cli-

TABLE 2. Commonly described differences between everyday ethical issues and dramatic ethical issues

Dramatic ethical issues	Everyday ethical issues
Focused on "extraordinary" high-technology and life-threatening interventions	Focused on daily life, "ordinary" healthcare and services
Often in acute care/high-risk settings	Often in non-acute care/low-risk settings
Less common (affects few)	More common (affects many)
Salient/high media and public profile	Less salient/low media and public profile
Associated with high-technology research, innovative care	Associated with everyday healthcare encounters, routine care
Perceived higher ethical stakes; high attention in bioethics	Perceived lower ethical stakes; limited attention in bioethics
Often described/set up as an ethical dilemma	Often described in nondilemmatic forms such as angst, moral distress, tensions
Of high interest for analyses based on ethical principles (for example, principlism, casuistry)	Of high interest to contextual forms of ethics (for example, feminist ethics, pragmatism, and narrative ethics)

nicians to patients were commonly cited in the literature.[42] Everyday ethics was seen as being an integral part of the professional practice, perhaps because it is reflective of the everyday experience of healthcare practitioners. Correspondingly, it was observed that everyday ethics is often captured in the ethics language of non-experts, or a folk taxonomy.[43] Indeed, everyday ethics is part of the ordinary experience of individuals, and the issues that individuals deal with daily are not always classified or described as ethical in nature. When an issue is examined more in depth and unpacked, its ethical dimensions can become clearer. Everyday ethical issues may arise from relational or contextual factors that are intrinsic to everyday encounters (for example, issues of communication),[44] or as the result of systemic or organizational issues (for example, challenges in the adequate provision of healthcare in light of limited resources).[45]

Core Features of Everyday Ethics

Upon this review of the literature, we observe that the following attributes have been used to characterize everyday ethical issues:

- First, everyday ethics encompasses real-life issues; everyday ethics is not hypothetical, it includes events that occur often and affect the many.
- Second, everyday ethics is situated in common interactions between people; issues may be especially tied to relational and contextual factors, but also systemic and organizational factors.
- Third, everyday ethics varies depending on the agent or stakeholder, including clinicians (nurses, physicians, *et cetera*), patients, and their relatives and caregivers. Notably, while everyday ethics affects more than just clinicians, it is often associated with professionalism.
- Fourth, everyday ethics is often captured in a folk taxonomy, or non-expert ethics language, and its ethical dimension may not always be apparent to stakeholders.

Note that not all of these attributes are necessary for an issue to be considered an everyday ethical issue, but these attributes can enable us to recognize these issues.

What is the Normative Importance of Everyday Ethics?

Despite the likelihood that patients and healthcare providers encounter everyday ethical issues, these issues are described in the literature as under-recognized, under-discussed,[46] and as attracting little attention.[47] For example, research in the context of Parkinson's disease suggests that everyday ethics (for example, issues encountered in communication or related to common aspects of clinical relationships) is overlooked in favor of ethical challenges associated with invasive interventions such as stem cells and deep-brain stimulation.[48] Several studies have also reported that, even in clinical ethics, there is a tendency to perceive the need for clinical ethics services only in what might be described as dramatic ("crisis") cases.[49] This points to a propensity for bioethics discussions to be held foremost when an issue is unusual or raises attention.

A focus on dramatic ethical issues can eclipse pertinent ethics discussions, and high-profile type concerns risk becoming, as Powers noted, the "[lens] through which the topic of ethics in health care is viewed."[50] This failure to recognize and discuss the importance of everyday ethics may be related to its "ordinariness."[51] Comparisons of everyday ethics to "tragic" ethical issues[52] perpetuate a problematic idea that everyday ethics cannot have important consequences. Perhaps most notably, everyday ethical issues have been described as having "seemingly small stakes."[53] Previous descriptions of them as mundane[54] likely do not help in illustrating their importance. This may explain why the bioethics literature has had little focus on these issues. The stakes of everyday ethics may only be perceived as small because the consequences of ignoring these issues may not be immediately apparent. In fact, unaddressed everyday ethical issues can have significant lasting effects (for example, may influence how individuals interact with and within the healthcare system). For example, in a qualitative study on the perspectives of young adults with cerebral palsy, the conduct of clinicians in everyday encounters (for example, belittlement) had a significant impact on the young adults' future trust in and use of healthcare services. Accordingly, suboptimal handling of everyday ethics led, in some cases, to significant negative outcomes for youth who disengaged with healthcare and lost trust in their clinicians. Furthermore, regardless of the size of the stakes of everyday ethics, if these issues occur regularly (that is, "everyday"), and affect a large number of people, then, as Smith noted, "the enormity of these ethical problems becomes staggering."[55] Accordingly, and in spite of its name, the concept should be recognized for its importance and implications.

At the same time, it may be challenging to recognize everyday ethics in practice. Stakeholders may overlook the ethical dimensions and the moral significance of everyday ethical issues. As a result,

these issues may be misclassified as purely logistical or as clinical "problems" to be solved.[56] It is also possible that a failure to recognize some everyday issues as ethical ones may be a result of their description within a folk taxonomy (that is, they are rarely captured in the "ethics language"). By ignoring the ethical components of these issues, approaches to resolve them may overlook important values, principles, and theories that are necessary in the consideration of ethical issues. In the next section, we make a proposal for a more explicit use of the concept of everyday ethics to seize ordinary moral experience.

<div align="center">

**PROPOSAL: AN INTEGRATIVE
MODEL OF EVERYDAY ETHICS**

</div>

Based on the normative importance of everyday ethics and our review of the relevant literature, we propose that everyday ethics, from a functional (pragmatist) perspective,[57] should be utilized as an integrative concept that (1) helps to detect current blind spots in bioethics (that is, shifts focus from dramatic ethics) and (2) mobilizes moral agents to address these shortcomings of ethical insight. This integrative model draws from multiple ethical theories and has important methodological, practical, and pedagogical implications (see figure 1).

What Is an Integrated Everyday Ethics?

We propose that the concept of everyday ethics can be enriched with open-ended descriptions that tap into the resources of diverse normative theories. Various ethical theories can be used as "lenses," an approach originally suggested by the feminist scholar Sherwin,[58] through which we see everyday ethics. The metaphor of lenses that was proposed by Sherwin is opposed to a more common metaphor of "foundations," which suggests that theories offer fundamental grounding principles and arguments. In contrast, the metaphor of a lens suggests that different theories may yield different perspectives on—and solutions to—ethical problems.[59] Moreover, the lens metaphor explicitly states that the employment of several standpoints can lead to a more comprehensive perspective, whereas the metaphor of foundations hints at the idea that one theory is likely to be stronger and better than another. The idea of
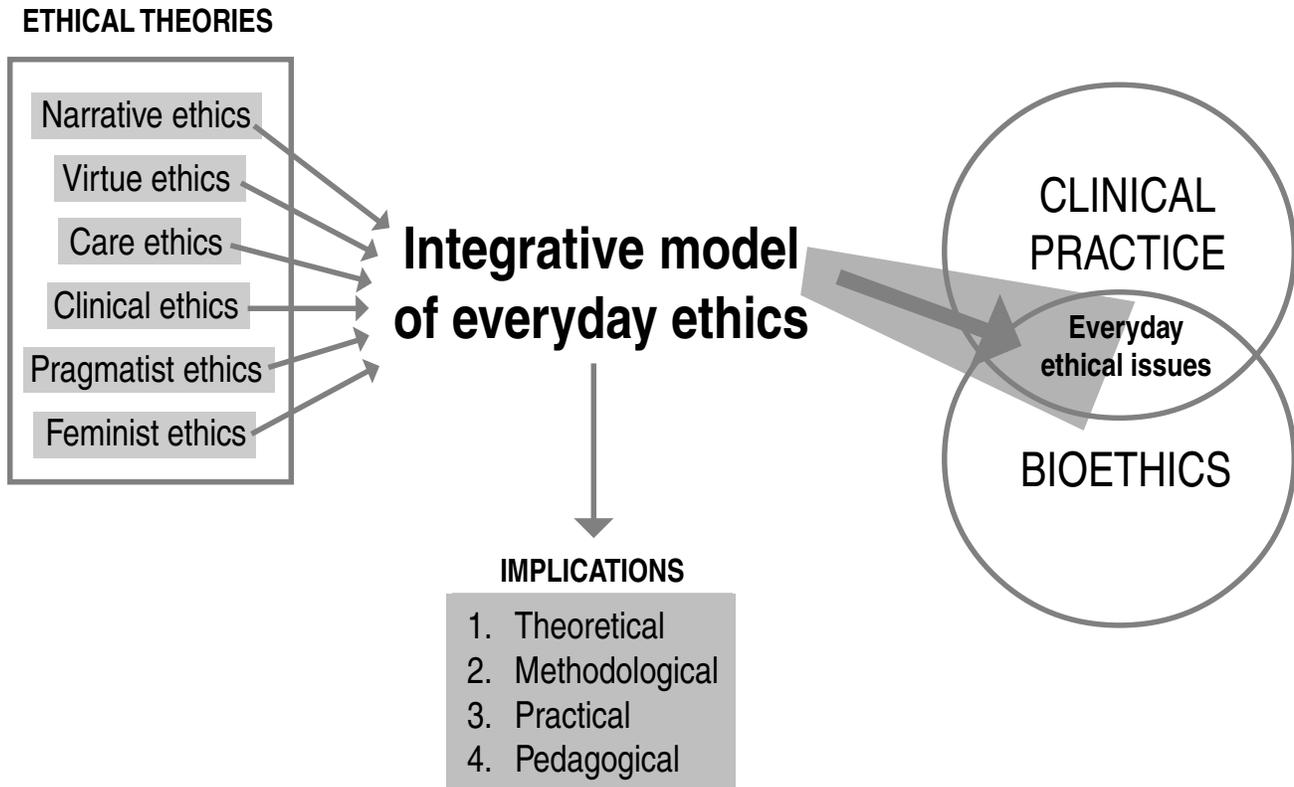

FIGURE 1. The integrative model of everyday ethics. Diverse ethical theories contribute to an integrative model of everyday ethics. The integrative model can shed light on everyday ethical issues in clinical practice and in bioethics. This model has theoretical, methodological, practical, and pedagogical implications.

lenses also enables us to address an issue with the normative theory or theories that are the most appropriate to the issue at hand.

Thus far, many different ethical theories have endeavored to attend to clinical and daily ethical issues; they have explored issues related to everyday ethics, but have not always identified them as such. The proposed integrative model brings together the contributions that these different ethical theories make to a concept of everyday ethics (see table 3). For example, narrative ethics has stressed the importance of listening to a patient and understanding how personal histories and different aspects of the clinical encounter, which may seem minor, can have major impact within the broader perspective of the person.[60] Indeed, there have been specific writings exploring the role of narrative in everyday ethical expertise and socially embedded caring practices.[61] We can also draw from pragmatism, which has stressed historically and in its contemporary rendition in bioethics the importance of understanding daily and ordinary challenges in ethics, as well as the importance of context in shaping our understanding of moral agents.[62] A role for clinical ethics is evident; it was actually first described by Jonsen and colleagues as a field that is "both about the ethical features that are present in every clinical encounter and about the ethical problems that occasionally arise in those encounters."[63] Levine considered the role of virtue ethics: "Ethical behavior is not the display of one's moral rectitude in times of crises. It is the day-by-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions."[64] Even the *Principles of Biomedical Ethics,* despite often being considered inadequate for the analysis of everyday ethical issues,[65] may illuminate everyday ethics. Within principlism there is an acknowledged role for common morality as a starting point for ethics. As a method, it does not preclude the analysis and consideration of everyday ethical issues.[66]

By superimposing different theoretical lenses, an integrative approach supports the richness of the concept of everyday ethics and strengthens its potential to "de-bias" bioethics. And since every lens has its blind spot, only a comprehensive model can help to introduce checks and balances for different perspectives. Table 3 schematically displays the idea that different ethical theories can serve as a lens through which we can view the different attributes of everyday ethics. Based on the domains of ethics identified by Ricoeur, separating everyday ethics into the ethics of (1) self; (2) proximate other; and

(3) distal other, helps to capture the notion that everyday ethics is multi-perspectival and that it should be considered and operationalized as such.[67] We consider each ethical theory's contribution to the integrative model, its practical contribution to both bioethics and clinical practice, and its operational contribution to the clinical encounter.

The Implications of an Integrative Everyday Ethics

This proposal for an integrative model has several theoretical, methodological, practical, and pedagogical implications.

Theoretical implications. From a conceptual standpoint, this integrative model moves us away from defining precisely the boundaries of the concept of everyday ethics, which, after some initial clarification and identification of common characteristics (for example, table 2), is bound to be superfluous. Indeed, a proposal for a precise definition of the domain and application of the concept would risk introducing unwelcomed positional biases. Such a definition would need to reflect a stakeholder's own everyday experience, which by definition is rooted in a first-person perspective. It also raises fundamental questions about whose everyday ethics is at stake: In which situation is a patient or other moral agent involved? and What is one's everyday? A rigidly defined concept can only have a limited degree of precision. Furthermore, if the concept is ossified in a precise definition, there is a risk that the normative functions of the concept (that is, its role as a detector of blind spots in bioethics) will be forgotten, and that everyday ethics will be reduced to a descriptive concept. Such an outcome would then defeat its purpose to enhance the moral lens. Any definition or specification of everyday ethics should remain open to enrichment to prevent the possibility that it becomes self-limiting.

Methodological implications. From a methodological standpoint, the integrative model of everyday ethics points to a need for bioethics to empirically investigate stakeholders' perspectives and experiences (a descriptive methodological contribution), and to attend to everyday ethical issues that may not be obvious or salient (a normative methodological contribution). In terms of the descriptive methodological contribution of everyday ethics, there has been qualitative research exploring everyday ethical issues in clinical practice,[68] and other research investigating some of the concept's descriptive components. An integrative model supports such research on the experience and perspectives of stakeholders and calls for multiple empirical research approaches (including qualitative and quan-

TABLE 3. Integrative model of everyday ethics and its applications

Sphere		
Self	Proximate other	Distal other
Contributions from narrative ethics: Theoretical: 　Everyday ethical issues are often captured in a personal or folk taxonomy/non-expert ethics language that merits full attention. Narrative ethics brings attention to non-expert formulation of ethical challenges and a comprehensive outlook on the person. Practical: 　Avoid using prematurely expert concepts in ethics to capture a patient's perspectives. Operational: 　Questions to keep in mind: How did the patient talk about his or her situation? Is my understanding of ethics overly constrained by assumptions? What is the history behind this problem? Are there ethical issues embedded in narratives that we fail to recognize?	**Contributions from care ethics:** Theoretical: 　Everyday ethical issues may arise as a result of relational and contextual factors. Care ethics brings attention to these factors, as well as to our obligations to particular others in relationships. Emphasizes the caring aspects of relationships. Practical: 　Avoid making no room or time to integrate the relational dimension of care. Operational: 　Questions to keep in mind: Does the patient feel comfortable with me? Is the patient censoring her or his own views?	**Contributions from pragmatist ethics:** Theoretical: 　Everyday ethics is embedded in contexts and the importance of context has been vastly neglected in philosophical ethics. Bioethics tends to abstract unduly and "essentialize" everyday ethical issues. Pragmatist ethics brings attention to the need to focus on "real-life" issues, the impact of different (clinical and societal) contexts, and how they are conducive or not to the ability and comfort of patients to voice everyday ethical concerns. Practical: 　Avoid an individualistic and abstract understanding of moral agency that impedes the ability to understand the broader context underlying everyday experience. Operational: 　Questions to keep in mind: Is this patient's experience of the situation shaped by his or her socio-economic status? Is my own social position impeding my ability to relate and understand the everyday experience of this patient?
Contributions from virtue ethics: Theoretical: 　Brings attention to the fact that an excellent (virtuous) clinician must have sound judgment on what the best interests of a patient are, based on a generous understanding of and significant engagement with the patient's values. Practical: 　Recognize that the ability to express everyday ethical concerns is contingent on good listening skills on the receiving end. Operational: 　Questions to keep in mind: Are my interpersonal skills as a clinician sufficiently developed to allow patients to express themselves and feel comfortable with me?	**Contributions from clinical ethics:** Theoretical: 　Brings attention to the fact that every clinical act involves values, and that ethics is an integral part of healthcare encounters. Practical: 　Avoid viewing ethics as something extrinsic to clinical practice, thereby evacuating ethics from everyday practice. Operational: 　Questions to keep in mind: Is ethics part of my analysis of the clinical situations I encounter? Does my view of my patients' decisions provide a generous understanding of values in clinical practice?	**Contributions from feminist ethics:** Theoretical: 　Everyday ethical issues can be shaped by asymmetrical relationships based on gender, race, professional hierarchies, and other socially constructed categories. Related biases and influences need to be taken into consideration. Practical: 　Avoid gender biases and propagation of relational asymmetries that disempower individuals and their ability to speak for themselves. Operational: 　Questions to keep in mind: Am I treating like cases alike? Are individuals with different social and cultural backgrounds equally able to express themselves?

Note: In this table, we only illustrate examples of contributions of different theoretical perspectives. We are not claiming that any of the cited approaches have relevance to only one sphere (self, proximate other, distal other) or that we have in anyway described their full or most important contributions.

titative, observatory, and participatory approaches) to understanding everyday ethics. That being said, based on its function, everyday ethics may be more legitimate as an initial focus of empirical research, rather than as an overall concept that should be applied deductively to interpret these experiences and perspectives. It is possible that research on the common experience of ethically problematic situations could help generate an ethical taxonomy that better reflects everyday moral experience.

Perhaps more novel is the normative methodological contribution of everyday ethics, which supports an understanding and application of moral theories that align with pragmatism and feminism. Within this understanding, moral theories can be described as "hypotheses" to be tested in real-world settings, as well as lenses or perspectives that can be used to determine the nature of a problematic situation as well as to find a path to its resolution.[69] The integrative model operationalizes this view, which broadens our outlook on the nature of everyday ethics and mobilizes resources from different perspectives to address concerns related to the neglect of everyday ethical issues. In drawing attention to ethical issues that have been ignored, the model points to a need to foster more-comprehensive analyses of the kinds of ethical issues that exist, and the active listening and engagement needed to capture them.

Practical implications. The integrative model of everyday ethics not only serves to draw attention to the methodological changes that bioethics can implement, but to the practical changes that can be implemented clinically. The model highlights various important practical contributions from different ethical theories (table 3), such as the need for narratives, attention to relational and contextual factors, and the recognition of the ethics that is inherent in every clinical encounter. These contributions could lead to practical changes that can be implemented clinically, with the goal of enhancing healthcare and addressing everyday ethical issues.

Changes can include recognition of the influence of contextual and relational factors on behavior and care (for example, racial, age, or gender-based attitudes and discrimination), with greater self-reflection and awareness of biases. The integrative model promotes a clinical practice model with greater room for patients' perspectives and calls for dedicated training on the skills required for active listening. It also recognizes the need to tackle systemic biases and impediments that exist for certain groups of patients. Indeed, as Messikomer and Cirka noted, improving an ethical climate and culture re-

quires a focus on "the everyday circumstances and situations in which issues or problems are defined to have ethical content, and how the organization resolves or manages them."[70]

These practical implications are only a few examples of what everyday ethics might contribute to healthcare. Further consideration may illuminate other important changes to undertake at the individual and organizational levels. By integrating the practical contributions from multiple ethical theories, the integrative model of everyday ethics can be utilized to support change in clinical practice.

Pedagogical implications. Finally, an integrative model of everyday ethics underscores the importance of teaching about everyday moral experience in the healthcare sciences. Moral theories have been taught with the assumption that they cultivate moral reasoning skills and provide ways of resolving ethical dilemmas. This understanding of ethics education sets the stage for teaching ethics in a way in which "ethical questions" can find "answers." Writings on everyday ethics, as well as many other movements in medical pedagogy,[71] have criticized this narrow focus of ethics education and called for a wider array of teaching methods (role playing, patients' presentations, films, and commentaries[72]), that more fully convey the experiential and personal aspects of ethical situations. In this scheme, a clinician or stakeholder is mobilized to act as a moral agent who must find a "response," and not simply an answer, to a problematic situation. These pedagogical approaches are also supported by the everyday ethics literature itself.[73]

By bringing attention back to the ethics inherent to the everyday clinical encounter, an integrative concept of everyday ethics provides support for a more comprehensive way of teaching ethics. An integrative model of everyday ethics supports the need to train clinicians in ethics in ways that are more in line with their practice (that is, with the everyday ethical issues they are likely to encounter). It becomes a tool for clinicians to scrutinize their position as moral agents.

