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Ethics Consultation: Continuing its Analysis

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Ethics consultations in major healthcare facilities and networks are now relatively common, and consultations are performed by physicians, nurses, social workers, psychologists, philosophers, and multi-disciplinary ethics committees. In the past decade, explicitly incorporating ethics into clinical and administrative practices has been required by such powerful regulatory agencies as the United States Joint Commission on Accreditation of Healthcare Organizations and the Canadian Council on Health Services Accreditation. Although three millennia ago Meno asked Socrates whether moral virtue could be taught and by whom, controversy continues today regarding the requisite teaching and credentialing of ethicists.[1] In the 1990s, for example, discussions ensued as to the conceptual differences between and the legitimacy of an ethics consultant claiming to be an ethics expert versus having ethics expertise.[2]

This article is the result of our many discussions on what clinical staff need to know to begin doing ethics consultations, the paradigmatic activity of ethicists and ethics committees. Admittedly, informative analyses are already available.[3] Our contribution to these analyses was prompted by two events. First, while developing an introductory training module for practitioners who had been chosen by their unit or program to work on ethics consults in their respective unit or program with their hospital's formally trained bioethicist, we found that certain aspects of ethics consultation often were overlooked or inadequately emphasized. Second, our examination of the intricacies of consultations became more energized after reading this journal's recent publication of six ethicists' testimonials about consults they felt had "haunted" them, or about which they still felt very ambivalent.[4]

In this article, the epistemological work of philosopher Gilbert Ryle and the pedagogical work of mathematics professors John Mason and Mary Spence are applied to ethics consultation.[5] More specifically, Ryle's concepts of "knowing that," "knowing how," and "knowing why," and Mason-Spence's concept of "knowing-to-act-in-the-moment" are used. We then analyze the ethicists' testimonials regarding which factors made the consults especially vexing and how these factors relate to the aforementioned types of knowledge. Yet this systematic analysis does not reflect fully our discussions about the nature of consultation. We

often resorted to metaphors to help capture the dynamics involved, to see the "whole," and to identify more nuances. The metaphors are included below to demonstrate the benefit of imagination to ethicists' self-reflective practices.

THE TESTIMONIALS

We commend the six ethicists for their courage and collegiality in sharing their consults that have tested, and at some points exceeded, their seasoned abilities and expertise. We, too, have done consults that have and continue to indelibly mark our own development as ethicists and therefore are indebted to these ethicists for reflecting on their personally formative consults. With this said, brief summaries of the ethicists' testimonial articles are warranted before applying the four kinds of knowledge to them.

Denise M. Dudzinski's misstep begins during discussions at team rounds about a patient's request to have her injured arm amputated.[6] Despite trying various interventions over 10 years to alleviate the disproportionately severe pain, the patient still experiences pain, hygienic problems, and bodily alienation. The clinical team, however, believes amputation will not end her psychologically based pain because phantom pain is likely. Team members are either adamantly opposed to the surgery or extremely hesitant. As the team works to resolve their quandary, Dudzinski decides to speak with the patient even though no ethics consult has been requested formally. Her candid article explains what likely caused her, an experienced ethicist, to "unnecessarily [interject] myself into the therapeutic relationship."[7]

The article by Joy D. Skeel, an ethicist, and Kristi S. Williams, a consultation-liaison psychiatrist, describes their work with an Internal Medicine team and consulting psychiatrists caring for a patient with severe borderline personality disorder (BPD).[8] The patient infuriates and exhausts the team by engaging in life-threatening self-harm behaviors, pitting team members against one another, and making erratic, often contradictory, treatment decisions. The authors detail their efforts to help the practitioners through a relentless cascade of vanishing improvements, interpersonal hostilities, and patient suffering. Yet despite Skeel and Williams' committed efforts, a palpable worry concludes their article: "was there anything more . . . we could have [done]?"[9]

Unfortunately the case described by Paul J. Ford continues to recur in acute care hospitals.[10] The patient's hospitalization for a heart attack and subsequent stroke is characterized by changing clinical teams, unpredictable prognoses, disagreement over the value of various medical interventions, and numerous team meetings with family members. The patient's hospitalization lasts several months, and, as per the title of the article, the outcome is "a messy spiral of complexity." This author admits to feelings of "dread, powerlessness, and frustration."[11] Reminiscent of Skeel and Williams, Ford worries he missed opportunities to help the family and clinical staff provide the patient end-of-life care that exemplified solidarity, compassion, and skill.

The fourth case begins with a seemingly minor question from an intensive care unit (ICU) team: can a young mother visit her baby, Angel, in the ICU?[12] Advice from the ethics service is warranted because the baby's profound neurological injury may have been caused by his mother or her boyfriend shaking him. Jeffrey Spike, a professor of medical humanities, reflects on his response to the ICU team's question as well as on the seeming inadequacy of ethics consultation to address tragedy.

Richard M. Zaner's article[13] complements his earlier works that explore the experiences of and meaning for a person when he or she becomes ill or injured and, just as importantly, becomes the subject/object of contemporary healthcare.[14] In this *JCE* article, Zaner chronicles a couple's anguished efforts to decide whether to abort their fetus after diagnostic tests predict spina bifida, a condition associated with serious physical and mental disabilities. Diagnostic uncertainty increases the difficulty of the parents' decision. Urgency further compounds this difficulty: the mother's pregnancy will soon reach its twenty-fourth week, after which abortions are performed locally only if the woman's life is in danger. Demanding that ethics consultation be responsive and useful, Zaner questions whether he could ever understand what this couple experiences and faces, enough to be able to help them through another form of parental "labor," that of surrogate decision making.

KINDS OF KNOWLEDGE AND ETHICS CONSULTATION

KNOWING THAT

Ryle defines this kind of knowledge as involving facts or what is true. For instance, children demonstrate knowing the color yellow when they repeatedly choose the yellow crayon in response to "Which one is yellow?" So too for your neighbor knowing that "you live there" if he or she routinely and correctly directs delivery people who are having trouble finding your home.

In terms of ethics for healthcare settings, initiates into ethics consultation work commonly find gaining this type of knowledge the most challenging. Fuelled by the World Health Organization's expansive definition of health, health ethics involves not just terminology, concepts, and theories from moral philosophy and the health and behavioral sciences, but also from political science, the law, economics and business, and religion. When a novel issue arises, a consultant must also know the evolution of related debates and academic exegeses; for instance, to decide whether organ donation after cardiac death should be permitted ethically, the history of defining death must be understood. Or to decide whether there is no obligation ethically to provide a particular therapy to a patient, the protracted debate regarding futility must be known. Sources of ethics-related "knowledge that" are typically courses or seminars, conferences or workshops, books, and a broad range of journals in each discipline.

Problems in communication are routinely identified as the reason for many ethics consults. Yet the word "communication" may be erroneously interpreted as referring only to issues about inadequate disclosure of information, inconvenient meetings, and rudeness. However, we believe that ethics consultants must view conversations as potentially relevant "facts" in a specific situation, just as a patient's diagnosis, test results, and content of her or his advance directive are considered germane facts. Too often, clinical teams disregard past conversations with other colleagues, the patient, or his or her family, and published ethics cases lack conversational details. Yet various theorists and ethicists stress the importance of dialogue, including Jurgen Habermas, Arthur W. Frank, and Larry R. Churchill-David Schenck.[15] Conversations themselves are performative activities wherein we make promises, validate others, demonstrate various virtues (for example, honesty, sincerity), and are accountable. With respect to the ethicists' testimonials, keeping track of what was said is challenging but important. Skeel-Williams actively intervened to try to change the conversations from being antagonistic to being patient and balanced. Ford and Zaner worried when, at some point in time, well-intended meetings between the clinical team and the family or parents became counterproductive.