LIMITATIONS

This article reports a first review of the literature on everyday ethics and attempts to define its core features. It also proposes a way forward to mobilize the resources of different moral theories to help operationalize everyday ethics. We acknowledge that, having provided a rather ambitious overview and model, the detailed implications of the integrative model would benefit from individual-

ized, dedicated attention. The aim of our general view is to explain the connections that could be drawn from a better understanding (generated by research) of everyday ethics toward the improvement of clinical and educational practices. By doing so, this model of integrative ethics generates possible pathways to bridge research (empirical or theoretical) and practice, informed by ethical theory. In this sense, moral experience is at the core of the model, as both a starting and ending point, and ethics is construed as a disciplined undertaking to help prevent and resolve ethically problematic situations.

We also note that our discussion of everyday ethics has been largely limited to the clinical context; this is a direct result of the existing everyday ethics literature, which is also focused in this domain. Few articles explored everyday ethics for researchers.[74] We acknowledge that everyday ethics may have its own considerations for research ethics, which is beyond the scope of this article, but which certainly merits investigation.

CONCLUSION

The concept of everyday ethics has been described and justified from several theoretical bioethics lenses. It has often been pitted against "dramatic ethics." Our review indicates the divergence in the descriptions and definitions of everyday ethics, but also the richness of theoretical perspectives on the concept. We propose that a broader theoretical perspective can lead to a view of everyday ethics as an integrative concept whose paramount functional roles are to identify blind spots created by dramatic ethics and to redirect attention to everyday ethical issues. Within this account, different theoretical lenses can be mobilized in the service of de-biasing bioethics and enriching the implications of the concept in research, practice, and education.

NOTES

1. C. Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass.: Harvard University Press, 1982).

2. J. Gouintlock, ed., *The Moral Writings of John Dewey, Great Books in Philosophy* (Amherst, N.Y.: Prometheus Books, 2002)

3. The roots and justification for the work undertaken in this article have foundations in philosophical pragmatism, which repeatedly stressed the need to capture everyday moral experience and bring back philosophy (and philosophical ethics) to the study of real-world problems. A similar plea could be consistent with the later work of Wittgenstein (although it is less clearly related to ethics), and obviously with more recent feminist critiques of acontextual moral theory and abstract individual autonomy (versus relational autonomy). Other clear connections can be made with clinical ethics and narrative ethics. In this article, we decided to describe the problem of everyday ethics based on more-immediate concerns that are more-proximate to clinicians, given the focus of *The Journal of Clinical Ethics.* Moreover, we state that concerns for such everyday day ethics problems were already part of the impetus for a "bioethics" in the 1970s, notably in reaction to increasingly specialized (and bureaucratized) healthcare sytem (that compromised considering the person as a whole). According to some authors, the suggestions made by philosophical pragmatism have already been integrated, to some extent, in bioethics. See, for example, J.D. Moreno, "Bioethics Is a Naturalism," in *Pragmatic Bioethics,* ed. G. McGee (Nashville, Tenn.: Vanderbilt University Press, 1999), 3-16.

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8. R.A. Kane and A.L. Caplan, *Everyday Ethics: Resolving Dilemmas in Nursing Home Life* (New York: Springer, 1990).

9. S. Toulmin, "How Medicine Saved the Life of Ethics," *Perspectives in Biology and Medicine* 25, no. 4 (1982): 736-50; D. Callahan, "Bioethics as a Discipline," *Hastings Center Studies* 1, no. 1 (1973): 66-73.

10. R.D. Truog et al., "Microethics: The Ethics of Everyday Clinical Practice," *Hasting Center Report* 45, no. 1 (2015): 11-17.

11. J.A. Erlen, "Everyday Ethics," *Orthopaedic Nursing* 16, no. 4 (1997): 60-3.

12. S. Van der Dam et al., " 'Here's my Dilemma.' Moral Case Deliberation as a Platform for Discussing Everyday Ethics in Elderly Care," *Health Care Analysis* 20, no. 3 (2012): 250-67.

13. K. Boyd, "Medical Ethics: Principles, Persons, and Perspectives: From Controversy to Conversation," *Journal of Medical Ethics* 31, no. 8 (2005): 481-6.

14. For example, studies by Moon et al., Quarini, and McDougall and Sokoll focused on investigating everyday ethics from physician perspectives. M. Moon et al., "Everyday Ethics Issues in the Outpatient Clinical Practice of Pediatric Residents," *Archives of Pediatrics & Adolescent Medicine* 163, no. 9 (2009): 838-43; C.J. Quarini, "A Day in the Life of a Junior Doctor: Everyday Ethical Encoun-

ters," *Postgraduate Medical Journal* 86 (2010): 632-5; R. McDougall and D.K. Sokol, "The Ethical Junior: A Typology of Ethical Problems Faced by House Officers," *Journal of the Royal Society of Medicin*e 101, no. 2 (2008): 67-70.

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Medical Education and Professionalism

The Medical Ethics Curriculum in Medical Schools: Present and Future

Alberto Giubilini, Sharyn Milnes, and Julian Savulescu

ABSTRACT

In this review article we describe the current scope, methods, and contents of medical ethics education in medical schools in Western English speaking countries (mainly the United Kingdom, the United States, and Australia). We assess the strengths and weaknesses of current medical ethics curricula, and students' levels of satisfaction with different teaching approaches and their reported difficulties in learning medical ethics concepts and applying them in clinical practice. We identify three main challenges for medical ethics education: counteracting the bad effects of the "hidden curriculum," teaching students how to apply ethical knowledge and critical thinking to real cases in clinical practice, and shaping future doctors' right character through ethics education. We suggest ways in which these challenges could be addressed. On the basis of this analysis, we propose practical guidelines for designing, implementing, teaching, and assessing a medical ethics program within a four-year medical course.

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SCOPE AND AIMS OF ETHICS EDUCATION IN MEDICAL SCHOOLS

In the last few decades, medical ethics has become an important aspect of the education of new doctors. A doctor with ethical competencies is more likely to be a trustworthy doctor. In order to further increase patients' trust in new doctors, however, it is important that the ethics curriculum be homogenous across medical schools.[1] Relevant work aimed at unifying the medical ethics curriculum includes, among others, documents produced by working groups in the U.K.,[2] the U.S.,[3] and in Australia,[4] containing guidelines for designing, implementing, and assessing ethics education in medical schools.

There is widespread agreement that staff with appropriate ethics backgrounds should be responsible for the delivery of ethics education in medical schools, at least in preclinical years. Actually, a shortage of staff with appropriate ethics training was identified by the working group of the ATEAM (the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools) as one of the main challenges in implementing an ethics curriculum.[5] According to the 1998 U.K. "Consensus Statement by teachers of medical ethics and law in UK medical schools," (hereafter, the 1998 U.K. "Consensus Statement"), implementation of a medical ethics curriculum requires "at least one full-time

senior academic in ethics and law with relevant professional and academic expertise."[6] During clinical years of training, a more effective way to deliver ethics education might be an ethics expert and a clinical expert co-leading ethics clerkship sessions, as effectively implemented, for example, at the Icahn School of Medicine at Mount Sinai in the U.S.[7]

The objectives of medical ethics education can be divided into two main categories: cognitive (or competency) objectives and attitudinal (or virtue) objectives.[8] The first category refers to the knowledge and understanding of the values, principles, and norms that inform and regulate medical practice; the second category refers to the development of the approach, attitudes, and virtues of a good doctor. This second category can be further divided into two subgroups: the formation of the character of the good doctor (which should include virtues such as compassion, honesty, integrity), and the development of an analytic approach and critical thinking skills. These include the capacity to critically examine one's own beliefs and values, especially when they conflict with professional obligations, and to develop ethical awareness, that is, a capacity to recognize ethical issues as they arise in clinical practice and to balance different competing principles.

Documents about the ethics curriculum of medical schools have placed different emphases on these aspects. The 1998 U.K. "Consensus Statement" is more focused on cognitive objectives and on the development of critical thinking than on shaping doctors' character. It stresses in particular the importance of knowing and understanding ethical and legal principles and professional obligations, and of developing critical thinking skills.[9]

In general, however, character formation is considered at least as important as teaching notions,[10] if not more important.[11] The AAMC (the Association of American Medical Colleges), in its "Learning Objectives for Medical Student Education—Guidelines for Medical Schools," (hereafter, the AAMC "Guidelines") states that medical education should not only provide students with a knowledge of the values and principles governing ethical decision making, but should also foster attitudes of compassion and respect towards patients: virtues such as honesty and integrity, respect for the roles of other healthcare professionals, and commitment to the best interests of patients over doctors' own interests.[12] The ATEAM "An Ethics Core Curriculum for Australasian Medical Schools" highlights the importance of both cognitive and attitudinal aspects: the ethics curriculum should aim not only at knowledge of ethical principles, but also at fostering critical thinking skills and humanistic qualities and behavior, particularly those that promote patients' interests (through doctor-patient relationships), interests of colleagues (through professional relationships), and students' own well-being.[13]

One reason for focusing on the development of the attitudes and character of medical students is that, as some have observed, students' positive attitudes—such as empathy and a desire to improve the human condition—tend to diminish during the course of the curriculum. This tendency is due in part to time pressures that prevent students from properly relating with individual patients, and in part to the alienating activities required of them, such as memorizing long lists of facts and exposure to "frustrated and overwhelmed faculty members."[14] Ethics education should counteract these effects by reinforcing desirable virtues.

Indeed, sometimes character and virtues are considered even more important than cognitive objectives.[15] For instance, the U.S. Accreditation Council for Graduate Medical Education's 2007 "ACGME Common Program Requirements," refers only to character and attitudinal aspects in stating requirements that residents must satisfy to demonstrate professionalism: compassion, integrity, respect, responsiveness to patients' needs superseding self-interest, respect for patients' privacy, accountability, and sensitivity to a diverse patient population.[16]

It is, however, misleading to conceive of cognitive and attitudinal aspects of medical ethics education as two separate types of objectives that can be pursued independently. As Favia and colleagues note, "developing knowledge and skills goes hand in hand with developing virtue. When students come to understand and accept their professional responsibilities, they also are more disposed to act on the principles that express those commitments."[17] According to Campbell and colleagues, medical ethics education has three main aims:

1. Knowledge of principles, values, and norms
2. Habituation, consisting in developing the right attitudes and character, such as the ability to empathize with patients and ethical sensitivity
3. Action, which consists in implementing knowledge and attitudes in practice.[18]

These three aspects form a pyramid, whose base is knowledge, middle is habituation, and top is ethical action. The metaphor of a pyramid indicates that developing the right attitude requires mastering knowledge of principles and values, and both are necessary to sustain ethical decision making in clinical practice. Thus, the cognitive and attitudinal as-

pects are equally important, and both are necessary to form doctors who are capable of acting ethically on wards.

WHAT TO TEACH

Cognitive Aspects: Concepts, Principles, and Professionalism

It is sometimes claimed that doctors should have at least a basic knowledge and understanding of the fundamental notions of ethics (not just of medical ethics), what it means to make an "ethical" choice (as opposed, for example, to making a choice based on convenience or on self-interest), what it means to balance different principles against each other, what the difference is between a consequentialist and a deontological approach to ethics, and so on.[19] A study from 2004 found that more than half of the medical schools in the U.S. and Canada had a mandatory introductory ethics course.[20]

While not every educational system mentions fundamental ethical concepts, and therefore an ethics course, as an essential aspect of the core curriculum (for example, the 1998 U.K. "Consensus Statement" does not), there is agreement about some specific notions of medical ethics and bioethics that students should know and master.

In particular, ATEAM stresses the importance of teaching medical students both foundational concepts in ethics and bioethics (such as autonomy, personhood, disease, and so on) and specific notions of medical ethics (such as the doctor-patient relationship, informed consent, and so on). The 1998 U.K. "Consensus Statement" and its 2010 update[21] list as fundamental topics to be covered in medical ethics education informed consent and refusal of treatment, confidentiality, topics in medical research (such as history of abuses), issues in human reproduction (for example, ethical and legal status of fetuses, the maternal-fetal relationship, and so on), the new genetics (for example, ethics of gene therapy), ethical issues regarding children (their rights, competence, and so on), mental disorders and disabilities, end-of-life decisions, vulnerabilities and responsibilities of doctors, resource allocation, and the notion of rights (what they are, international declarations, *et cetera*).

To all of these aspects, the 2010 update of the 1998 U.K. "Consensus Statement" added "professionalism" as an essential notion: future doctors should be able to understand what their role requires, what their responsibilities are, the professional boundaries that need to be maintained between them and patients, the limits of conscientious objection.[22] Indeed, in recent years "professionalism" has become a central notion in the literature on the ethics education of medical students. Thus, for example, the U.K. Institute of Medical Ethics (IME), in its *Medical ethics and law: A practical Guide to the assessment of the core content of earning* (hereafter, IME *Medical ethics and law*), listed "professionalism" as first among the 11 key topic areas that constitute the core content of the medical ethics curriculum; professionalism is there defined with reference to the criteria set in the U.K. In its "Good Medical Practice," the U.K. General Medical Council states that good professional doctors "are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law."[23] The IME's list of key topics is attached at the end of this article as Appendix 1.

Also relevant in the professional education of medical students are legal notions (for example, battery, trespass, tort of negligence) and an understanding of what doctors can be liable for.[24]

Most topics mentioned above are taught in most medical schools. A study from 2004 reported that more than 70 percent of medical schools in the U.S. and Canada covered the following topics in their preclinical ethics teaching: informed consent (96 percent of the surveyed schools), end-of-life issues (92 percent), confidentiality (92 percent), truth-telling (90 percent), allocation of scarce resources (75 percent), assessing patients' competence (71 percent), and access to care (70 percent).[25]

Attitudinal Aspects: Virtues, Critical Thinking, and Conscience

In Australia and New Zealand, ATEAM acknowledges the importance of promoting humanistic qualities and behaviors in prospective doctors by fostering adequate professional attitudes. Among the essential attitudes listed are the following:
- Honesty, integrity, and trustworthiness
- Critical self-appraisal (including recognition of limitations and errors)
- Empathy and compassion
- Respect for [the dignity of] patients as people
- Respect for the roles of other healthcare professionals in the care of the patient
- Responsibilities of the medical professional towards the local and global community
- Responsibility and reliability
- Commitment to clinical competence and lifelong education
- Commitment to self-care.[26]

Another important attitude that many documents highlight is a critical approach to ethical issues. Students need to learn not only what principles and values are, but how to apply them to real cases, how to balance them against each other in cases, and how they should be balanced against students' own personal values. More precisely, according to ATEAM, critical reasoning requires a capacity to analyze ethical issues, construct arguments and counter arguments that are valid and sound, and examine and interpret the arguments of others. According to ATEAM, to achieve these objectives, some familiarity with ethical theory and principles, and not just with medical ethics, is required.

The 2011 Project to Rebalance and Integrate Medical Education in the U.S., which included the participation of a group of U.S. educators whose aim was to improve the medical ethics curriculum, highlighted the importance of the "question everything" approach to medical professionalism: "The unique critical skills of ethics and humanities will equip our students and residents to be professionally adaptive to the future organization and financing of health care, whatever they might become."[27] At Icahn School of Medicine at Mount Sinai, Favia and colleagues have adopted a template to assist students in developing clinical moral reasoning.[28] Their template follows this article as Appendix 2.

One thing worth noticing is that an emphasis on critical thinking may seem inconsistent with conscientious objection in healthcare, as it is currently construed. Conscience clauses that allow doctors to refrain from performing legal activities to which they have some moral and/or religious objection (for example, abortion) typically do not require doctors to provide reasons and arguments for their views (although some have suggested they should[29]), nor to question their views in light of a patient's views and needs, and of professional values and obligations. This is in contrast to the emphasis the literature places on critical thinking, on the "question everything" approach, and on the importance of being able to construct valid and sound arguments to justify ethical choices. Of course, some conscientious objectors can provide good arguments for their positions, but, for many, such positions may be held on faith without a willingness to consider or to tolerate other justifiable value systems. Indeed, the issue of healthcare practitioners' conscientious objection is an under-explored topic in the literature and in work group documents. An exception is the 2010 update of the 1998 U.K. "Consensus Statement," which states that students should be able to understand "issues raised by the religious beliefs of patients, students and other healthcare professionals and the role and limits of conscientious objection."[30] The topic of conscientious objection, however, has not been further explored in this or in other documents. This is a gap that needs to be filled, especially in light of increasingly frequent conflicts of values in clinical settings due to the multi-cultural character of our societies and to the broad range of medical services that doctors are asked to provide, or will likely be asked to provide in the future.

HOW TO TEACH: STRATEGIES AND METHODS

While ATEAM states "there is no single 'best' method by which ethics should be taught,"[31] work on medical education in subsequent years—including research based on students' experiences—has suggested that some methods of teaching ethics are more effective than others.

Lakhan and colleagues propose that a longitudinal approach is an effective strategy (ethics education throughout the medical curriculum) that includes course work and projects that are relevant to real-life medicine.[32] They mention, as a good example of this strategy, the ethics curriculum at the University of Pittsburgh, which includes an elective area of concentration program, which is student-driven, theme-based, and personalized: students pursue specific areas of inquiry according to their own interests.[33] For instance, students who choose to focus on disability attend regular meetings in which faculty members tell about their experiences dealing with disabled patients and discuss themes relevant to that area, such as how to elicit a medical history from a patient with a mental disability or to respectfully perform a physical examination with an individual who is in a wheelchair. Often these meetings include encounters with real patients, and teaching staff may put teaching into practice by, for example, physically examining an individual who is in a wheelchair in front of students. In this way, students have an opportunity to engage in a deeper form of learning, in which personal and societal values regarding disability are not just a matter of theoretical discussion, but inform the actual medical practices of working with (that is, touching, medically inspecting, talking to, asking for consent, *et cetera*) persons with physical and/or mental disabilities. Students pursue this type of activity throughout the curriculum, and in the fourth year they engage in an ongoing research project in the field. They keep a portfolio that includes research reports, personal considerations, and journal entries, and are

required to produce a deliverable, such as an oral presentation or a short film.[34] Both Kanter and colleagues[35] and Lakhan and colleagues[36] claim that this strategy is more effective than one based on lectures and large classes, although a separate course entirely dedicated to ethics should be offered to give students the fundamental notions they need to carry out their more personalized projects.

The example of the University of Pittsburgh is in line with a more general tendency to discount the importance of lectures and large classes in favor of a small group or even an individualized focus. ATEAM maintains that "ethics education is fundamentally discursive, and thus it is essential to facilitate at least some learning of ethics knowledge in small groups."[37] ATEAM also suggests that, in order to teach the attitudes and the critical approach necessary for doctors' professional life, three strategies have been particularly successful: values journals and portfolios, case discussion with a particular focus on personal experience, and debriefing sessions devoted to discussing the attitudes and behaviors encountered in day-to-day practice. Lehman and colleagues' survey of medical ethics education at U.S. and Canadian medical schools in 2004 revealed that small-group discussion is the most widespread form of course structure, and case discussion the primary pedagogic method.[38]

This structure reflects what students themselves consider to be the most effective teaching strategies. Foundation year one students (that is, one year after graduation) in the U.K. reported that ethics education could be improved by giving more space to case discussions and to role play, that is, activities that are better carried out in small-size groups than in large classes.[39] Smith and colleagues compared the efficacy of two slightly different teaching methods that were implemented at the University of Washington School of Medicine. One group of students was assigned a written case analysis of four consecutive cases, and another group had the same assignment, but with participation in a discussion session before submitting the fourth case analysis. In this session, students in the second group discussed the analysis of the previous three cases with the supervision of an external reviewer with formal training in medical ethics. Students in the second group had higher scores on the fourth assignment.[40] The four cases discussed are attached as Appendix 3.

Other teaching strategies that are effectively implemented include not only repetition of content (for example, ethics case analysis in the first year that is applied in clinical clerkship in subsequent years), but also the use of first-person narratives,[41] and role play scenarios with simulated patients after gaining ethical knowledge in the classroom.[42]

The use of narratives is particularly useful to develop students' ability to recognize ethical issues as they arise in their day-to-day work, to better explore[43] their moral beliefs, to consider cases from different ethical perspectives, and to gather material for small-group discussion, so that they can learn from their colleagues' experiences.[44] Van Ments describes role plays as follows:

Ask[] someone [in the class] to imagine that they are either themselves or another person in a particular situation. They are then asked to behave exactly as they feel that person would. As a result of doing this they, or the rest of the class, or both, will learn something about the person and/or situation. In essence, each player acts as part of the social environment of the others and provides a framework in which they can test out their repertoire of behaviors or study the interacting behavior of the group.[45]

Role play in medical ethics education involves students acting as patients, as interviewers, or as observers. Role play has been shown to have a positive effect on students' learning and capacity to reflect on ethical issues by enhancing their motivation to engage in critical ethical analysis of cases (especially when the cases are based on students' improvisations in dealing with fictitious patients[46]) as well as by enhancing their communication skills.[47]

Appendix 4 provides an example of how different objectives of teaching medical ethics can be integrated in a unified teaching strategy, from the IME *Medical ethics and law* 2013 report.

THREE CHALLENGES FOR MEDICAL ETHICS EDUCATION

Three main problems can be identified in current medical ethics education, which correspond to three challenges for those engaged in developing a medical ethics curriculum.

The "Hidden" Curriculum

Alongside formal ethical training in class, there is a "hidden" or "silent" curriculum in which students take up the attitudes of senior clinicians on the ward, particularly by interiorizing and imitating their behaviors. Such attitudes and behaviors are a substantial part of the ethics education of future doctors and can influence students' attitudes as much as or even more than the official curriculum. The influence of these dynamics on the forma-

tion of future doctors' moral character cannot be overstated. According to Hilton, the hidden curriculum "is probably the most important factor influencing development of professionalism."[48] Recognizing the importance of hidden forms of teaching and learning in medical schools means recognizing that ethics education does not occur in a cultural or social vacuum, that is, in value-neutral environment, but is always influenced by the values displayed by teaching staff.[49]

The types of messages that are conveyed to students through the hidden curriculum span from evaluations of the nature and scope of science to gender or racial stereotypes (for example, through jokes or personal anecdotes told by faculty). Students may be led by clinical staff's attitudes to believe that their ignorance about technical notions is a form of ignorance about ethical notions, or in any case that the two kinds of competencies depend on each other,[50] which need not be the case. Ethical sensitivity and reasoning presuppose a distinct set of skills that encompass, for example, cultural competence (the skills and behavior allowing a professional to relate and work efficiently with patients from different cultural backgrounds), empathic consideration for patients, recognition of responsibility in decision making with patients, a capacity for shared decision making, and communication skills.

This type of learning by apprenticeship tends to be conservative and is based on copying rather than reasoning.[51] Therefore, the hidden curriculum involves the risk that students will simply assimilate the unethical behaviors of their teachers. The hidden curriculum is often driven by pragmatic rather than ethical considerations.[52] For example, in a survey by Hicks and colleagues of 108 students who were one year out of medical school at the University of Toronto, 61 percent said they had seen a clinical teacher acting in a way that was perceived to be unethical very frequently/frequently/occasionally, and 47 percent declared that very frequently/frequently/occasionally they felt pressure from teachers to make unethical choices.[53] The problem is not so much that by witnessing unethical behavior students lose the capacity to distinguish what is morally acceptable and what is not, but that they feel disempowered to act according to what they think is good or to refrain from doing what they think is bad. With time, this translates into an insensitivity towards the importance of acting ethically.[54] For example, students might feel disempowered to ask for consent when treating a patient,[55] such as when they should ask for consent to perform an intimate examination, but fail to do so.

From Theory to Practice

One of the main difficulties that students report in their ethics learning lies not in the identification of ethical principles and critical engagement with these principles, but in their implementation and critical reflection in daily practice.[56] Vivekananda-Schmidt and Vernon found that foundation year one doctors felt ill-prepared and often unsupported by senior members in the implementation of the medical ethics and law curriculum in their practice.[57] Some of the foundation year one doctors declared that no amount of undergraduate teaching could fully prepare them for taking responsibility for ethical decisions in clinical practice.

Shaping Character

Another problem is that those who enter medical school will probably have already formed certain moral beliefs, attitudes, and ultimately their moral characters. Therefore, formal medical ethics education might have little influence on the values that will inform doctors' medical practice.[58]

THREE WAYS OF
MEETING THE CHALLENGES

Having the Right Role Models

The presence of a hidden curriculum in medical ethics suggests that role models play a pivotal role in shaping the ethical approach of future doctors.[59] This means that doctors who are involved in the teaching of medical students should have expertise in ethics and act according to appropriate ethical principles. If teachers did not receive adequate ethics education (for example, because they graduated a long time ago), then medical ethics education should be required of them—while this would be desirable for all medical doctors, it is very important for those involved in the education of new doctors. The 1998 U.K. "Consensus Statement" proposes ethics courses and workshops for teachers.[60] Professional ethicists (for example, moral philosophers) could provide this type of training.

Practical Approaches to Medical Ethics

Mills and Bryden[61] have proposed the use of Sokol's ethical checklist (which Sokol proposed for clinical practice[62]) for teaching purposes. This involves providing students with a list of ethical issues during their rounds with patients. Sokol's ethical checklist includes the following issues: patient's wishes are unclear, patient refuses treatments, questionable capacity to consent to or refuse treatment, disagreement involving relatives, end-of-life issues

(for example, advance directives, lasting power of attorney, *et cetera*), issue regarding the goal of care and appropriateness of treatment, confidentiality or disclosure issues, resource or fairness issues, other issues (to be explained), no ethical issues. Students are required to tick the relevant boxes that correspond to the ethical issues that arise. A way to make the use of an ethical checklist more effective is to discuss it in dedicated tutorials, as well as any notes relative to the list that students might have made, so that the ethical issues that have emerged can be discussed with staff in the same way that medical issues would be.[63]

A student who used the list for the purpose of her ethics education reported the following: "using the ethical checklist made me look at the patients in a way that I probably should, but never had, considered before. I was able to apply what I had already learnt in lectures to real-life situations."[64]

While the method of using an ethical checklist might be valid, we think that a more effective way to implement this method is to have students compile their own checklists. As we illustrate in the proposal for a medical ethics curriculum in the final section, during clinical years students will have acquired the knowledge and competencies that will enable them to recognize ethical issues as they arise in practice, and therefore to build up their own list of ethical issues as they encounter them on wards.

Professionalism

Defining medical professionalism is difficult, which makes it challenging to teach when clear competencies and skills do not exist.[65] However, this clearly remains an essential component of medical education,[66] considering that professional obligations should prevail over doctors' particular attitudes and beliefs. As Doukas and colleagues note, being professional means to have "mastery of the fund of knowledge and skills, and the cultivation of professional virtues, essential to the ethical concept of medicine as a profession."[67]

It is therefore important to teach new doctors to be, first and foremost, serious professionals. A good doctor is a professional doctor.[68] Medical students themselves consider professionalism as one of the topics with greater value and relevance in medical ethics, and increasingly more as they proceed toward the final years of their training;[69] also, in this case, they think that ethicists or medicolegal experts are best suited for delivering the relevant teaching.[70] In order to have doctors who are serious professionals, three main (not mutually exclusive) strategies have been proposed: the first is to only select stu-

dents for medical schools who have the right character; according to Lakhan and colleagues, for instance, "Admission committees must seek to find those individuals that best exemplify "virtue" among their applicants, if the school truly seeks to produce ethically oriented physicians."[71] This strategy would be the best one if we agreed with Campbell and colleagues' scepticism about the influence that ethics education can exert on the already formed character of medical students. The second strategy is to introduce curricular changes that support students' focus on patients rather than on their own values and preferences, for example, providing earlier clinical experience or requiring them to participate in student-directed clinics.[72] The third strategy is to assess professionalism rigorously and not allow students who lack the necessary skills to advance in training.[73] The Australian Medical Council lists "Professionalism and Leadership" among the requirements that medical students must demonstrate at graduation.[74] According to the ACGME, professionalism requires students to demonstrate "compassion, integrity, and respect for others; responsiveness to patient needs that supersedes self-interest; respect for patient privacy and autonomy; accountability to patients, society and the profession; sensitivity and responsiveness to a diverse patient," covering all the fundamental cognitive and attitudinal objectives of medical ethics education.[75]

HOW TO ASSESS

Effectively assessing ethics competencies is an important aspect of medical ethics education. If we think medical ethics is a fundamental component of the education of medical students, then it should be formally assessed on a par with medical competencies.[76]

Medical students often perceive ethics as a "fluffy" discipline.[77] This perception might change if ethics assessment was brought to the same high standard of rigor that characterizes the assessment of medical competencies. A good way to do this is to link its evaluation to specific learning objectives through the so-called "SMART" approach, that is, creating teaching objectives that are **s**pecific, **m**easurable, **a**ction-oriented, **r**easonable, and **t**ime-bound.[78] This approach is based on the idea that, as Favia and colleagues put it, there is a "critical relationship between a program's goals and the design of an assessment strategy."[79]

Linking assessment to specific objectives facilitates the design of an assessment strategy that satisfies the four fundamental requirements indicated by

Savulescu and colleagues: assessment must be (1) valid, meaning it should assess only the relevant ethical skills, and not other aspects (for example, clinical competencies); (2) reliable, meaning it should guarantee that the same performance be assessed equally, regardless of who assesses it; (3) relevant to clinical practice; and (4) publicly justifiable and subject to review.[80] Savulescu and colleagues developed a marking system for vignette-based tests to assess critical thinking skills, and statistically demonstrated their system displays good reliability in terms of inter-rater and test-retest consistency. An example of their system is presented below as Appendix 5.

While this assessment tests a specific set of skills (critical thinking), Campbell and colleagues suggest that different assessment methods are required for the three different ethical competencies that medical students must demonstrate: essay-style questions are best suited to assess knowledge; case analyses are best suited to habituate competencies; students' behavior in clinical practice is better assessed using an ethics objective structured clinical examination method, in which students are observed and assessed during planned clinical encounters.[81]

At the Icahn School of Medicine, the following assessment method is adopted. In a case-based written assessment, students are asked to define some basic ethical concepts and to identify ethical issues that arise in the given case, and then a case-based oral exercise requires students to demonstrate communication skills by mapping effective communication strategies with peers, patients, and families. In the first three years, students are required to complete short writing tasks (for which they receive feedback) and three formal assessment exercises to test their knowledge of basic concepts and a capacity to apply the concepts to a given case.[82]

Appendix 6 contains a model used at the University of Wisconsin School of Medicine to assess students' ethical knowledge.[83] A review of attempts to develop standardized tests can be found in an article by Savulescu and colleagues published in 1999; it includes semi-structured interviews based on given moral dilemmas to assess moral reasoning, and subjective reports based on vignettes to assess ethical sensitivity, inspired by Kohlberg's theory of childhood moral development.[84]

A PROPOSAL FOR DESIGNING A MEDICAL ETHICS CURRICULUM IN MEDICAL SCHOOLS

We propose the following medical ethics curriculum for medical schools. It is tailored to a four-year course that includes two years of preclinical education and two years of clinical education. This curriculum takes into account the positive and most effective teaching strategies and contents that emerged from the previous review, and it avoids or minimizes the presence of strategies that appeared to be negative or less effective.

This curriculum is based on constructivist pedagogy, in which knowledge is built upon and core concepts are revisited to further "construct" knowledge with new information. In this curriculum, students learn the "facts" of health law and the principles of ethics in the preclinical years, with increasing opportunities to practice application of these principles throughout those years. In the clinical years, students apply the knowledge and skills they learned in their preclinical years to experiences in the clinical context.

We intend this as a practical suggestion for those engaged in designing and teaching a medical ethics curriculum, and as an attempt to unify medical ethics education across schools. More importantly, we intend it to be a focus and source of development for others as they revise, contribute, and develop such a program. There will necessarily be some inter-school variation of the content and methods of the teaching, to reflect local practices (for example, euthanasia in the Netherlands) and cultural factors (for example, a significant presence of a Muslim population in a given area). However, we think any medical ethics curriculum should have the following minimal components.

We suggest a timetable of one to two hours per week across each semester. This ensures that the content can be logically constructed over time and has the added advantage of utilizing cases and content from other areas of the curriculum, for example, bioscience and clinical skills. For example, early in case-based learning in bioscience subjects and in clinical skills, students could learn principles of bioethics and the legal requirements for consent. Simple clinical skills such as phlebotomy and giving injections can be used to demonstrate the application of autonomy, consent, and, with some alteration of scenarios, best interests.

Year One

Year one is preclinical and includes introductory medical ethics, professionalism, and law courses. These can be delivered in large classes (although dividing students into small groups, when possible, would be an advantage) and should be taught by relevant content experts, such as a medical ethicist, a health law expert, and an expert on

professional regulation. This could be the same person or several visiting experts.

At this early stage, students should also be taught a framework for ethical deliberation in the clinical context. Tutorials or large-group work, using a team-based learning format, can be used to help students "practice" the application of this framework, using concepts taught in the current teaching period. An example is provided in Appendix 7.

The goal is to provide students with the fundamental notions of medical ethics, law, and professional regulation that will inform their further medical ethics training in preclinical and clinical years.

Courses should include the teaching of basic concepts of medical ethics and medical law, as well as the teaching and critical analysis of the deontological code of the relevant medical association. Topics to be covered could include informed consent, autonomy, confidentiality, trust, professionalism, different conceptions of doctor-patient relationship, and conscientious objection (both in its legal and ethical aspects). We suggest something like the handbooks by Kerridge and colleagues[85] or Hope and colleagues[86] as course books, as they cover all of the fundamental concepts in medical ethics and law that a health professional should master.

Year Two

Year two is also preclinical, and includes small-group classes with case discussions in the form of seminars and role-plays. The objective is to develop students' critical thinking skills by rationally applying the principles and concepts learned in year one to clinical cases. It is ideal for the content of these scenarios to align with other content in the curriculum. Concurrent problem-based learning or content-based learning from bioscience subjects can also be used. For example, during the children's health block, students can build on content they learned earlier on consent and best interests by learning about consent for the "mature minor" and decision making using the "best interest" framework for older teenage children, including family-centered care. The continued use of the framework in deliberating these cases will structure and reinforce learning in a meaningful way for the students. The content relates back to information learned in year one, and knowledge continues to be constructed and applied.

Ideally, these seminars should be run jointly by a professional ethicist and a clinician, as this is more likely to guarantee acquisition of the required ethical expertise and the medical expertise—which will increase students' trust in their teachers. Students are presented with different cases that include ethi-cal dilemmas in the clinical setting, and are asked to indicate which principles and concepts are involved and what kind of decisions are more ethical in each. Textbooks exist that can be used as sources of cases for discussion,[87] or real cases from senior doctors' experience could be used.

Assessment can be based on small-group work, including collaboration and communication and the use of the framework to work logically through case scenarios. Alternatively a case presentation—written or verbal—can be assessed using the tools provided in Appendix 5 and Appendix 6.

Year Three

Year three is clinical, and includes small-group classes and one-on-one discussion sessions with a clinical supervisor and a professional ethicist, ethical checklists, and debriefing sessions. Classes and one-on-one discussions should be based on the students' own experience on wards. Also, as mentioned in the section "Three Ways of Meeting the Challenges," point two, "Practical Approaches to Medical Ethics," at this stage students could be required to compile "ethical checklists" on the basis of the ethical issues they recognize in their encounters with patients. The ethics education received in their first two years should have equipped them with the knowledge and abilities required to perform this task. As students build their own checklists, they will be able to apply it to subsequent cases and to continuously update or refine it. To ensure that their new knowledge is constructed and reflected upon, it is important that learning sessions occur regularly and not in discreet "blocks" or "residentials" only once or twice in the academic year.

The objective is to give the ethics training of the two previous years practical application that is relevant to students' professional development.

Since students also find debriefing sessions with peers to be very useful for their professional development,[88] this type of activity could make a valuable addition to the ethics teaching offered in clinical years. It should be based on first-person narratives under the supervision of a professional ethicist, in which students in small-sized groups tell about how they managed ethical dilemmas, what kind of values they applied in different circumstances, and what attitudes informed their behavior. Students are encouraged to identify their own clinical experiences and apply the framework in considering ethical considerations in coming to a conclusion or action. Assessment could be based on identification of ethical issues and the use of the framework in the clinical context.

Year Four

Year four is clinical, and includes individualized projects by medical students and reports on their ethical checklist. This year should involve individual research and the writing of a short essay on a student's chosen topic (for example, respecting the autonomy of mentally impaired patients, handling family-patient conflict about clinical decisions, *et cetera*), based on the students' clinical experiences and on their research on the relevant literature on their topic. Objective outcomes that involve both cognitive and attitudinal objectives should be assessed in this project, including the application of critical thinking and students' ability to reflect on their own biases, beliefs, and values in considering professional responsibility. Students should also be able to review the ethics literature, summarize it, synthesize it, evaluate it, and apply it to real-life cases. Skilled tutors in both ethics and clinical knowledge should facilitate this.

Both a professional ethicist and a clinician would act as supervisors. It is important to bear in mind that, in the final year, the main source of ethics learning is observation of clinical practice on ward rounds,[89] so it is important that clinical staff act ethically and professionally when in the presence of medical students, and, if necessary, receive adequate ethics training.

Also, at this final stage, the ethical checklist that students have built during their previous two years should be assessed: students should be required to write a short report or narrative about their checklist, illustrating the situations in which they have recognized ethical issues and how the same issues arose in subsequent situations. The checklist should be assessed for completeness and accuracy.

Taking into account the distinction between the cognitive and the attitudinal objectives of medical ethics education, the former objective is more suited for the preclinical years and the latter for the clinical years. However, as pointed out in the review above, the two types of objectives are not easily separable, and, from the very beginning, students should start forming an idea of what it means to be a serious professional, which involves mastering a knowledge of ethics, having the right approach to patients and to one's professional duties, and being capable of rationally reflecting on the ethical implications of different medical options. Professionalism, in its different dimensions, should be a core concept in medical ethics education, both as a theoretical concept (particularly in the preclinical years) and as a practical approach (particularly in the clinical years). Medical students report that professionalism is very important, but are very critical of the efficacy of the lecture-based system of teaching professionalism. They believe that a seminar-style instructional setting would work better.[90] It is therefore important that there is a follow up, in the form of case discussion and clerkship, to the formal teaching of the first years about professionalism.

APPENDIX 1
Core Content of the Ethics Curriculum

- Professionalism: "good medical practice"
- Patients: their values, narratives, rights, and responsibilities
- Informed decision making and valid consent/refusal
- Capacity and incapacity
- Confidentiality
- Justice and public health
- Children and young people
- Mental health
- Beginning of life
- Towards the end of life
- Medical research and audit

Institute of Medical Ethics, *Medical ethics and law: A practical guide to the assessment of the core content of learning* (Gloucestershire, U.K.: Institute of Medical Ethics, 2013), 2, box 2.

APPENDIX 2
How to Approach a Clinical Ethical Dilemma

- Collect all relevant data that could help with resolving the matter.
- Identify the basic principles involved and explain how they relate to the case.
- Consider whether principles conflict in this situation OR whether there is uncertainty about what a particular principle (e.g., beneficence, respect for autonomy) directs you to do.
- Formulate a question that reflects the conflict.
- Decide which principle should have priority in this case and support that choice with factors relevant to the case OR find an alternative that avoids the dilemma.
- When uncertainty persists, note whether there is some missing information that would help you to resolve the dilemma. Which information? How will it help to resolve the dilemma?
- Evaluate your decision by asking if it is what a consensus of exemplary doctors would agree to do.
- Plan the practical steps that you should take, focusing on the details of the case and the future issues that you foresee.