Limitations to "knowing that" explain some of the frustration experienced during a consult. Uncertainty is one such complication and is clearly part of all five testimonials: Will amputating the patient's arm alleviate her pain (Dudzinski)? Will any treatment produce a lasting benefit for the bipolar patient (Skeel-Williams)? Will the patient recover neurologically (Ford)? Did the mother or her boyfriend actually shake the baby (Spike)? And does the fetus have spina bifida (Zaner)? Ambivalence, another limitation, complicates claims of "knowing that." Conflicting emotions can reduce a person's confidence in the cogency and defensibility of his or her viewpoint. Consider, for example, team members' reactions to their patient's request to amputate her arm. Feelings of horror, pity, and helplessness were likely mixed together, and yet each reflects different assessments of "what's wrong" that, in turn, may justify different resolutions. The same mixture of feelings is described in the case about the patient with BPD and the splitting of his clinical team. A third limitation, ambiguity or lack of clarity, occurs when it is difficult to choose concepts and theories that have adequate and relevant explanatory power. In the case of the shaken infant, Spike acknowledges that society's criteria are unclear as to what constitutes a "good enough mother," such that the mother's request to see and hold her baby should or should not be granted.

In summary, an ethics consult is more thorough when past conversations and discussions are included in "knowing that." Yet whatever is considered a pertinent "fact" must be accurately understood relative to any uncertainty, ambivalence, or ambiguity.

KNOWING HOW

This type of knowledge involves the skills, abilities, and judgment to bring about a particular outcome. Someone "knows how" boiled eggs are made by going through all the necessary steps to produce an edible boiled egg. This kind of knowledge has been labelled "practical knowledge" in contrast to "knowing that," which has been labelled "theoretical knowledge."

Knowing how, the performative aspect of ethics consultation, often proves to be the most challenging and the most tiring. It includes such skills as clarifying the questions to be answered, determining how best to obtain required information, ascertaining which individuals need to be involved and which do not, mediating conflict, and "keeping moral space open."[16]

The importance of these skills reflects the dynamics and complexity of most health-related situations. We find the metaphor of a spider web useful for analyzing this type of knowledge. An ethics consultant helps identify those who are and should be involved and then supports these connections. When an ethicist, for instance, asks if the nursing home staff will be apprised of the substitute decision maker's record of treatment decisions and refusals, she or he is pointing to the responsibilities of the hospital team, those who will assume care of the patient. Because each connection differs depending on the history, responsibilities, character, and power of each party, consults can be broadly disparate, even though the central question is the same (for example, "Should this adolescent's preference be honored against parental wishes?"). These differences can make the web of connections hard to balance, which in turn makes the connections easy to break, threatening the whole network. The cases described by Skeel-Williams and Ford reflect the arduousness of trying to keep the appropriate people connected when different values, competing interests, changing work patterns, and strong emotions are involved. Based on our own practice as bioethicists, we have found that when a consult contributes to a sustaining and affirming network of relationships, it has a kind of aesthetic quality, just as a spider's web in a garden qualifies as an aesthetic accomplishment. Similarly, when the relationships cannot be preserved, we sometimes feel a regret that may be similar to that felt when we see a tattered and abandoned spider's web. (We note that this metaphor has one shortcoming: a web is meant to snag a victim, food for the spider.)

A related skill often not explicitly discussed in articles about ethics consultation relates to the politics of engagement. This skill begins with a type of "knowing that," namely who inside and outside a healthcare organization has responsibilities, power, and authority to answer a question, address an issue, or resolve a problem. Such political acumen requires refined diplomatic skills to help link up the duties, rights, power, and influence to achieve an ethically positive outcome. Doing ethics consultations is often said to require courage. However, courage requires diplomatic skills when an ethicist must find ways for those who are powerful and advantaged to include, hear, and involve those who are invisible, vulnerable, or less powerful.

Some of the consults we have been considering nicely highlight the importance of an ethicist's diplomatic skills. Dudzinski's worry about her self-initiated meeting with the patient indicates her intuition that any interaction with a patient must first be justified. Reflecting on all the team meetings the stroke patient's family was asked to attend, Ford laments the family's increasing psychological burdens created by the changing of clinical teams. Spike's discomfort when the mother visits her baby in the ICU for the first time stems from his awareness that he is a poor substitute for the person who should be present on behalf of the patient as well as the clinical team, the attending pediatrician.