Adapted from R. Rhodes and D. Alfandre, "A Systematic Approach to Clinical Moral Reasoning," *Clinical Ethics* 2, no. 2 (2007): 66-70.

APPENDIX 3
Description of Ethics Cases and Issues Raised for Use in Two Pediatrics Clinical Ethics Teaching Methods, University of Washington School of Medicine, 1999-2000

Case	Issues raised
An intelligent 16-year-old girl with cystic fibrosis who is not a candidate for lung transplant because of the severity of her disease, wishes to have a DNR order written during a current hospitalization for a severe pulmonary infection exacerbation. Her parents do not wish such an order written, and demand all care, including resuscitation, be continued.	Adolescent decision making Parental decision making Informed consent End-of-life care Triadic relationships in pediatrics
You are a primary care physician who is assuming the care of a family. Upon review of the medical history of the 1-year-old daughter, you find that she has no immunizations although she received several well-child examinations. You ask the parents about this and they state, "we don't believe in immunizations."	Parental decision making Cultural/religious differences Responsibility to patient and society Informed consent
During your rotation on pediatrics, you have the opportunity to perform a lumbar puncture on a 1-month-old infant. You have seen one done by your resident but you haven't done one. Your resident introduces you as "Dr. X" and explains that you will be doing the procedure.	Misrepresentation Informed consent Adequate supervision Confronting a supervisor Training and providing "best care"
Final: You are in a busy clinic seeing a 15-year-old girl for a "sore throat." Her physical examination findings are normal and as you are ready to leave the room, she blurts out that she thinks hat she is pregnant. Her mother is in the waiting room.	Adolescent decision making Reproductive health issues Parental decision making Confidentiality

S. Smith et al., "Finding Effective Strategies for Teaching Ethics: A Comparison Trial of Two Interventions," *Academic Medicine* 79, no. 3 (March 2004): 265-71, 267, table 1.

APPENDIX 4
Embedding Learning Outcomes

The following is an example of embedding or mapping learning outcomes into the curriculum.

TOPIC: Towards the end of life

LEARNING OUTCOME: Demonstrate in practice an understanding of the ethical and legal issues of dignity, patient choice and the limits on respect for patient autonomy

IMPORTANCE AND RELEVANCE: Over the last five years there has been a profusion of media, legal and ethical discussion regarding patients anticipated to be in the last year of life. This subject touches on the aging population, rationing and economics, advance decisions and patient choice but the list is not exhaustive. Doctors in virtually every specialty would be expected to have a working knowledge of these areas.

In relation to mental capacity, students will need to be able to:
• Know how to assess capacity for a specific treatment
• Establish the clinical relevance of an advance decision
• Establish the legality of lasting power of attorney
• Know how to assess a patient's best interests

In relation to end of life guidance, students will need to be able to:
• Establish a patients preferred priorities of care
• Identify a means of recognizing patients who are in the last year of life
• Discuss the relevance of patient choice, religion and the law in the context of different cases *[continued next page]*

APPENDIX 4, Continued

In relation to ethical principles, students need to be able to:
• Define and discuss the concept of dignity
• Define and discuss the concept of autonomy and its limits in different settings (for e.g. acute illness, terminal illness, acute hospital).

TEACHING: The relevant teaching could initially be delivered in a lecture format. After or during clinical attachments, students could be expected to more widely explore the issues and limitations around end of life autonomy and decision making in a small group setting. Teaching can be reinforced at the bedside such that students would be expected to demonstrate a working knowledge of assessing capacity, best interests and relevant end of life guidelines.

LINKING AND MAPPING: Throughout the course, regular links need to be made to the relevance and importance of the subject and also to the learning outcomes. These can be used as a driver for learning if students are assessed on their ability to demonstrate achievement.

Issues of autonomy, capacity, dignity, and best interests are not particular to older adults in palliative care. These issues can be explored, and learning reinforced, in a number of other appropriate settings including:
• Child health
• Mental health
• Humanities and social science
• Acute care settings

Institute of Medical Ethics, *Medical ethics and law: A practical guide to the assessment of the core content of learning* (Gloucestershire, U.K.: Institute of Medical Ethics, 2013), 31, Appendix A.

APPENDIX 5
Critical Thinking Skills Vignettes

Here is one example of the vignettes with marking instructions.

During your morning general practice surgery a 50-year-old woman comes to see you, complaining of some mild clumsiness and worsening memory. She tells you that her father and his mother both died from Huntington's disease in their mid-fifties. The rest of her family do not know of the occurrence of Huntington's disease in her relatives. She insists that you do not tell them and forbids you to let them know your present concern. Later that morning this woman's daughter sees you to discuss coming off the contraceptive pill as she and her husband wish to conceive a child.

[There follows some information about Huntington's disease].

What should you say to the daughter?

Justify your decision and note what other options are open to you.

Why do you think that these other options are less satisfactory than the one you chose to adopt?

Give one mark only for each point—broadly construed—made from the list below. Note any point made which you consider appropriate but which do not appear on the list.

1. Obligations and confidentiality
2. "Implied contract" argument for respecting confidentiality
3. Utilitarian argument for respecting confidentiality
4. Autonomy-based argument for respecting confidentiality
5. Duty of care to one's own patient
6. Trust and the doctor-patient relationship
7. Autonomy versus beneficence conflict
8. Consequences for the potential child
9. Interests of the husband
10. Counselling of the mother
11. Counselling of the daughter
12. Advising the daughter to research into grandparents' medical history

J. Savulescu et al, "Evaluating Ethics Competences in Medical Education," *Journal of Medical Ethics* 99, no. 25 (1999): 366-74, 373, Appendix 1.

APPENDIX 6
Sample Feedback Form Used to Evaluate Students' Ethics Case Number 1 [see Appendix 3]
During their Pediatrics Rotation, University of Washington School of Medicine, 1999-2000

Ethical issues suggested by the essay   **Implicit (0.5 pt)   Explicit (1 pt)**

    Determination of end-of-life care   _____   _____

    Rights of adolescent patients   _____   _____

    Parental rights to guide care   _____   _____

    Ability of physician to maintain relationship with all parties with conflicting views _____   _____

                                        Score (# identified): (0-4) [ ]

Consideration /weighing the issues (discussion of the following)
<u>Scale:</u>

Excellent: (4)	In depth discussion of all/most of the identified ethical dilemmas
Good: (3)	In depth discussion of at least one of the identified ethical dilemmas plus a limited discussion of all/most of the identified ethical dilemmas
Satisfactory: (2)	In depth discussion of at least one of the identified ethical dilemmas or a limited discussion of all/most of the identified ethical dilemmas
Borderline satisfactory: (1)	Limited discussion of at least one of the identified ethical dilemmas
Unsatisfactory: (0)	No clear discussion of the identified ethical dilemmas

In depth discussion—addresses multiple aspects of the issue using correct information;
Limited discussion—addresses one aspect of the issue

End-of-life care/DNR   **Score (0-4)** [ ]

    What constitutes futility?

        Who decides this?

        What is competence?

        Deals with issues of quality of life?

    Does the student recognize his/her own biases?

Rights of the adolescent patient

    Emancipated vs. mature minor

    Philosophy of increasing involvement of care with increasing age/maturity

Parental rights to guide care

    What are the responsibilities of parents to their children?

    Are there any limitations to these responsibilities?

Informed consent

    What are the elements of informed consent?

    In this case who will give this? To whom should the physician speak?

Ability of physician to maintain relationship

    Recognition of physician/student bias—why have they their chosen position?

    Is there an advantage for maintaining relationship with all parties? Why?

Forming a plan: **Score (0-4)** [ ]

(One point each for):

Presence of plan

Degree of detail

Feasibility of the plan

Addressing multiple critical issues with the plan

Explicit justification of plan by identification of ethical principles/professional duties: **Score (0-1):** [ ]

Comments:

Total score: [ ]

S. Smith et al., "Finding Effective Strategies for Teaching Ethics: A Comparison Trial of Two Interventions," *Academic Medicine* 79, no. 3 (March 2004): 265-71, 268, figure 1.

APPENDIX 7

MEDICAL ETHICS AND LEGAL DECISION-MAKING FRAMEWORK

What is the ethical issue?

Evidence

Medical

CLINICAL

Information that impacts on the decision

FACTS

Unknown facts

Enquiry

MACRO ISSUES

Law

Regulatory

Social

Consideration of bioethical principles/rules

**Identify stakeholders affected by the outcome
Discover their values/concerns**

- Hope
- Trust
- Best Interest
- Empathy

- What is your role?
- To whom do you have responsibilities?

MICROETHICS

PATIENT'S AUTONOMY NOW

- Preferences
- Relationships
- History & culture

TRANSPARENCY IN DOCTOR'S VALUES & PREFERENCES

- What is your personal view?
- Does this conflict with the patient's preferences?
- How do your values affect your decisions & interactions?

COMMUNICATING MEDICAL INFORMATION

- Communicating risk
- Dosing information for this patient
- Who should be there?
- When & where do you give information?
- Libertarian paternalism
- Selection bias
- Nocebo effect

CONSIDER CONFLICTS
1. Responsibilities   3. Principles
2. Professional & personal   4. Law/ethics

DOES THE DECISION ANSWER THESE QUESTIONS?
- Does it fulfil a general moral rule for people in similar situations?
- Does it support the character traits we value most?
- Does it produce the most good and least harm?
- Does it focus mostly on the most vulnerable & can we maintain relationships?

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5. Ibid.

6. "Consensus Statement," see note 2 above.

7. A. Favia et al., "A Model for the Assessment of Medical Students' Competency in Medical Ethics," *American Journal of Bioethics—Primary Research* 4, no. 4 (2013): 68-83.

8. Ibid.; see also E.D. Pellegrino and D.C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993).

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Medical Boards and Fitness to Practice: The Case of Teleka Patrick, MD

Katrina A. Bramstedt

ABSTRACT

Background

Medical boards and fitness-to-practice committees aim to en-sure that medical students and physicians have "good moral char-acter" and are not impaired in their practice of medicine.

Method

Presented here is an ethical analysis of stalking behavior by physicians and medical students, with focus on the case of Teleka Patrick, MD (a psychiatry resident practicing medicine while un-der a restraining order due to her alleged stalking behavior).

Conclusions

While a restraining order is not generally considered a crimi-nal conviction, stalking behavior is clearly unprofessional and a marker of inappropriate character and fitness, yet the reporting obligations for such matters are complex. Medical schools and train-ing programs that fail to assess, record, and report matters of moral conduct such as this potentially allow impaired students to gradu-ate and enter the work force (unless a robust licensing process identifies them). Patrick's case should be a wake-up call for medi-cal schools and medical boards to better integrate the profession-alism domain into their operations. Further, the professionalism of students and doctors need to be integrated into the legal domain, so that those who are unfit to practice are, in fact, prevented from doing so. Guidance for integration is provided.

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As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.
—American Medical Association

INTRODUCTION

Physicians are expected to have "good moral character"[1] and not be impaired in their practice of medicine.[2] Inappropriate behaviors and impairments are sometimes identified in medical school and are generally managed by fitness-to-practice commit-tees. Case management (including mentoring and psychological counseling) is generally supportive, but can include a punitive component if policy vio-lations have occurred (for example, plagiarism, fab-rication of data, bullying). When medical boards have registration oversight of medical students, no-tification of certain fitness-to-practice cases is man-datory (for example, students with impairments who may place the public at substantial risk of harm[3]). In the setting of licensed physicians, medical boards' evaluation of "character and fitness" in the United States is one of the four major elements of licen-sure.[4] Evaluation can include criminal background check, fingerprint analysis, professional reference check, review of disciplinary actions in other juris-dictions, personal interview, and application screen-ing questions.

According to the American Medical Association *Code of Medical Ethics Opinion 9.031,* "Unethical

conduct that violates state licensing provisions should be reported to the state licensing board."[5] Similar reporting obligations are also stated in *AMA Opinion 9.0305*.[6] While these statements specifically refer to reporting by colleagues, it is important to note that many jurisdictions also require self-reporting.

The recent case of stalking behavior by a physician, Teleka Patrick, has received international attention.[7] Presented here is neither a psychiatric nor forensic analysis of her case, but rather an ethical analysis pertaining to issues of fitness to practice and regulatory reporting.

CASE REPORT

Teleka Patrick, age 30, was a May 2013 MD-PhD graduate of Loma Linda University, and a first-year psychiatry resident at Western Michigan University School of Medicine/Borgess Medical Center in Kalamazoo, Michigan. A few months into her residency at Borgess, she was served a personal protection order (a PPO, a civil order that restrains intrusive behavior).[8] A few days earlier, she had received a letter rescinding her church membership.[9] The person requesting the PPO was her church pastor, Marvin Sapp, an internationally known gospel singer, who described nearly a year's duration of inappropriate behavior: Patrick had stalked him and his children, and Patrick had sent several hundred pages of unwanted correspondence, in some of which Patrick claimed Sapp was her husband.[10]

On 5 December 2013, Patrick left work at the hospital and drove to a local hotel where she attempted to rent a room with cash, but was turned away. Her car was found later that evening on the side of the road with a flat tire, about 110 miles away from her home. Her body was found four months later, drowned in Lake Charles, a few hundred feet from her car. The death was ruled accidental.[11] One can only speculate whether Patrick had concerns about the medical board or her institution becoming aware of the PPO and its detailed contents, especially because her institution required her to undergo drug testing in the summer of 2013 after she reportedly exhibited strange behavior.[12] Any such fears could have prevented Patrick from seeking psychiatric help.

DISCUSSION

Stalking is an inappropriate social behavior and a criminal offense characterized by repeated unwanted intrusions such as texts, phone calls, emails, giving gifts, following, and surveillance. While stalking itself is not a mental illness, the behavior can coexist with various psychopathologies, including delusional disorders, personality disorders, and schizophrenia.[13] Numerous cases of patients stalking their physicians have been reported in the medical literature;[14] however, physicians and medical students have rarely been reported as stalkers (see table 1). Furthermore, what makes the case of Patrick unique is her medical specialty: psychiatry.

In the state of Michigan, stalking is legally defined as "a willful course of conduct involving repeated or continuing harassment of another individual that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested and that actually causes the victim to feel terrorized, frightened, intimidated, threatened, harassed, or molested."[15] The stalking of an adult is a misdemeanor punishable by imprisonment for not more than one year or a fine of not more than $1,000, or both,[16] whereas the stalking of a child is a felony punishable by imprisonment for not more than five years or a fine of not more than $10,000, or both.[17] Patrick's case, a potential felony, raises speculation about whether the Michigan Department of Licensing and Regulatory Affairs Board of Medicine was aware of her stalking behavior and the PPO. *Did Dr. Patrick report her court order? Did the court report this information?* The answers to these questions are not publicly known; however, it is unlikely that any reporting occurred, because Patrick continued her clinical work at the medical center while under the PPO.

While a stalking PPO is not (generally) considered a criminal conviction, stalking behavior is clearly unprofessional and a marker of problematic character and fitness, which are under the jurisdiction of medical boards and educational institutions. As indicated in table 1, stalking behavior is often not an isolated issue, as other inappropriate behaviors are also identified. Similar findings have been reported elsewhere.[18] If Patrick's court order was unreported, this was a missed opportunity to explore her global conduct and behavior so as to understand her wellness and her fitness to practice. If the court order was reported and she was allowed to continue to practice medicine, this raises questions about the ethical appropriateness of such a decision.

With regard to initial licensing applications for new graduates, the Michigan Department of Licensing and Regulatory Affairs Board of Medicine Application for Medical Educational Limited and Controlled Substance Licenses (2014) asks only one question with regard to psychiatric matters: *Have*

you ever been treated for substance abuse in the past 2 years? The application does not inquire about current or past psychiatric diagnoses or psychiatric hospitalizations. Fingerprint scans are used for criminal background checks, and applicants are asked to indicate if they have ever been convicted of a felony or convicted of a misdemeanor "punish-able by imprisonment for a maximum of 2 years."[19] In Michigan, Medical Educational Limited licenses (that is, the license held by interns and residents) are valid for one year. License renewals require only the completion of a one-page form that informs the medical board of the contact information for the physician's training program and the signature of

TABLE 1. Doctors and medical students with stalking behavior

Date	Location	Specialty	Gender	Victim	Stalking behavior	Other behaviors	Outcome
2013[1]	U.S.	Psychiatry	Female	Gospel singer	Emails, home visits, claimed to be victim's wife.	Delusions, paranoia, auditory hallucinations.	Drowned in icy lake in 2014.
2012[2]	Australia	Medical student	Male	Patient	Calls, texts, home visit.	Plagiarism of medical school coursework.	1-year suspension from medical school & medical board notification (stalking); written reprimand & rotation failure (plagiarism).
2009[3]	U.K.	Emergency medicine	Male	Physician	Texts, gift giving, home visit, vandalized victim's car, threat to kill.	Impersonation; self-harm; faked illness (brain tumor) for attention.	Permanently removed from medical register; 4-year prison term.
2009[4]	U.S.	Medical student	Male	Prostitutes	Stalked victims on-line then met them at hotels; beat and robbed them; 1 killed; kept their lingerie.	Alleged gambling addiction; did not attend medical school classes (studied from home.)	Suspended from school; committed suicide in jail while awaiting trial (no note).
2008[5]	U.K.	Vascular surgery	Male	Secretary	Accessed her medical record; stole item from her office; hired private investigator to "vet" her.	Pornography addiction	3-month suspension.
2004[6]	U.K.	Sr. house officer	Male	Actress	Emails, texting, confronted victim at her home while showering.	Alcohol addiction, depression; spousal abuse conviction.	Struck off medical register.
1997[7]	U.S.	Cardiology	Male	Nuclear medicine technician	Followed victim while she worked; followed her home; phone calls, gift giving; vandalized victim's car.	Pattern of stalking: another victim filed a complaint prior.	$50,000 award to victim by jury trial.

NOTES

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2. *Bond University Fitness to Practice Medicine Registry,* Research Protocol RO1631.

3. *http://www.nottinghampost.com/Stalker-doctor-banned-life/story-12202282detail/story.html.*

4. *http://www.boston.com/news/local/massachusetts/articles/2011/04/01/files_tell_more_about_ craigslist_killer/?page=1; http://www.dailymail.co.uk/news/article-1085751/Married-surgeon-suspended-stalkingsecretary.html.*

5. *http://www.nowmagazine.co.uk/celebrity-news/228799/abi-titmuss; http://www.thefreelibrary.com/Abi+stalker+admits+to+beating+his+wife.-a0148513046.*

6. *http://articles.mcall.com/1999-07-30/news/3265860_1_harassment-nuclear-medicineunwanted-sexual-advances; http://www.clearinghouse.net/chDocs/public/EE-PA-00639000.pdf.*

the director of medical education.[20] These yearly renewals require no criminal background check or disclosure (by self or institutional) about harmful or criminal behavior.

Disability discrimination is a concern of medical boards,[21] and physicians' licensing applications are generally exceedingly cautious about questioning applicants about medical or mental health ailments. As an example, the above-mentioned Michigan form, asks about substance abuse treatment, but not about diagnoses of abuse or dependence.[22] Furthermore, the footer of the form is clear to state that the Department of Licensing and Regulatory Affairs "will not discriminate against any individual or groups because of . . . disability. . . ."[23] From an ethics perspective, medical boards need to balance their fear of disability discrimination against the need to identify impaired medical graduates seeking licensure. Patrick's stalking of her pastor began while she was a medical student, but it is unclear whether her medical school was aware of her behavior. This said, medical schools may indeed be awarding medical degrees to students who have "satisfied" academic requirements but who have impairments in the professionalism domain (impacting their behavior with society).[24] Medical students and physicians may be afraid to seek help for their impairments due to concerns about stigma and censure or punishment.[25] Indeed, there are two critical elements for students and educational bodies to consider: support and management. Medical schools and training programs have dual interests, in that they aim to support students who are having professionalism problems by referring them to interventions that provide assistance (medical, psychological, academic), while also managing the matter and its consequences (for example, plagiarism, stalking, social media misconduct). If educators are not balanced in their approach, over-focusing on support could send a message that the unwanted behavior and its consequences are insignificant (compared to the root cause). Conversely, over-focusing on the behavior and consequences could embolden a punitive and fear-based approach to handling unprofessionalism, and this could seclude students who might already fear seeking help.