"Knowing how" is key for successful ethics consultations. Accordingly, training must include learning relevant skills, and provide opportunities for practice (and more practice) and time for self-evaluation.

KNOWING WHY

Knowing that a water molecule has one atom of oxygen and two atoms of hydrogen and knowing how it is formed (that is, electromagnetic attraction) is different from knowing why the molecule exists as it does: the electromagnetic charges of oxygen and hydrogen differ. According to Ryle, "knowing why" refers to stories that explain how a situation arises, unfolds, and ends. This characterization mirrors the concept of narrative. Narrative is an ethical and epistemic approach that has garnered considerable attention in bioethics

in the past decade because it can help to deepen our understanding of the clinical situation that is "at hand."

In Zaner's article, the parents of the at-risk fetus are faced by the decision they have because of technological advances in fetal diagnostics, legal protection of parents' right to decide, continued social stigma and disadvantages for those with disabilities, and society's restrictions on women's access to abortion. The case in which Ford's help was requested grew from the public's high expectations of ICU care, a lack of consensus about futility as a sound basis for the rationing of care, and the erosion of trusting relationships in modern tertiary hospitals. Dudzinski's consult involved a confluence of the legal doctrine of informed consent, the continued subjectivity of pain reports, and disparate assessments of the body's sacredness (that is, the philosophical concept of embodiment).

Answering the question "How did we come to be here?" or "Why are we here?" is valuable for two reasons. First, it can offer much needed respite from the seriousness and urgency of the immediate situation. Skeel and Williams likely talked about the "whys" from time to time, to help the clinical team accept that they were not responsible for every disappointment and failure that occurred during their patient's hospitalization. Second, "knowing why" should help a consultant be proactive in identifying future quandaries and in situations of moral distress. As Ford notes, too frequently consultations are reactive, rather than proactive. Just as emergency medical care should not be the primary form of healthcare, we believe that "rescue ethics" should not dominate an ethicist's work. Like our clinical colleagues in emergency departments, when ethics consultants continually try to rescue others, it can take a heavy emotional and psychological toll, and become an inefficient use of healthcare and personal resources.

KNOWING-TO-ACT-IN-THE-MOMENT

Mason and Spence's article was prompted by repeated observations of their graduate mathematics students: "as students are given something more general or less familiar, or a task requiring several steps, they are mostly at sea. They don't appear to know-to use what they have learned."[17] The authors came to see that there is a moment when a student knows to apply a particular theorem and when not to. Knowing-to-act requires "relevant knowledge to come to the fore so it can be acted upon," according to Mason and Spence.[18]

We were intrigued by these insights because we see the same complexity in teaching others to do ethics consultations. There is something more here than just decision making. Knowing-to-act relates to the concepts of agency, presence, and being that such theorists as George J. Agich, Zaner, Churchill, and Frank continue to examine. While Mason and Spence recommend creative practice to develop this type of knowledge, they concede that it is erroneous to believe that practice only "makes perfect." All too briefly, unfortunately, they describe Caleb Gattegno's pedagogical idea that "integration through subordination" hones knowing-to-act.[19] Integration through subordination involves repeating an activity while simultaneously directing one's attention to something else. We interpret Gattegno as advocating skilled habits plus cognitive openness to new stimuli. In other words, competence that is responsive, rather than rigid, and humble, rather than arrogant, in light of the inescapable complexity and dynamism of most situations.

Armed with knowing that, knowing how, and knowing why, what kinds of knowledge does an ethicist need for "knowing-to-act-in-the-moment"? The ethicists' testimonials provide diverse and subtle examples: knowing to not initiate a conversation or to begin a meeting (Dudzinski, Spike), knowing to visit a unit before staff go home to see how they are coping (Skeel-Williams), knowing to stop talking and listen (Zaner), and knowing to cease being involved (Ford).