In 1993 the State of Michigan created the Health Professional Recovery Program (*www.hprp.org*) for physicians and other clinical practitioners. Practitioners can self-refer or they can be referred by external sources such as their employer, the medical board, patients, family members, or the state. The service provides confidential treatment and monitoring for cases involving impairments due to mental or physical conditions "before their impairment harms a patient or damages their careers through disciplinary action."[26] Participation costs are paid by the enrollee, and the program is confidential, such that practitioners' names are not disclosed to state regulatory authorities or the public. Exceptions to this confidentiality are (1) physicians who are referred by the State of Michigan Attorney General's Office or the Licensing and Regulatory Division, or (2) physicians who are deemed noncompliant with one or more elements of their monitoring. It is unknown whether Patrick was referred to or enrolled in this program; however, considering the PPO, a referral from the court would have been ethically appropriate (although not legally required).

The features of this case are troubling because they raise questions about the assessment and reporting of professionalism issues during medical education. Medical school accreditation bodies do include ethics and professionalism as required items for curriculum, assessment, and remedy in situations of breach.[27] Curriculum generally includes core skill building, such as safe use of social media, empathy and communication training, hygiene and personal wellness, cultural safety, and ethical decision making. Assessment methods include reflective writing assignments, exam questions, and personal feedback from peers, patients, standardized patients, teachers, tutors, and clinical supervisors. Schools map their curriculum and assessment for tracking and audit purposes, and remedy panels (for example, fitness-to-practice committees) document their cases and outcomes. Medical schools are the "eyes and ears" that assess performance domains that are hugely relevant to the safety and welfare of patients, society, and the student-doctors themselves.[28] In addition to assessing clinical and basic science, medical student academic transcripts and dean's letters should contain assessment information pertinent to professionalism, so that medical boards and potential employers are aware of behavior and performance issues (see table 2).

It is not enough, however, for medical school accreditation bodies to require "ethics and professionalism" as a core competency. Universities, as the umbrella institutions for the schools, must also embrace such competency as a graduation requirement. Cases of unprofessional behavior (including those involving student wellness) often transition from the medical school up to the university (for example, matters of suspension, expulsion, students' appeals of cases). Thus the university mind-set must be aligned with that of the medical school, so that unprofessional and impaired students are appropri-

ately managed (see table 2). Universities should not be viewed as "safe havens" away from medical schools, where policies are "softer" and professionalism is "less valued." Medical schools and their partnered universities must be unified in their goal of ensuring that their medical graduates are safe and professional in their clinical practice. Unity can be achieved by ensuring that the misconduct policies of medical schools and universities align, and no loopholes exist that could allow unprofessional or impaired students to graduate.

Also, it is critically important that professionalism integrates into the legal domain, so that students and doctors who are unfit to practice are, in fact, prevented from practicing (see table 2). If the legal system fails to recognize professionalism as an essential core competency for medical graduates, this undercuts the integrity and authority of medical schools and their accreditation bodies.[29] There is ample evidence that the courts have used medical codes of ethics to inform legal decisions.[30] Thus, not recognizing professionalism in this same manner is

TABLE 2. Recommendations regarding professionalism and fitness to practice

Accreditation bodies	Professionalism must be valued on an equal footing with science and clinical competencies.
Medical schools (and post-graduate training programs)	1. Professionalism must be valued by faculty on an equal footing with science and clinical subjects. 2. Payment of tuition does not cause schools to automatically award medical diplomas to students.[1] 3. Matters of unprofessionalism should be potential grounds for dismal from a medical program, even if pass results are achieved in all other domains/courses.[2] 4. Respect for medical school professionalism policies must occur across all organizational structures (department, school, university).[3] 5. Professionalism assessment, feedback, and remediation should begin in year one of medical programs. 6. Student honor codes should require self-reporting of serious unprofessionalism[4] to their school/post-graduate training program/medical board (if regulated by medical board). 7. Transcripts and dean's letters should report matters of serious or trending unprofessionalism.[5]
Medical boards	1. Professionalism must be valued on an equal footing with clinical and research skills. 2. Medical boards should require self-reporting of serious unprofessionalism,[6] as well as reporting by medical schools/training programs, employers, and courts (if the individual has failed to self-report). 3. Medical boards should require certain matters of serious unprofessionalism to be directly reported by schools/training programs, employers, and courts.[7]
Legal system/courts	1. Courts should legally recognize the professionalism domain of medical practice, using codes of ethics and other standards as a legal basis for decisions. 2. Courts should order students and doctors to self-report to medical schools/medical boards serious matters of unprofessionalism for cases in their purview. 3. Courts should have the power to directly report certain matters of serious unprofessionalism to medical schools and medical boards, or report when students/doctors fail to adhere to court-ordered self-reporting.[8]

NOTES

1. The rules of progression should include exit pathways (e.g., expulsion, alternate degree) for students who are unable to achieve the requirements of the medical degree such that these students cannot continue along the path toward a medical diploma and licensure

2. Ibid.

3. Universities which offer programs in addition to medical degrees must recognize the unique societal obligations and professional standards of the medical profession.

4. Examples include plagiarism, fabrication, falsification, human or animal abuse, boundary violations, poor reliability and responsibility, lack of self-improvement and adaptability, poor initiative and motivation, negligence, inappropriate use of drugs or alcohol, criminal behavior, serious matters of moral character. M. Papadakis, C. Hodgson, A. Teherani, and N. Kohatsu, "Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board," *Academic Medicine* 79, no. 3 (2004),244-249.

5. Ibid.

6. Ibid.

7. This recommendation is consistent with current practice in some jurisdictions. American Medical Association, "Opinion 9.031 - Reporting Impaired, Incompetent, or Unethical Colleagues," *AMA Code of Medical Ethics,* adopted December 1991, *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page?*

8. Ibid.

inconsistent and potentially puts the public at risk.[31] Concurring with the Ottawa 2010 Conference, "Assessment [of professionalism] involves characterizing societal expectations, through dialogue and meaningful input from public stakeholders, and measuring the degree to which the profession . . . meets these expectations."[32] In doing so, medical schools help their students to recognize their responsibility to patients, to society, to other health professionals, and to self.[33] Those who do not meet these expectations should not enter the medical work force.[34] For those who have problems arising after they have entered the work force, successful remediation is essential if they are to safely remain in the profession.

Admittedly, there will be occasional "misses"—unprofessional and impaired medical students will receive degrees and enter the work force. Misses can result when undesirable behaviors go unreported by teachers, due to apathy or a desire to rid students from their roster by moving them along into the next rotation or subject. This "failure to fail" can also be the result of matters such as the desire to avoid an institutional appeal,[35] or to avoid the personal emotional toil of failing a student.[36] Fear of litigation can also causes misses,[37] especially when students view their degree as an entitlement based on a contract.[38] A recent investigation in Australia has concluded that some universities hesitate to fail under-performing students because failing them would shut off a valuable tuition income stream in the setting of weak government funding.[39] Much of this "failure to fail" can be more accurately termed "fear to fail."

CONCLUSION

Even an "ideal" system won't be perfect. This is because teachers and institutions will likely always have conflicts of interest that steer them away from reporting or failing unprofessional and impaired students. Furthermore, there is no crystal ball that predicts which students will successfully remediate. Some trainees, with the aid of needed mental and physical health supports, will gain wellness across these areas, as well as gain improvement in their professionalism.[40] Some trainees, unless they gain insight, will continue to have professionalism problems.[41] The recommendations in table 2 aim to either optimize existing systems or to create new and better ones. The resulting systems would have policies that align within schools and universities, fill loopholes, and add transparency that protects patients' welfare. These recommendations should be considered by a national task force that includes all stakeholders (including representatives from medical student cohorts, fellowship training programs, and community members). The resulting systems should also include a support mechanism for teachers/supervisors who struggle emotionally with the task of reporting or failing under performing trainees. (Practice points are listed in table 3.)

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DISCLOSURES

The author declares no conflict of interest. No funding was received for this work.

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TABLE 3. Practice points

- Professionalism must be recognized as an assessable core competency, fully integrated into medical school as well as post-graduate training programs.
- The legal system (courts) must recognize professionalism as an essential core competency for medical graduates, preserving the integrity and authority of medical schools, training programs, and their accreditation bodies, and protecting the safety and welfare of patients and society.
- Students and doctors recognized as "unfit to practice" from a professionalism standpoint should be prevented from doing so and should be referred for appropriate remediation.

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Clinical Ethics Consultation

Gender and Race in the Timing of Requests for Ethics Consultations: A Single-Center Study

Bethany Spielman, Christine Gorka, Keith Miller, Carolyn A. Pointer, and Barbara Hinze

ABSTRACT

Background

Clinical ethics consultants are expected to "reduce disparities, discrimination, and inequities when providing consultations," but few studies about inequities in ethics consultation exist.[1] The objectives of this study were (1) to determine if there were racial or gender differences in the timing of requests for ethics consultations related to limiting treatment, and (2) if such differences were found, to identify factors associated with that difference and the role, if any, of ethics consultants in mitigating them.

Methods

The study was a mixed methods retrospective study of consultation summaries and hospital and ethics center data on 56

age-and gender-matched Caucasian and African American Medicare patients who received ethics consultations related to issues around limiting medical treatment in the period 2011 to 2014. The average age of patients was 70.9.

Results

Consultation requests for females were made significantly earlier in their stays in the hospital (6.57 days) than were consultation requests made for males (16.07 days). For African American patients, the differences in admission-to-request intervals for female patients (5.93 days) and male patients (18.64 days) were greater than for Caucasian male and female patients. Differences in the timing of a consultation were not significantly correlated with the presence of an advance directive, the specialty of the attending physician, or the reasons for the consult request. Ethics consultants may have mitigated problems that developed during the lag in request times for African American males by spending more time, on average, on those consultations (316 minutes), especially more time, on average, than on consultations with Caucasian females (195 minutes). Most consultations (40 of 56) did result in movement toward limiting treatment, but no statistically significant differences were found among the groups studied in the movement toward limiting treatment. The average number of days from consult to discharge or death were strongly correlated with the intervals between admission to the hospital and request for an ethics consultation.

Conclusion

Our findings suggest race and gender disparities in the timing of ethics consultations that consultants may have partially mitigated.

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INTRODUCTION

Clinical ethics consultants are called upon in healthcare settings when ethical uncertainty, conflict, or disagreement over the care of patients arise. Consultants are expected to address ethical and communication problems and to help to ensure that the values of patients and healthcare professionals are respected. Some literature suggests that ethics consultation may improve the quality of care by reducing treatment that does not benefit patients.[2] Ethics consultation may also ensure that treatment options are matched to patients' preferences, influence the timing and manner of death, and perhaps improve the quality of interpersonal aspects of other healthcare services.

In addition to providing these benefits to patients and healthcare professionals, ethics consultants may reduce disparities in a healthcare system that is marred by inequity. The ASBH "Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants" (hereafter, the ASBH "Code of Ethics) recommends that consultants "reduce disparities, discrimination, and inequities when providing consultations."[3] While there is a massive literature on disparities in healthcare, the literature on the role of disparities and inequities in healthcare ethics consultation is scant. A 2014 literature review concluded that no empirical studies specifically addressed whether race/ethnicity is considered or documented in ethics consultations, and that no studies analyzed whether the same underlying factors that contribute to other racial/ethnic healthcare disparities influence ethics consultation.[4] One study, however, did find that race was not a significant factor in access to ethics consultation at a trauma center.[5] Another, more recent study found that race was not a significant factor in ethics committees' approval of unilateral do-not-resuscitate (DNR) orders.[6] A third study, too small to draw definitive conclusions, did not find that race made a difference in dissatisfaction with ethics consultation.[7] Responding to the thinness of the literature on ethics consultation and race, Silberman and colleagues called for "greatly expanded consideration of bias in the medical ethics literature, including rigorous studies to detect bias."[8] Even more problematically, although there is a significant literature on gender disparities in healthcare,[9] we are aware of no empirical study that focused on gender disparities and ethics consultation.

If ethics consultants are to "reduce disparities, discrimination, and inequities when providing consultations," as recommended by the ASBH "Code of Ethics," then the factors that affect access to ethics consultation must be carefully examined. Access to ethics consultation is directly affected by several factors, including who can make a request,[10] when requests for consultations are made, whether consultations can occur without a request (for example, as part of a hospital or research protocol),[11] whether physicians are permitted to block access or retaliate against requestors when a request is made,[12] and when ethics consultants are available.[13]

Our focus is on the second of these access factors: when requests for consultations are made. This factor is not well examined in the literature. Johnson and colleagues reported that consultations were made, on average, 25 days after admission, and that requests for "end-of-life" consultations occurred later after admission than requests for "shared decision-making" consultations, but the authors reported no racial difference in the timing of ethics consultation and did not examine gender.[14] Nilson and colleagues reported a 10-day median interval from hospital admission to ethics consultation and did not examine race or gender.[15] Gorka and colleagues' longitudinal study reported a reduction in the average interval from admission to request for consult, from 22 to seven days, and did not examine race or gender.[16] No studies of which we are aware attempt to determine an optimal time for a consult, but one study reported that ethics consultations that were offered in the absence of ethical conflict, or without an underlying sense of ethical disquiet among participants, do not seem to be effective.[17]

The purpose of this retrospective case survey was to determine if there were racial or gender differences in the timing of requests for ethics consultation related to limiting treatment, and, if there were, to identify the factors associated with those differences, and the role, if any, of ethics consultants in mitigating them.

METHODS

Memorial Medical Center is a 500-bed tertiary care academic medical center with a Clinical Ethics Center that performs 400-500 ethics consultations annually. At Memorial Medical Center, ethics consultations are performed upon request. Consultations may be requested by healthcare professionals and trainees, patients, families, and others; a physician's consent is not required for a consult. Ethics consultations are available 24 hours a day, seven days a week. Three full-time ethics consultants were employed by the hospital at all times during the study period.

The Clinical Ethics Center receives requests, responds to them with consultation, and maintains a database that tracks its work. Data for this study were obtained retrospectively from the center's database, from consultation summaries written by the ethics consultants for the purpose of review by the hospital ethics committee, and from hospital data.

An exploratory quantitative study was conducted to evaluate the salience of race to requests for ethics consultation. The exploratory study analyzed data on 754 ethics consultations performed from 2011 through 2014 whose reason for request had been identified, at the time of the request, as one of several related to limiting treatment.[18] The racial difference in the mean intervals between hospital admission and the date of a request for ethics consultation on Caucasian versus African American patients was 4.1 days (8.1 days for Caucasians and 12.2 days for African Americans). The two-tailed P-value was 0.0080, which indicates that it is unlikely the difference in mean intervals was caused by random chance. No statistically significant differences were found when comparing the mean admission-to-request interval for any other groups of patients identified by race or ethnicity (Hispanic, Asian, Pacific Islander, other), or by status of the payer (Medicaid, self-pay, commercial insurance).

After examining the results of the exploratory study, a mixed methods study on a smaller sample of these consultations was designed for in-depth investigation. The sample included 14 ethics consultations related to limiting treatment from 2011 to 2014 on African American male Medicare patients for whom data were complete, and 14 limiting treatment ethics consultations from 2011 to 2014 on age-matched Medicare patients from each of the following groups: Caucasian males, Caucasian females, and African American females (see table 1). Quantitative analysis and qualitative textual analysis were performed on the 56 matched consultation summaries and on additional data available in the Clinical Ethic Center's database and Memorial Medical Centers' database.[19] Two investigators who performed none of the ethics consultations served as coders of the qualitative data. When required for further statistical analysis, tie breaking was performed by additional investigators, none of whom had performed any of the ethics consultations being studied.

RESULTS

Pre-Consultation

We examined several factors that occurred prior to the ethics consultants' direct involvement in the cases: the admission-to-request interval, the specialization of the attending physician, the reason for consult request, and whether an advance directive was on file at the beginning of the consultation. Several additional factors that occur prior to a consultant's involvement, and which a consultant's summary may describe, were also investigated: whether the patient had expressed any treatment preferences prior to the consultation, and whether, prior to the request but during this hospital admission, a physician had had a conversation with the patient about limiting treatment, goals of treatment, or end-of-life issues. We report below our quantitative results, as well as qualitative results when moderate or better interrater reliability was achieved.

Admission-to-request intervals, measured in days. The average number of days ("interval") from hospital admission to request for ethics consult for the four groups was significantly different at the $p < 0.05$ level. Statistical significance was measured using ANOVA, and the P value calculated was 0.038. The shortest average interval from admission to consult request was for African American females (5.93 days); the longest was for African American males (18.64 days). Using a one-tailed hypothesis t-test, the difference in average intervals for African American females and African American males was statistically significant at $p < .05$, with a $p <$value of .024. The difference between the average for all females and all males was statistically significant at the $p < 0.05$ level (the $p <$ value was .0033). Other observed differences between groups were not statistically significant at the $p < 0.05$ level (see table 2). This suggests that the observed differences in the average admission-to-request intervals for all women and all men in the 56 cases were not due merely to chance, and that the observed differences between African American women and African American men in the study were also not due merely to chance.

TABLE 1. Demographics

Patients' demographics	Number of consults	Mean age*	Standard deviation
African American males	14	70.86	9.93
African American females	14	70.93	9.93
All African Americans	28	70.89	9.93
Caucasian males	14	70.93	9.85
Caucasian females	14	70.86	9.96
All Caucasians	28	70.89	9.90

*Ages greater than 90 were reduced to 90 to protect patients' identity.

Requestor and the specialty of the attending. Most consultations were requested by nurses (24); physicians were the next most frequent requestors (16). Consultations with African American patients were, however, more frequently requested by physicians (11) than by nurses (10); this difference was not statistically significant.

Patients for whom a consult was requested were attended by 15 types of specialists.[20] Requests for ethics consultation were most frequently made for patients who were attended by hospitalists (14), pulmonologists (10), internal medicine specialists (10), critical care specialists (five), and family medicine physicians (three). (Critical care specialists were available in the hospital only in 2013 and 2014; prior to this time pulmonologists were the critical care specialists.) A *chi*-square "goodness-of-fit" test was done to determine whether the distribution of specialists was different from an equal distribution to a statistically significant degree. There were no statistically significant differences among the groups for distribution of the three highest attending specialists. This means that we did not see statistically significant trends regarding which specialties did or did not request ethics consultation.

The reasons for consult requests. There were 28 reasons for ethics consultation requests identified as potentially related to limiting treatment. Most consult requests included only one reason, but some included as many as three reasons. The top four stated reasons for consult requests were goals of care (17 consults), code status (13 consults), competency (six consults), and disagreement regarding treatment (five consults). All other reasons were listed for fewer than five consults. The two reasons with the highest frequency—goals of care and code status—were analyzed using a *chi*-square test, and no significant differences were detected among the groups. That is, race and gender did not seem to determine which of the 56 consult requests were made for these reasons. Because the number of occurrences for any other reason was small, no other statistical tests were attempted on the reasons for the consult request.

Advance directives. For purposes of the study, advance directives included durable powers of attorney for healthcare, living wills, Department of Public Health DNR orders, physician orders for life sustaining treatment (POLST), and mental health treatment declarations. More advance directives were on file for Caucasian males (nine) and Caucasian females (nine) than for African American females (seven) or African American males (five), but the differences among those groups were not statistically significant. A lower percentage of African Americans who died in the hospital had durable powers of attorney for healthcare, but the differences among the groups in this study were not statistically significant. The average admission-to-request interval was not significantly correlated with the average percentage of advance directives on file for the four groups. Therefore this study did not detect evidence of a statistically significant relationship between having an advance directive and the number of days before the first consult after admission.

Physicians' discussions of limiting treatment and patients' preferences expressed during this admission. Raters achieved perfect agreement for the question "Did the summary indicate that, during this hospital admission, any physician had spoken with the patient or family or other surrogate about goals of care, possibly limiting care, end-of-life-care, etc., before ethics was involved?" with a Cohen's *kappa*

TABLE 2. Pre-consult data

Patients' demographics	Hospital admission to consult request interval in days†	Number of advance directives on file	Number of consults with prior limiting care conversation with MD this admission
African American males	18.64*	5	0
Caucasian males	13.50	9	3
Caucasian females	7.21	9	4
African American females	5.93*	7	2
All males	16.07**	14	3
All females	6.57**	16	6

*   Denotes statistically significant difference at .05 level.
** Denotes statistically significant difference at .05 level.
† Denotes correlation with length of stay from consult to discharge or death.

of .931. In most ethics consultation summaries (47 of 56), no prior conversation with patients, family, or surrogates was noted. Using a *chi*-square "goodness-of-fit" test of $P < .05$, no statistically significant differences of race or gender were found. We note, however, that no indication of a discussion of this kind was found in summaries of any of the consultations with African American males; each of the other three groups of summaries noted several such discussions (see table 2).

In just under half of consults (27 of 56), the summary "note[d] that the patient has expressed . . . care preferences . . . prior to ethics consult during the hospital stay." Raters achieved substantial agreement with a Cohen's *kappa* of .712 for this question. Using a *chi*-square "goodness-of-fit" test of $P < .05$, no statistically significant differences for race or gender were found concerning who did and did not express preferences about care prior to the consult.

ETHICS CONSULTATIONS

To assess whether ethics consultations may have either mitigated or exacerbated the gender and race differences evident in the timing of requests, we examined the following features for each ethics consultation: how much time the consultant spent on the consultation, whether the consultant interacted more than once with the patient and/or family members or surrogates, and whether the consult summary reflected any movement toward limiting treatment during or after the ethicist's involvement.

Consultants' Time

The average number of minutes that ethics consultants spent on consults for African American males (316 minutes) was greater than for Caucasian males (284 minutes), African American females (268 minutes), and Caucasian females (195 minutes). Although there were no statistically significant differences among groups at the $p < .05$ level, there was nearly a statistically significant difference detected between the mean minutes for African American males and the mean minutes for Caucasian females, with $p = 0.050115$. The average for African American males scored 4 on a scale of 1 to 5 in Bruce's time intensity scale for ethics consultation, while averages for other groups scored 3.[21] (See table 3).

The Number of Consultants' Interactions with Patient, Family, or Surrogate

Raters achieved substantial agreement for the question "Does the summary indicate that the ethicist interacted with the patient and/or family mem-

bers or surrogates more than one time?" with a Cohen's *kappa* of 0.701. In 24 of 56 summaries, consultants said they interacted with these stakeholders more than once. Using a *chi*-square "goodness-of-fit" test at $p < .05$, no statistically significant differences for race or gender were found (see table 3). This does not mean that the groups had exactly the same percentage of consults reporting multiple family or surrogate visits. Although not statistically significant, a higher percentage of African American males than other groups had a surrogate decision maker who was a niece, nephew, grandchild, family guardian, or state appointed guardian, rather than a spouse or adult child. Because these more distant surrogates may have less information about a patient's values than close family members do, consultation with them may have required more of the consultant's time.

Limiting Treatment at the End of a Consult

In the majority of consult summaries (40 of 56), movement toward limiting treatment during or after an ethicist's involvement was noted. Agreement between raters about movement toward limiting treatment was substantial, with a Cohen's *kappa* of .616. Using a *chi*-square "goodness-of-fit" test at $p < .05$, no statistically significant differences among race or gender groups were found (see table 3). Of those patients who died in the hospital or were discharged to hospice following an ethics consult, a lower percentage of African Americans, particularly African American males, had DNR orders, but the difference was not statistically significant.

POST-CONSULTATION

We also examined several post-consultation issues: concerns about readmission reflected in the

TABLE 3. Consult data

Patients' demographics	Consultant minutes	Number consults with patient/ family interactions	Number consults with movement toward limiting care
African American males	316*	6	12
Caucasian males	284	6	10
Caucasian females	195**	5	9
African American females	268	7	9

* Denotes statistically significant difference at .10 level, $p = .50115$.

consult summary, days from consult to hospital discharge or death, the number of deaths that occurred in the hospital, and discharges to hospice.

Concern about Readmission

For the question, "Does the summary reflect any concern about/interest in discharge planning or 'rebounding'?" (that is, readmission shortly after being released), raters achieved moderate agreement with a Cohen's *kappa* of .595. Using a *chi*-square "goodness-of-fit" test at $p < .05$, no statistically significant differences for race or gender were found in how many consults in each group included these concerns.

Days from Consult to Discharge or Death

The average number of days for each group from admission to consult request were paired with the average days from consult to discharge or death. These pairs showed a strong linear relationship, using Pearson's linear correlation measure, $R = .718$. This means that if a patient had a relatively long interval between admission and a request for a consult, the patient was likely to have a relatively long interval between the consult and either discharge or death. Using a two-tailed value of P, the association between the two variables was statistically significant at the $p < 0.05$ level, $p = 0.01352$ (see table 2, column 1, and table 4, column 1). The difference in average days from consultation to discharge or death for African American males (18.21) and African American females (8.07) was statistically significant at $p < .10$, $p = .066518$ (see table 4).

Death in the Hospital, Discharge to Hospice, and DNR in Pre-Morbid Patients

Of the 56 patients with whom ethics consultations were conducted, 23 died in the hospital. Using a *chi*-square "goodness-of-fit" test, there was no statistical difference for the gender and race between this distribution of death and an equal distribution of death (see table 4). Also, no differences among groups in the number of discharges to hospice were statistically significant. Among the subset of patients who either died in the hospital or who were discharged to a hospice, a higher percentage of Caucasian patients than African American patients had DNR orders, but the difference was not statistically significant (see table 4).

DISCUSSION

It is likely that some ethics consults in the 56 cases that were studied occurred too early and some too late to provide optimal care to patients. When the male/female difference in average days from admission to consult request was highly significant ($p = .0033$) and not explained by other factors, as was the case in our study, there is cause for concern that the difference represents a gender disparity that should be addressed by clinical ethicists.[22] Because the gender difference for African American patients in our study was both significant ($p = .024$) and especially large (> 12 days), research and interventions should particularly focus on the interaction between race and gender in consult requests.

Future investigators could help determine which uncertainties, biases, and/or stereotypical thinking among requestors contribute to gender and race disparities in the timing of requests for consultation,[23] and to help design interventions that address disparities and yet are sensitive to requestors' perceived need for help when a request is made (not earlier or later). Among the possibilities that should be explored are these: (1) that requests for "limiting care" consults for African American women may be occurring too early, and (2) that requests for consults for African American men may be occurring too late to provide optimal care. If requestors believe that females–especially African American females—are

TABLE 4. Post-consult data

Patients' demogrphics	Length of stay from consult to discharge or death†	Number out of 14 discharged to hospice or death in hospital	Number discharged to hospice or death in hospital with DNR
African American males	18.21*	10	6
Caucasian males	12.57	6	6
Caucasian females	11.00	8	8
African American females	8.07*	6	3

* Denotes significance at $p < .10$.

† Denotes correlation with admission-to-request interval.

less rational than males, that belief may translate into premature requests for consults whose stated or implicit reasons include ascertaining female patients' capacity for healthcare decision making. If the stereotype that females are or should be more self-sacrificing, or prefer dying more "naturally" than others is operative among requestors, it may result in the expectation that females—especially African American females—will be more open to limiting treatment earlier in the course of a hospitalization than males.[24] Either perception related to gender could contribute to a shorter admission-to-request interval for females than for males and to potentially premature requests for consultations about limiting treatment.

Later-than-optimal consult requests are at least as problematic as earlier-than-optimal requests; a late ethics consultation cannot ensure that a patient or proxy decision maker can participate in shared decision making and have his or her preferences taken seriously.[25] When requests are made later for African American males than for others, investigators should determine which uncertainties, biases, and stereotypical thinking about African American males are operative among requestors, so that clinical ethicists and educators can address them. Late requests may be related to health professionals' reluctance to fully engage with African American males about their treatment preferences. This possibility is prompted by our findings that nurses, as a group, requested a lower percentage of consults for African Americans than for Caucasians, and that physicians' conversations with African American males or their family or surrogate prior to ethics consultation may not occur. Reluctance to fully engage with African American males would be consistent with other studies that suggest that African American patients receive lower quality interpersonal care than others in healthcare settings.[26] Further, if it can be determined that delays in requests for ethics consultation for African American males are the result of stereotypical thinking about the preferences of specific racial groups (for example, that African American males prefer aggressive treatment such as cardiopulmonary resuscitation or prefer not to discuss treatment preferences), the difference would clearly represent a disparity that should be investigated and addressed.

Ethics consultations have the potential to mitigate disparities, to exacerbate disparities, or to have no discernible effect on them. We found that ethics consultants spent the most time, on average, on consultations involving African America males (316 minutes). This amount of time could mitigate prob-lems that may have developed during, or been exacerbated by, the significant lag in consultation requests for African American males. Because African American males in our study tended to be dependent on surrogates who were more socially distant from them (and likely less intimately knowledgeable about their values and treatment preferences), ethicists' time may have been spent ensuring that the surrogates were functioning well as surrogates (that is, mitigating disparities in family-social networks). Our study did not suggest that ethicists spent significantly more or less time on consults with African American females (268 minutes), who fell at the other extreme of average admission-to-consult intervals, but who had surrogates who were, on average, more closely related to them.

Because we did not find that ethics consultations more frequently resulted in movement toward limiting treatment for one group than for another, it is possible that the consultations mitigated the disparate admission-to-request intervals. That is, although requests for consults about limiting treatment were made earlier for females (especially African American females) than for males (especially African American males), consults with females did not more frequently or less frequently result in movement toward limiting treatment than consults with males.

Consultants did not mitigate all disparities. The significant difference in post-consult lengths of stay between African American males and African American females is worth further investigation and may be related to weak family/social supports for African American males. The difference in rates of DNR orders between dying African Americans and dying Caucasians, as well as the correlation between disparate admission-to-request intervals and disparate post-consultation lengths of stay, are also worth further investigation.

CONCLUSION

Our findings suggest that there are race and gender disparities in the timing of ethics consultations. A research and intervention agenda is necessary for ethics consultants to understand race/gender interactions in the organizations where they practice and to design informed interventions to "reduce disparities, discrimination, and inequities when providing consultations," as recommended by the ASBH "Code of Ethics." Ethicists have opportunities to mitigate or exacerbate disparities during consultations, and should conduct research on best practices for mitigation.

LIMITATIONS OF THE STUDY

Ethics consultation reports are somewhat subjective summaries of consultation contexts, issues, interventions, recommendations (sometimes), and follow up as reported by ethics consultants. The reports are limited in length. Lengthier, more comprehensive narratives of consultations might provide details that would suggest other interpretations of some results.

Some database entries were incomplete and were eliminated from the exploratory study. The database entries for all of the 56 cases in the more detailed study were sufficiently complete for analysis.

IRB

This project was reviewed by the Springfield Committee for Research Involving Human Subjects.

NOTES

1. ASBH, "Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants," 2014, *asbh.org/uploads/publications/ASBH%20Code%20of%20Ethics.pdf.*

2. W.S. Andereck, "Seeking to Reduce Non-beneficial Treatment in the ICU: An Exploratory Trial of Proactive Ethics Intervention," *Critical Care Medicine* 42, no. 4 (2014): 1-7.

3. Ibid.

4. R.S.M. Angove, E.M.Ngui, and M. Repenshek, "Inclusion and Use of Race and Ethnicity in Ethics Consultation Research," Catholic Health Association of the United States, 2014, *https://www.chausa.org/docs/default-source/hceusa/race-and-ethnicity-in-ethics-consultation-research.pdf?sfvrsn=2.* Danis, Wilson, and White urged bioethicists, including clinical ethicists, to address racism in M. Danis, Y. Wilson, and A. White, "Bioethicists can and should contribute to addressing racism," *American Journal of Bioethics* 16, no. 4 (2016): 3-12.

5. L. Johnson, J. Lesandrini, and G. Rozycki, "Use of the Medical Ethics Consultation Service in a Busy Level I Trauma Center: Impact on Decision-Making and Patient Care," *American Surgeon* 78, no. 7 (2012): 735-40.

6. A. Courtwright, "Experience with a Hospital Policy on Not Offering Cardiopulmonary Resuscitation When Believed More Harmful than Beneficial," *Journal of Critical Care* 30, no. 1 (2015): 173-7.

7. L. Schneiderman, "Dissatisfaction with Ethics Consultations: The Anna Karenina Principle," *Cambridge Quarterly of Healthcare Ethics* 15, no. 1 (2006): 101-6.

8. J. Silberman, W. Morrison, and C. Feudtner, "Pride and Prejudice: How Might Ethics Consultation Services Minimize Bias?" *American Journal of Bioethics* 7, no. 2 (2007): 32-4.

9. R. Bugiardini, "Gender Bias in Acute Coronary Syndromes," *Current Vascular Pharmacology* 8, no. 2 (2010): 276-84; D.E. Hoffmann and A.J. Tarzian, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain," *Journal of Law, Medicine & Ethics* 29, no. 1 (2001): 13-27; A. Abuful, Y. Gidron, and Y. Henkin, "Physicians' Attitudes Toward Preventive Therapy for Coronary Artery Disease: Is There a Gender Bias?" *Clinical Cardiology* 28, no. 8 (2005): 389-93.

10. G. McGee, "A National Study of Ethics Committees," *American Journal of Bioethics* 1, no. 4 (2001): 60-4.

11. Several studies have focused on "proactive" ethics consultations, i.e., those undertaken so that researchers could investigate the effectiveness of a consultation at a particular point in the patient's stay in the hospital or stay in the intensive care unit, rather than wait to see if and when participants would make a request.

12. E.J. Gordon and A.B. Hamric, "The Courage to Stand Up: The Cultural Politics of Nurses' Access to Ethics Consultation," *The Journal of Clinical Ethics* 17, no. 3 (Fall 2006): 231-54; M. Danis, "Does Fear of Retaliation Deter Requests for Ethics Consultation?" *Medicine, Health Care and Philosophy* 11, no. 1 (2008): 27-34.

13. In some organizations, ethics consultants are not easily accessed; ethics consultants may be part-time or authorized to do only retrospective case reviews. We are unaware of any organization that makes the cost of ethics consultations a barrier for patients by billing for them.

14. E.G. Nilson, "Clinical Ethics and the Quality Initiative: A Pilot Study for the Empirical Evaluation of Ethics Case Consultation," *American Journal of Medical Quality* 23, no. 5 (2008): 356-64.

15. L.S. Johnson, J. Lesandrini, and G.S. Rozycki, "Use of the Medical Ethics Consultation Service in a Busy Level I Trauma Center: Impact on Decision-Making and Patient Care," *American Surgeon* 78, no. 7 (2012): 735-40.

16. C. Gorka, "Growing an Ethics Consultation Service," forthcoming in *American Journal of Bioethics Empirical Ethics.*

17. W.S. Andereck, "Seeking to Reduce Nonbeneficial Treatment in the ICU: An Exploratory Trial of Proactive Ethics Intervention," *Critical Care Medicine* 42, no. 4 (2014): 824-30, 828.

18. The following reasons for requests were included in reasons related to limiting treatment: goals of care, competency, code status, durable power of attorney for healthcare, Illinois Department of Public Health do-not-resuscitate order, physician orders for life-sustaining treatment (POLST), treatment refusal, treatment decision making, treatment disagreement, treatment withholding or withdrawing, discharge plans, counsel family, artificial nutrition and hydration, hospice, counsel patient/family, futility, and inappropriate treatment. A narrower definition

was considered for the in-depth study ("consults in which a key question was the appropriateness of interventions or care settings that may under some circumstances, extend life or delay death"). The broader definition proved more appropriate because it facilitated age matches close enough to eliminate male/female age differences as a reason for differences in timing of requests, and because more than 70 percent of the consults it captured ultimately resulted in movement toward limiting treatment.

19. Coders who were trained on a sample of consultation summaries that were selected randomly from ethics consults conducted during years not included in the study. After the initial draft codebook was developed, coding rounds were completed on multiple random samples of consultation summaries as the codebook was modified. Questions included: Does the summary reflect any concern about/interest in discharge planning or "rebounding"? Does the summary note that the patient has expressed any care preferences at any point prior to ethics consult during the hospital stay? Did the summary indicate that, during this hospital admission, any physician had spoken with the patient or family or other surrogate about goals of care, possibly limiting care, end-of-life care, etc., before ethics was involved? Does the summary indicate that religion influenced the patient or family or surrogate to limit or reduce the aggressiveness of treatment? Does the summary indicate that the ethicist interacted with the patient and/or family members or surrogates more than one time? Does the summary reflect any movement toward limiting any treatment during or after ethicist's involvement?

20. Specialty areas included cardiology, critical care, colon-rectal surgery, family medicine, general surgery, hematology, hospitalist, internal medicine neurology, oncology, plastic surgery, psychiatry, pulmonology, and trauma surgery.

21. C.R. Bruce, "An embedded model for ethics consultation: Characteristics, outcomes, and challenges," *American Journal of Bioethics Empirical Bioethics* 5, no. 3 (2014): 8-18, 12.

22. P.L. Hebert, J.E. Sisk, and E.A. Howell, "When does a difference become a disparity? Conceptualizing racial and ethnic disparities in health," *Health Affairs* 27, no. 2 (2008): 374-82.

23. A.I. Balsa and T.G. McGuire, "Prejudice, Clinical Uncertainty and Stereotyping as Sources of Health Disparities," *Journal of Health Economics* 22, no. 1 (2003): 89-116.

24. N.S. Jecker, "New Challenges for Ethics Consultation: Combining Feminism, Multiculturalism, and Caring," *Public Affairs Quarterly* 17, no. 2 (2003): 83-95; J.A. Parks, "Why gender matters to the euthanasia debate: On decisional capacity and the rejection of women's death requests," *Hastings Center Report* 30, no. 1 (2000): 30-6; S. Rubin and L. Zoloth-Dorfman, "She Said/He Said: Ethics Consultation and the Gendered Discourse," *The Journal of Clinical Ethics* 7, no. 4 (Winter 1996): 321-32.

25. J.W. Mack, "Racial disparities in the outcomes of communication on medical care received near death," *Archives of Internal Medicine* 170, no. 17 (2010): 1533-40.

26. M.Y. Lin and N.R. Kressin, "Race/ethnicity and Americans' experiences with treatment decision making," *Patient Education and Counseling* 98 (2015): 1636-42, DOI: 10.1016/j.pec.2015.07.017; L.A. Cooper, "Delving below the surface," *Journal of General Internal Medicine* 21, no. S1 (2006): S21-7; A.M. Elliott et al., "Differences in Physicians' Verbal and Nonverbal Communication With Black and White Patients at the End of Life," *Journal of Pain and Symptom Management* 51, no. 1 (2016): 1-8.

Measuring Quality in Ethics Consultation

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ABSTRACT

For all of the emphasis on quality improvement—as well as the acknowledged overlap between assessment of the quality of healthcare services and clinical ethics—the quality of clinical ethics consultation has received scant attention, especially in terms of empirical measurement. Recognizing this need, the second edition of *Core Competencies for Health Care Ethics Consultation*[1] identified four domains of ethics quality: (1) ethicality, (2) stakeholders' satisfaction, (3) resolution of the presenting conflict/dilemma, and (4) education that translates into knowledge. This study is the first, to our knowledge, to directly measure all of these domains. Here we describe the quality improvement process undertaken at a tertiary care academic medical center, as well as the tools developed to measure the quality of ethics consultation, which include post-consultation satisfaction surveys and weekly case conferences. The information gained through these tools helps to improve not only the process of ethics consultation, but also the measurement and assurance of quality.