Awareness is emphasized in the mathematicians' article. Along this line, another metaphor we employed in our analysis of ethics consultation was Taoism, a variety of ancient Chinese philosophical and religious traditions. The Tao is often translated into English as "way" or path. Followers of the Tao seek to find and follow the appropriate or fitting path forward or through a situation. Clarity of insight, wisdom, and concern for others assist one in following the Tao.[20] In an article about the role of ethics consultants, Churchill and Schenck repeatedly invoke Taoist concepts: a couple deciding about their at-risk fetus seek "to discern their proper place in the scheme of things,"[21] and for most patients and families, "the task [is] to find the path . . . to locate the right way."[22] Moreover, Taoism involves humility: in the context of ethics consultation, finding

the most fitting way may involve other people, not the consultant herself or himself. This aspect, we believe, is key to skilled consultation because it is illegitimate for a consultant to assume that she or he is responsible for fixing a problem or telling others what they must do. As Zaner notes, "those whose circumstances pose the problem . . . are the ones from whom the resolution must come."[23]

All five of the ethics consultants' testimonials describe the ethicists' efforts to-act-in-the-moment in the all-too-human and unfolding situation they have joined. Sometimes they are successful, and sometimes they are not. Sometimes they are in limbo, all of which affirms the considerable complexity and sizeable risks of doing ethics consultation.

CONCLUSION

The different types of knowledge, Ryle's "knowing that," "knowing how," "knowing why," and Mason-Spence's "knowing-to-act-in-the-moment," contributed significantly to our development of an introductory ethics training module for practitioners. Moreover, we routinely draw comparisons to what the practitioners had to learn to become technically competent clinicians, and ask them to reflect on their own situations; for instance, "What is it that you are aware of when you know-to refer your client to someone else?" Such comparisons reinforce that many of their technically related skills are very valuable for addressing ethical aspects of working with patients and colleagues. In the module, we also emphasize that it can be very risky to overlook past conversations in the "fact finding" part of an ethics consultation, just as not clarifying the degrees or levels of uncertainty, ambivalence, and ambiguity represents haste or carelessness and would not be tolerated in clinical decision making. The concept of the politics of engagement and associated diplomacy skills — too infrequently discussed explicitly — is also essential to successful consultation, given that the consultant is not a decision maker, but helps others to preserve or reach an ethically sound state of affairs.

Finally, sharing less-than-successful ethics consults is obviously personally hazardous, but certainly generous and brave. An initially benign question can prove complex and political. We close here with a metaphor that helps capture the experience of many consults. A children's board game, Chutes and Ladders, has a few hundred numbered squares, some connected by ladders that, if landed on, permit one to advance several steps at once. Some squares are connected by chutes that, if landed on, require one to go back several steps. The objective is to use dice to advance to the last square. In the context of ethics consultation, success would be an ethical resolution of the question or concern by those directly involved, within a relatively short time. Yet in working through a consult with diverse parties, there will be points when a shortcut appears, and the consultant has to decide whether to take it to expedite the process or to just continue step-by-step. Skipping a step may mean someone is not involved who should be, or that a possibly relevant policy is not sought. At other points, something will occur that reverses whatever progress has been made; perhaps the rehabilitation therapist unknowingly divulges privileged information to a patient, or a newly assigned psychiatrist reaches a very different diagnosis. We find that this metaphor helps clinical staff to comprehend more deeply that consultation is much more than knowing applicable laws and familiar ethical concepts and posing good questions. In sum, teaching staff how to work with an ethicist in a consultation requires a multi-faceted and mentored training approach.

NOTES

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8. Skeel and Williams, see note 4 above.

9. Ibid., p. 205.

10. Ford, see note 4 above.

11. Ibid., 208.

12. Spike, see note 4 above.

13. Zaner, " 'But How Can We Choose?' " see note 4 above.

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20. B.N. Moore and K. Bruder, *Philosophy: The Power of Ideas* (London: Mayfield Publishing, 1996).

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