BACKGROUND

Over time there has been increasing attention given to the assessment of quality in healthcare. Addressing concerns ranging from improving patients' safety to eliminating unnecessary costs, the measurement of quality affects public perception,[2] professional accreditation,[3] and reimbursement for organizations[4] as well as individuals.[5] Quality assessment efforts do not merely note the level of the quality of care currently being provided, but also identify ways the level of quality can be increased. As Sir William Thomson, Lord Kelvin, famously said, "If you can not measure it, you can not improve it."[6]

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As part of the "quality movement," there has been a growing recognition of the overlap of ethics and quality assessment.[7] In other words, ethical organizations tend to be high-quality organizations.[8] When applied to clinical ethics consultation (CEC), however, the measurement of quality is particularly complex, due to the unique nature of each patient and dilemma, as well as the many variables involved, which range from the practice environment (for example, teaching hospital, community hospital, critical access hospital), to the professional background of consultants (for example, medicine, law, philosophy), to their degree of formal training (for example, advanced degree, clinical fellowship, apprenticeship).[9] Absent a reliable method to measure quality, it is impossible to determine whether an ethics consultation service aligns with accepted standards, or to identify aspects of the ethics consultation service that require improvement.[10] This may negatively affect the care of patients and prevent necessary resources from being allocated to CEC.

Recognizing the need for reliable measures, the Ethics Consultation Service (ECS) at the University of Vermont Medical Center—a 562-bed academic hospital that serves a population of more than one million—recently undertook a two-year project to measure and improve its quality. The ECS is staffed by two clinical ethicists (SEB, RCM) who, combined, have more than 40 years of clinical practice experience, each having completed advanced degrees and mentorship in ethics; and a halftime administrative assistant (GJM).

We used the three study areas suggested by Donabedian to begin our project:
1. Structure: the material and/or human resources, professional qualifications, and organizational reporting that frames the service.
2. Process: "the interactions between the service that is being evaluated and the individuals who are served by the service."[11]
3. Outcomes.

The literature on measuring the quality of CEC is modest at present,[12] and literature that focuses on the processes of CEC tends to be descriptive, not empirical.[13] But while an appropriate process is a necessary condition to provide high-quality ethics consultation, it is not a sufficient condition. It is quite possible to be responsive, inclusive, and attentive to detail, yet still provide inaccurate or ill-advised counsel, fail to positively affect a complex situation, and alienate key stakeholders.

A few studies have sought to measure the quality of CEC, generally using indirect measures such as length of stay in the hospital or expenditures.[14] These are important considerations, to be sure, but it is not always "ethical" to save money, nor is it necessarily unethical to prolong a patient's length of stay.

Recognizing a need to directly measure the quality of outcomes in ethics consultation, the second edition of the American Society for Bioethics and Humanities' *Core Competencies for Healthcare Ethics Consultation* (hereafter, the *Core Competencies*) lays out four specific domains:
1. Ethicality
2. Stakeholders' satisfaction with consultations
3. Resolution of the presenting conflict/dilemma
4. Education that translates into knowledge.[15]

Ours is the first study, to our knowledge, to directly measure all of these domains, primarily through the use of a Post-Consultation satisfaction Survey (PCSS) and discussion of each consultation during a weekly case conference. Previous studies that have measured stakeholders' satisfaction were either limited to specific settings[16] or a pediatric population,[17] surveyed only the requesting physicians,[18] or surveyed only patients and their family members.[19] The only other study, to our knowledge, to survey both staff as well as patients and families included only 20 patients, and did not include other measures of outcome quality that more directly address ethicality and education.[20]

The remainder of this article describes our quality improvement process, the tools developed, and the valuable lessons learned through "operationalizing" quality improvement.

METHODS

Recognizing that the structure of the ECS had been determined largely by higher level institutional decisions, our quality measurement and improvement project focused on process and outcomes.

Process

We reviewed the key process elements noted in the *Core Competencies* and divided them into three phases: (1) preceding formal consultation, (2) during the course of the consultation, and (3) following the documentation of recommendations from the consultation (see table 1). Phase 1 involves the initial response to the consultation, including verification that there is a legitimate "ethics question" (as opposed to a biotechnical, communication, or relational question[21]), as well as notification of key stakeholders such as the attending physician. Phase

2 includes the acquisition of information directly from the patient, staff, and other involved parties, as well as analysis of the ethical dilemma at hand and the provision of recommendations. Phase 3 involves post-consultation follow up and application of the lessons learned, which largely depends on the outcome of the consultation, and thus will be discussed in the next section of this article.

We hypothesized that completing all of the recommended elements would promote increased attention to detail and assist in identifying practical steps to improve the overall process, and so we devised the Intake Quality Improvement Form (the IQIF, shown in figure 1). The top section of the IQIF is completed by the ethics consultant, and the information recorded by the consultant allows the ECS to measure *responsiveness* (the time from the request for an ethics consultation, to the initiation of the consult, to its completion), as well as *adherence to expectations related to confidentiality* (whether the requestor requested that her or his identity to be withheld) and *transparency* (the notification of the patient's attending physician and the patient's primary careprovider that a consult was requested). We record the number of nonbusiness hours spent on a consult, as it may ultimately impact levels of staffing (and, thus, the structure of the ECS).

All CECs at the University of Vermont Medical Center are documented in the patient's medical record using a Consultation Note Template, based on the Orr-Shelton Model of CEC.[22] This Consultation Note Template (see figure 2) includes all of the process elements recommended in the *Core Competencies*. The format of the Consultation Note Template may seem familiar, since it mirrors the clinical progress note format utilized by medical clinicians across the United States. The Template records information from each consultation in three sections:

(1) identification/assessment, (2) analysis/discussion, and (3) conclusion/recommendations. For the purposes of quality improvement, we evaluate theory and application separately in the "Discussion" section of the Template, which results in nine scored sections (see table 2). Our administrative assistant (who was trained in a field that is unrelated to bioethics) assesses whether all of the required elements were recorded in each Consultation Note Template, and this rate of completion is entered as a score on the IQIF that is created for each consultation. The IQIFs thus serve as records of the (in-)completion of the recommended process elements for each CEC.

As just described, the scoring of the completeness of each Consultation Note Template on an IQIF is based solely on components included in the Consultation Note. This scoring does not require any specialized training in bioethics (although some basic explanations and definitions of terms are required to indicate the inclusion/exclusion of the required elements). When the information recorded on a Consultation Note is missing or unclear—or if every element of a section (for example, the demographics) is not complete—this is scored as a deficiency. Our administrative assistant maintains an internal spreadsheet that tracks the CECs performed, the completeness of Consultation Notes, and identifies topics or themes that recur. These topics and themes are further coded to identify trends and/or opportunities to make corrections to the consultation process or offer educational interventions.

In addition, two of the elements of our Post-Consultation Satisfaction Survey (the PCSS, which is discussed in detail below) have relevance to the process of ethics consultation. These elements are the timeliness and accessibility of the ECS, and the timeliness and informativeness of the CECs.

TABLE 1. Ethics consultation process elements

Phase 1	Phase 2	Phase 3
Timely response	Visit patient, if applicable	Follow up with stakeholders
Assess for appropriate consultation	Interview stakeholders	Identify systems issues
Notify stakeholders	Facilitate moral deliberation	Evaluate/improve consultation process
Clarify and/or formulate ethics question	Identify decision maker(s), as needed	
Review medical record	Determine need for formal meeting	
Gather ethics knowledge	Synthesize, communicate information	
	Provide recommendations	
	Provide documentation	

Elements adapted from ASBH, *Core Competencies for Healthcare Ethics Consultation,* 2nd ed. (Glenview, Ill.: ASBH, 2011).
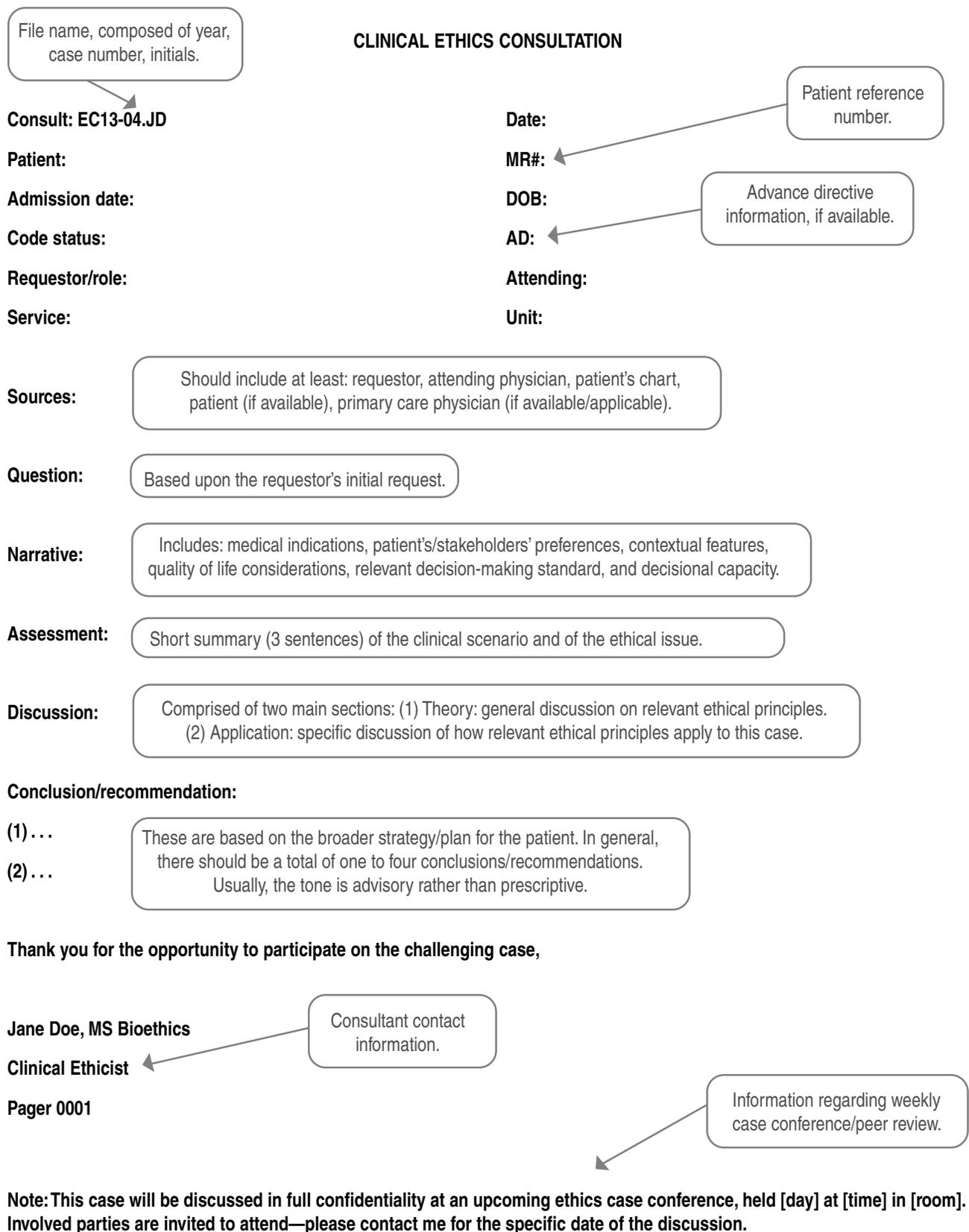
FIGURE 1. Intake Quality Improvement Form (IQIF),

Ethics Consultation Intake/Quality Improvement/Coding Worksheet (May 2012)

CONSULT # EC-13.JD _____	**NAME:** _____
Date Consult Requested: _____ Request Urgency: [Stat] [Today] [As Convenient] ____ Date Initiated: _____ Any Non-Business Hours Involved? [Y] [N]	Health prior to admission: [Ex] [Gd] [Fr] [Sr] [Cr] Health at Time of Consult: [Ex] [Gd] [Fr] [Sr] [Cr] PCP* Name:_____
Confidential Consult? [Y] [N] 　　If YES Reason: _____	PCP Notified? [Y] [N] Attending Notified? [Y] [N]

Question Coding

[ ] Patient Autonomy
[ ] Decision Making Capacity
[ ] Professional Obligations & Duties
[ ] Surrogate/Substitute Decision Making
[ ] Goals of Treatment—Identify/Clarify
[ ] Technology/therapeutics—start/stop; use/not use
[ ] Other

Discussion Coding

[ ] Beneficence
[ ] Non-Maleficence
[ ] Autonomy
[ ] Justice
[ ] Utilitarianism (greatest good for greatest number)
[ ] Deontology (action based on duties)
[ ] Rights & responsibilities
[ ] Moral distress
[ ] Surrogate decision-making role or hierarchy of
[ ] Maternal/fetal
[ ] Pediatric
[ ] Cultural/religious issues
[ ] Informed consent (accuracy, completeness)
[ ] Medical error
[ ] Professional ethics
[ ] Legal issue or question
[ ] Nonbeneficial treatment

Recommendations/Conclusions

[ ] Moral standing of various persons
[ ] Continue to evaluate patient's decision making capacity
[ ] Actions to promote autonomy/decision making capacity
[ ] Respect patient refusal/treatment of objection
[ ] Determine limits of patient/surrogate autonomy
[ ] Establish level of certainty about patient previously spoken requests
[ ] Recommend consult
[ ] Recommendations about plan of care
[ ] Articulate the ethical standard of care
[ ] Differentiate between obligatory and optional treatment
[ ] Need a management/patient/family conference
[ ] Appropriate wording for specific orders, etc.
[ ] Discharge or disposition plans
[ ] Moral support for staff
[ ] POLST/COLST/Advance Directive Forms

Quality Measurements

[Y] [N] Patient Demographics
[Y] [N] Sources
[Y] [N] Question
[Y] [N] Narrative/Case Summary
[Y] [N] Assessment
[Y] [N] Discussion: theory section
[Y] [N] Discussion: application of theory
[Y] [N] Recommendation/Conclusion
[Y] [N] Closing/Contact Information

Case Follow Up

Quality Surveys Sent:　　　　[ ]
Discharge date/Disposition:　　[ ]
Coding Completed:　　　　　　[ ]

* PCP is an acronym for primary care physician

FIGURE 2. Consultation Note Template, created using the Orr-Shelton Method.

CLINICAL ETHICS CONSULTATION

> File name, composed of year, case number, initials.

Consult: EC13-04.JD

Patient:

Admission date:

Code status:

Requestor/role:

Service:

Date:

MR#:

DOB:

AD:

Attending:

Unit:

> Patient reference number.

> Advance directive information, if available.

Sources:
> Should include at least: requestor, attending physician, patient's chart, patient (if available), primary care physician (if available/applicable).

Question:
> Based upon the requestor's initial request.

Narrative:
> Includes: medical indications, patient's/stakeholders' preferences, contextual features, quality of life considerations, relevant decision-making standard, and decisional capacity.

Assessment:
> Short summary (3 sentences) of the clinical scenario and of the ethical issue.

Discussion:
> Comprised of two main sections: (1) Theory: general discussion on relevant ethical principles. (2) Application: specific discussion of how relevant ethical principles apply to this case.

Conclusion/recommendation:

(1) . . .

(2) . . .
> These are based on the broader strategy/plan for the patient. In general, there should be a total of one to four conclusions/recommendations. Usually, the tone is advisory rather than prescriptive.

Thank you for the opportunity to participate on the challenging case,

Jane Doe, MS Bioethics

Clinical Ethicist

Pager 0001

> Consultant contact information.

> Information regarding weekly case conference/peer review.

Note: This case will be discussed in full confidentiality at an upcoming ethics case conference, held [day] at [time] in [room]. Involved parties are invited to attend—please contact me for the specific date of the discussion.

Outcomes

Recognizing the challenges inherent in measuring the quality of the outcomes of consultations, we use three tools to evaluate the four outcome-related domains listed in the *Core Competencies:* the PCSS, which is sent to all staff participants; weekly ethics case conferences; and discussion of especially complex cases (as needed) by the ECS.

Post-Consultation Satisfaction Survey

After a CEC is completed, our administrative assistant sends an invitation to complete a PCSS to the staff who were identified as sources for the consultation and for whom email addresses are available. (This anonymous survey was deemed exempt by the University of Vermont Institutional Review Board.) The online survey is deployed through SurveyMonkey and consists of nine questions, including three that elicit demographic information about the respondent. The remaining six questions ask the respondent to rate the following statements on a five-point Likert scale from "strongly disagree" to "strongly agree":

Q1. I would recommend an ethics consult to others in a similar situation.

Q2. The ethics consultation clarified the goals of care.

Q3. The ethics consult improved my understanding of the situation.

Q4. The ethics consult was informative and timely.

Q5. The ethics consult clarified aspects of the question raised.

Q6. The ECS was accessible and timely.

At the conclusion of the survey, respondents are given the opportunity to provide free-text comments and feedback. Three analysts (GJM, as well as two retired ethicists who serve on the ECS) independently code the comments to identify recurring themes and categorize them as having negative or positive sentiments. Any discrepancies in the coding are discussed by the three analysts as a group until they achieve consensus.

Weekly Clinical Ethics Case Conference

The ECS utilizes the rather rare "individual consultant model," by which each consultation is performed by the on-call ethicist.[23] The benefit of such a model is responsiveness, but the primary drawback is a lack of interdisciplinarity and the risk of bias. To compensate for this, a weekly, hour-long ethics case conference is held to review recent consultations. The conference is held at a regular place and time, to provide ease of attendance for multi-

TABLE 2. Sections of the Consultation Note Template based on the Orr-Shelton Method, see figure 2

Consultation note section	Goals	Elements of documentation
Demographics		Patient's name, clinical service or unit, attending physician, request date, requestor's name and role
Sources		Stakeholders communicated with during the consultation
Question		Requestor's ethical concern (the ethics question that initiated the consultation)
Narrative		History, summary of current context*; requestor's description of circumstances; relevant information from advance directive (if present); meetings held; ethical concerns and steps already taken
Assessment	Identification	Clear, concise statement of the ethics question
Discussion (theory)	Analysis	Summary of ethical analysis
Discussion(application)	Analysis	Identification of decision maker, options considered and whether they were deemed ethically justifiable, explanation of whether agreement was reached
Conclusions and recommendations	Resolution	Recommendations and actions planned
Closing		Name of consultant, contact information

*Information should include: medical facts, patient's preferences, stakeholder's preferences, contextual features (culture, religion, social supports), quality of life considerations.

The model is based on these sources: R. Orr and W. Shelton, "A process and format for clinical ethics consultation," *The Journal of Clinical Ethics* 20, no. 1 (Spring 2009): 79-89. R. Jonsen, M. Siegler, and W.J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (New York: McGraw Hill, 2006); ASBH, *Core Competencies for Healthcare Ethics Consultation,* 2nd ed. (Glenview, Ill.: ASBH, 2011).

disciplinary participants. The de-identified cases that are discussed are most often resolved by the time of the weekly case conference, although some open or ongoing cases are discussed. All members of the hospital/medical school community are invited to attend. The weekly case conference offers attendees continuing medical education (CME) credit hours, and, as part of the CME certification process, gathers weekly and yearly quantitative feedback for the ECS.

Discussion with the Healthcare Ethics Committee

For especially complex consultations—as well as those with significant organizational implications—discussion with the Healthcare Ethics Committee (HCEC) is available. This can take place in the context of its regularly scheduled monthly meetings, or else on an *ad hoc* basis (usually with a subset of the HCEC). The relationship of all measurements of the four domains of outcome quality is summarized in table 3.

RESULTS

In the calendar years 2011 and 2012, there were 153 consultations performed and evaluated using the quality assessment tools. The overwhelming majority of the Consultation Note Templates included every one of the nine required process components (see table 2 for the Consultation Note Template sections). Approximately 9 percent of the Consultation Note Templates were missing a demographic element, but each of the other eight sections was complete at least 97 percent of the time. This high rate of completion is consistent with what has been reported at other institutions.[24]

The timeliness of a CEC was calculated from the IQIF, which records the dates the consult request was received, the consult was initiated, and the consult was completed. Consultation requests were categorized as "stat," "today," or "as convenient." The completion of a consult is defined as the time at which the Consultation Note Template was placed in the patient's chart. The average time from request to completion was less than one day for both the "stat" and "today" categories, which comprised 19 percent and 50 percent of the total consults, respectively. The "as convenient" category, which comprised 31 percent of the total consults, had a median time from request to completion of two days. A more detailed analysis is provided in table 4.

During the study period, 76 weekly case conferences were held (taking into account occasional holidays and a summer hiatus in July and August), with an average attendance of 14 (range, 6 to 32), usually including three other trained clinical ethicists (who worked in other areas of the organization). Although on rare previous occasions a substantial number of attendees disagreed with the recommendation of the ethics consultant on the case—and in some instances, this prompted further discussion with the stakeholders to ensure an appropriate recommendation was made—during the study period the ethics consultant's conclusions were met with near-unanimous or greater agreement. Based on end-of-year CME-required surveys, 77 percent of those attending a weekly case conference said the case conference "definitely" identified the root ethical issue of a case. Only 3 percent said it definitely did not.

Case-based discussions with the ECS occurred prior to the study period (regarding responses to re-

TABLE 3. Ethics consultation outcome quality evaluation tools

Quality outcome	Weekly case conference	Post-consultation satisfaction survey (PCSS)						ECS discussion
		Q1	Q2	Q3	Q4*	Q5	Q6*	
Ethicality	X	X				X		X
Satisfaction		X	X	X	X	X	X	
Resolution		X	X			X		X
Education	X		X	X	X	X		X

*These questions also have relevance to process measures involving timeliness and accessibility of consultation.

quests for nonbeneficial treatment, reported elsewhere[25]) and following it (regarding institutional policy on abortion). No such discussions occurred during the study period.

Of the 451 PCSSs sent to involved staff, 184 were completed, a 40.8 percent response rate. Figure 3 depicts the distribution of health professionals involved in the consultations who responded to the survey. Outcome-related questions on the PCSSs generated 86 to 92 percent positive responses (that is, agreement or strong agreement) (see figure 4).

The two process-related questions that addressed the timeliness of the ECS and the Consultation Note Template report itself were rated negatively (that is, "disagreement" or "strong disagreement") by 9 percent and 4 percent of respondents, respectively, with the former representing the highest negative score of all of the questions on the survey. A summary of negative responses is presented in figure 5 as a Pareto diagram, commonly used to identify frequently occurring problems and to prioritize quality improvement efforts.[26]

Of the 184 responses to the PCSS, 95 (52 percent) also provided free-text input addressing the respondents' experiences with CEC. We identified four recurring themes. The first involved the timeliness and accessibility of the CEC. Many of these comments were positive. For example, one respondent wrote, "the ethics group as a whole sets an amazing example in regards to access, timeliness, and follow up. I really appreciate their services." Another wrote: "very glad consult requested [was] informative and timely in a very difficult situation." Of the 95 free-texts, 5 percent expressed negative sentiments on the timeliness of a consult, such as: "[I] feel strongly we do not get this started soon enough in most cases."

A second theme involved a clarification of the patient's goals for care. Many respondents' reports were positive regarding the role that CEC served in clarification of the patient's care goals. For example, a respondent wrote, after the patient's death, "I feel patient and family were aware of risks largely because of the ethics consult. Still bothered by case." Another wrote, "I was glad to finally be able to be present when an ethics consult was happening. It provided insight into the patient and family thought process that I was unaware of." One individual declared that the consultation "helped clarify the patient's goals and communicate with the patient and family those interventions that would help meet those goals and those that would not be productive to meet those goals."

Some responses were less positive, but the criticisms had to do with the need for the ethics consultation, rather than the consult itself. For example: "I personally did not feel that an ethics consult was needed in this case. . . . The ethics consult helped the [intensive care unit] staff feel better about the situation, however it did not have a large impact on the overall plan of care for this patient." Another wrote, "This consult was not really necessary as far as I could tell. . . . there was no ethical dilemma to solve, just some more preoperative workup was felt to be needed. . . ."

A third theme focused on the helpfulness of the CEC to staff and family members. Positive responses included, "I always have a phenomenal experience with the ethics team and appreciate their help in many different clinical situations," and, "Great help with a very difficult family. Great role model to the house staff and myself." There were no explicitly negative comments. The most critical reflected a measure of ambivalence: "I had little to do with [the]

TABLE 4. Analysis of timeliness in days, from the IQIF, for the period 2011 and 2012 (*N* = 153)

Urgency	Consultation phase	Mean	Median	Standard deviation
Stat (*n* = 29)	Request to initiation	0.0	0	0.2
	Initiation to completion	0.1	0	0.4
	Total time elapsed	0.2	0	0.5
Today (*n* = 76)	Request to initiation	0.1	0	0.2
	Initiation to completion	0.5	0	0.7
	Total time elapsed	0.6	0	0.8
As convenient (*n* = 48)	Request to initiation	2.6	1	11.9
	Initiation to completion	2.1	1	3.1
	Total time elapsed	4.7	2	12.2

process. [I] have not seen report directly. Outcome [was] helpful; [I] disagree, but helpful."

The fourth and final theme was appreciation for the professionalism and compassion of the ethics consultants. One representative comment was: "[It was] very helpful to have a perspective other than our own in a

FIGURE 3. Health professions responding to PCSSs, 2011-2012.

FIGURE 4. PCSS questions and responses.

1. Recommend ethics consult to others in similar situation
2. Clarified goals of care
3. Improved my understanding of the situation
4. Report was informative and timely
5. Clarified ethical aspects of the question raised
6. Ethics consultation service was accessible and timely

-20 0 20 40 60 80 100

Strongly disagree   Disagree*   Neutral   Agree   Strongly agree

* Respondents only selected option "Disagree" on items 1, 3, and 4.

challenging case we had been working on for over a week; input valuable and appreciated." Another respondent wrote that the ethics consultants' "work in this institution is of the highest caliber in terms of professionalism, importance and basic human care. We need them very much. They make this Level I trauma center a better place to help heal human beings."

Overall, the respondents' comments provided greater insight into how clinical ethicists' participation helps at the bedside. The comments allowed the stakeholders to offer a narrative regarding their experiences, which were descriptive beyond the kind of responses allowed by the use of a Likert scale. The free-text comments highlighted the timeliness, accessibility, and professionalism of the ECS, the value respondents placed on the assistance they received in clarifying goals for patients and family members, and the support staff received in challenging situations.

Another component of the educational focus of the ECS was the weekly case conferences themselves. For the study period of 2011 to 2012, of the conference attendees who completed forms for CME credit, 97 percent indicated that the ECS met—or at least partially met—their educational needs; 87 percent indicated it would or at least partially change/improve their practice. These data are derived from 222 CME forms. Completion of the form was optional for attendees.

DISCUSSION

Using process measures, we found very high adherence to the standards set forth in the *Core Competencies.* The overwhelming majority of Consultation Note Templates included all of the suggested information, analyzed the ethical dilemma, and made recommendations. The one area that generated the most negative feedback—both in terms of Likert-scaled questions and the free-text comments on the PCSS—had to do with timeliness and accessibility. This was surprising, given that timeliness was also one of the most frequently cited positive free-text comments, and, based on the information recorded in the IQIFs, the average time required to complete consults seemed very reasonable.

There are two possible reasons for the discrepancy. The first is that the consultation may have come "too late" for a patient due to a delay in requesting the consultation, rather than a tardy response to the request by the ECS. Multiple barriers have been noted by staff who request an ethics consultation,[27] and these may have delayed the request and thus—by extension—the completion of the consultation. One survey response highlights this possibility: the consultant "was very nice and very clear. However, the patient had already made her wishes clear and patient and family and Advance Directive were already clear and in agreement. Consult was really a duplication of service."

Another possible reason may be the steps required to complete an ethics consultation. Often it takes significant time and effort to contact stakeholders (for example family members, friends, healthcare professionals, nursing home staff, spiritual advisors, *et cetera*), which can affect the promptness of the resolution of an ethics consultation. The data gathered from IQIFs allow a more detailed analysis of the time elapsed by breaking it down into the period from request for a consult to its initiation, and from its initiation to its completion (see table 4). Notwithstanding "as convenient" consultation requests (which are not time sensitive), the time elapsed from the initiation of consults to their completion was substantially longer than that from request to initiation. This suggests that factors outside the control of the ECS may have led to delays in completion, in turn prompting negative feedback. One clinician responded,

In retrospect, I missed an important step in the process. I should have alerted the attending/team that this consult was being asked. It led to an uncomfortable situation and ended in loss of respect and trust from the team. I still feel that the

overall plan was not [the patient's] true wishes of returning home. The consult did not relay the communication as quickly as I thought it would. . . . I love what [the ethics team] does; the other teams seem to consider input more of an invasion of space.

As noted above, quality is not just about measurement, it is also about improvement. And while it may not be possible to acquire the information required for a consult any more quickly—as this depends on factors that are outside a consultant's control—the perception of a lack of timeliness can be addressed by more thorough charting. In response to the survey results noted here, the ECS has begun to include an "initial note" in the patient's chart for "stat" or "today" consults. This note simply indicates that the ECS is involved and a full consult is to follow, which we hope will allay any concerns of the staff related to timeliness and accessibility. Further, the inclusion of this initial note is now included in an updated version of the IQIF, providing another example of a quality feedback loop, in which the lessons learned are incorporated into the process, and then measured.

That questions related to "timeliness" generated both positive and negative responses on the PCSSs also suggests that the questions related to "timeliness" might have been poorly framed. For instance, a single question asks about "timeliness" and the "accessibility" of the ECS, which may create uncer-

FIGURE 5. Pareto diagram of negative survey responses.
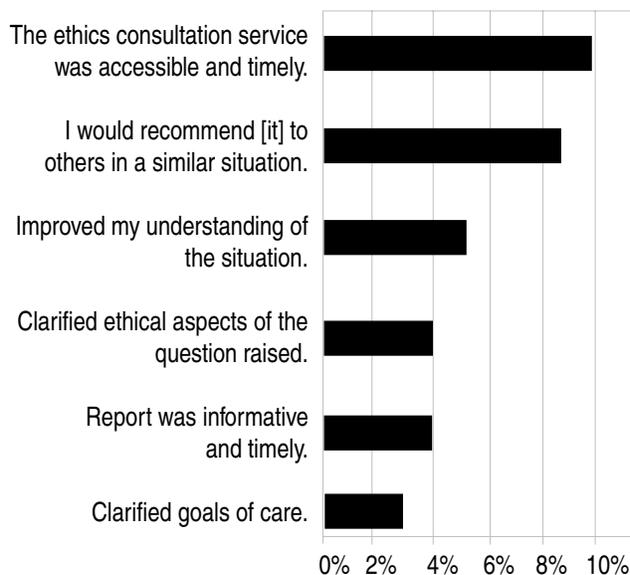
tainty regarding which is being viewed positively (or negatively). In addition, the concept of "accessibility" is susceptible to multiple interpretations (including a lack of awareness of how to access the ECS, as well as potential pressure not to request a consult). The process of quality improvement, therefore, involves not only consultations, but also the ways in which quality is measured. As a result, some questions on the PCSS were modified to improve clarity. "Accessibility" is now assessed with its own question, and is specifically defined in terms of responsiveness of the ECS, once contacted.

Merely including certain process components is no guarantee of a quality outcome, however, and therefore we went further by measuring the elements of the outcomes of our consultations. Previous attempts to measure outcomes focused on indirect variables, such as patients' survival and length of stay, which are subject to confounding and also overlook the large proportion of ethics consultations that don't involve end-of-life decision making.[28] This study is the first to attempt to incorporate the four components of outcome quality that are set forth in the *Core Competencies.*

To measure something, one first must define it. This can prove challenging with concepts such as "ethicality," which has been defined as "the degree to which clinical practices conform to established ethics standards."[29] But which standards should be used? And who is qualified to assess the degree of conformity? This is especially problematic in clinical ethics, since experienced ethicists often disagree with each others' recommendations.[30]

We measured the "ethicality" of ethics consultations with two different tools. The first was the PCSS, in which the overwhelming majority of respondents said that consultations clarified ethical aspects of the question raised, and also that they would recommend ethics consultation to others in a similar situation. Each of these seems to be a reliable measure of the "ethicality" of a consultation.

On the other hand, these respondents were not trained ethicists, and perhaps rather than deeming a recommendation "ethical" on its own merit, respondents may have assumed that since an ethicist made the recommendation, the recommendation must have been ethical. This weakness is addressed through the weekly case conferences, which allow more in-depth discussion and critique. During the period studied, as many as five trained clinical ethicists attended a conference, and while this is not a guarantee of ethicality, it gives more credence to a claim of ethicality than the word of an individual consultant. That a consensus of the conference at-

tendees (which, in addition to trained ethicists, included the staff who were involved in the consult that was being discussed and other members of the hospital and university community) supported the recommendations made during the study period, suggests that they were ethical.

Our second outcome metric is the satisfaction of stakeholders, which is touched on by nearly all of the questions in the PCSS, particularly the first ("I would recommend an ethics consult to others in a similar situation"). That only 8 percent of respondents disagreed with this statement is strong evidence of their satisfaction. That small minority may not have been dissatisfied with the quality of a consultation; rather, they may have felt that an ethics consult was not necessary in the situation, consistent with the negative feedback in the free-text comments related to the "need" for a consult. For example, one respondent wrote, "This consult was not really necessary as far as I could tell. It was I believe initiated by Anesthesia but there was no ethical dilemma to solve, just some more preoperative workup was felt to be needed from their end."

Resolution of the ethical conflict—the third component of outcome quality—was measured by the same questions as "ethicality," with the addition of a query regarding the clarification of the goals of care. Such clarification would at least further resolution, if not fully achieve it.

Education is the final measure. Information recorded in the PCSSs can be understood to indicate the educational component of the consultation process; we received very high scores on the questions related to informativeness and increased understanding. Further, some of the steps meant to measure quality served to assure quality. For instance, the weekly ethics case conferences measured ethicality and provided education to those who attended. This is indicated because nearly all of those attending the weekly ethics conferences noted that the conference met their educational needs—as did the ECS discussions of cases.

Not every respondent had a positive view of the ethics consultation. The few negative responses are amenable to multiple interpretations. For instance, if a respondent said that the consultation did not clarify an ethical aspect or goal of care, it might have been because he or she felt these were sufficiently clear prior to the consultation. For example, one respondent said that the patient's consult "was a communication problem more than an ethical question. An experienced communicator and facilitator was needed." Similarly, the consultation may not have improved a staff person's understanding of a

situation if the staff person already understood the situation rather well.

A less sanguine interpretation of the data is possible. Perhaps an ethical aspect to the question raised remained unidentified by the ethics consultant. The goals of care might have needed further clarification, despite the consultant's best efforts. Therein lies one of the greatest challenges in measuring (and improving) the quality of ethics consultation: valuable tools may still leave room for improvement. The methods presented here are first steps toward achieving a more robust program to measure and improve the quality of ethics consultation.

There also remains the question of whether all of the relevant stakeholders are being considered. The choice to survey only hospital staff was largely based on regulatory concerns (approval by an IRB) and logistical concerns (for example, readily available email addresses). Generally, though, the primary stakeholders in CECs are the patient and family, but expanding the PCSS to include them raises practical and emotional issues. From a practical standpoint, the email addresses of staff participants were readily accessible, whereas patients and families would have to be asked to provide this information. Given the emotionally charged nature of many ethical dilemmas, to ask patients and family members about their potential willingness to take part in a research study at the beginning of a conversation might lead to confusion as to the nature or purpose of the consultation. To inquire at the conclusion of a conversation might feel insensitive at best, or manipulative at worst, given the inherent vulnerability of many patients and family members.

Nevertheless, measurements of quality are inherently patient-centered, and measurements of the quality of CECs should ideally include patients and family members, as has been done in other studies.[31] The ECS is currently exploring ways to do this in an appropriate and efficient manner, as part of our ongoing quality-improvement program.

Our study has several limitations. One is that it involves one center with two ethicists, thus limiting generalizability. Different healthcare settings or those that use another model of CEC may experience different opportunities and challenges. Further, several of the measures (such as the questions on the PCSS) are amenable to multiple interpretations, and thus definitively identifying the reasons for a stakeholder's (dis-)satisfaction is not possible. In addition, the "Discussion" section of the Consultation Note Template (see figure 2) is skewed toward a principlist approach, limiting documentation and analysis of consequentialist or casuistic approaches.

The "Question Coding" block of the IQIF (see figure 1) is structured in a way that may bias toward focusing on shared decision making. Such a strategy may not be appropriate in all consults; for example, a physician-directed or patient-directed decision-making process may be more useful in some instances. The "Discussion Coding" block fails to distinguish the case-specific discussion itself and the theoretical arguments that may be used to justify the recommendations made. This balance of theory and its application is a component of the Orr-Shelton Model, but is absent from the IQIF. The IQIF also fails to include an option that considers counter-arguments, which indicates the addition of an added layer of consideration. Finally, the "Recommendations/Conclusions" coding block does not clearly allow for multiple recommendations. Having identified these limitations through our quality improvement process, they are now being addressed.

CONCLUSION

Quality measurement and improvement is a priority in all healthcare endeavors, including CEC. Most attempts to measure the quality of ethics consultation focus on process, which, while easily measured, may not directly correlate with outcomes. Up to this point, only indirect measures have been used to measure the quality of CEC outcomes. This study represents the first attempt, to our knowledge, to measure not only the quality of a CEC process, but also its outcomes, based on the components identified in the *Core Competencies.* As such, our study is an important first step, open to refinement and expansion, on the road to optimizing and assuring the quality of ethics consultations.

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

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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."[1] The main goal of consultation is to strengthen the quality of care through the identification, analysis, and resolution of ethical questions.[2] 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-

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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.[3] In addition, patients are more likely than healthcare providers to be excluded from the process of CEC.[4] 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.[5] When ethical conflicts arise, patients may find themselves in especially frightening, stressful, and confusing situations, which can increase the need for patient advocacy.[6] 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."[7] 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.[8] 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.[9]

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.[10]

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."[11] 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.[12] 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-

pacity. 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.[13] 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.[14] 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,[15] there tends to be a more critical account of this approach.[16] 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.[17] 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.[18] 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.[19] 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.[20] In the bioethics literature, the idea of rights is more often accompanied by the commitment to protect patients' rights.[21] 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 breech.

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-

resentational 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.[22] 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.[23] 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.[24]

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."[25] 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."[26] Empowerment is enabling people to speak for themselves so that they may play a part in the construction of their own lives and destinies.[27] 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.[28] 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.[29]

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.[30] Advocating through the empowerment approach might involve encouraging patients to ask their own questions[31] or taking a more active role in giving suggestions, coaching, and sharing information.[32] 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
Best interest: Aims to protect the interests held by a patient who is not able to participate in decision making.[1]	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. Patient is not a participant in the CEC.	Case Example: A parent refuses life saving treatment for a child with a good chance of full recovery 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.
Patients' rights: Ensures that the patient's rights are recognized and protected.[2]	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. Patient may or may not be a participant in the CEC.	Case Example: A surrogate attempts to override a patient's previously explicitly stated preference for withdrawal of life-sustaining therapy. 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.
Representational approach: Ensures that the patient's (and/or their surrogate's) wishes and interests are represented to those who most need to hear about them.[3]	Relationship between patient and advocate is at the center of the advocacy process. The advocate: • represents the patient's point of view to the team • acts as a liaison between patients and the medical team • supports patients' autonomy or their right to make their own decisions • provides support for patients who may feel alienated from the institution Patient may or may not be a participant in the CEC.	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. Representing views in ethics consultation is a core responsibility stated in the ASBH *Core Competencies*—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."[4] While the role is to help represent all "sides", if 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.
Empowerment approach: 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.[5]	Places the patient at the center of the advocacy process. The advocate: • encourages patients to ask their own questions • gives suggestions, shares necessary information Patient is able and encouraged to participate in the CEC.	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.) The ASBH *Core Competencies* require that "fair, inclusive and transparent discussion takes place that empowers the voices of all stakeholders."[6]

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 Consult?" *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. Zimbelman, "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.[33] 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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12. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics,* 6th ed. (New York: Oxford University Press, 2009).

13. 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; 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.

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21. Nelson and Bosek, "The Case of Ms. M," see note 13 above; M.H. Thompson, "Ethics committees: Their share in the advocacy role," *Seminars in Perioperative Nursing* 5, no. 2 (1996): 62-7.

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26. Ibid., 9

27. Forster, "Patient Advocacy in Psychiatry," see note 24 above.

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