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Professional Clinical Ethicist: Knowing Why and Limits

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Clinical ethics consultation practice will continue to improve if we strengthen our understanding of the general issues, strive to improve our performance, and commit to investing time in each case to understand the context and history. These three elements require a personal openness to revising our beliefs, attitudes, and ideas, since a self-reflective honesty and integrity underpin such explorations. Learning and improving consultation must come from reflection of our own experiences as well as engagement with our peers who practice in other contexts. Clinical ethicists become either dangerous or irrelevant when they believe there is nothing more to learn and that all consultations can be solved by quickly plunking them into generic categories based on a single report. To this end, we do a disservice to our colleagues when we are unwilling to share our cautionary tales about the potential pitfalls of cases and emotional costs experienced as ethics consultants.

If clinical ethics consultants are relevant to the clinical environment, they must be effective. Starting from this premise, we can both help and harm a situation. Conversely, if we do not attempt to alter the situation in some way toward the good, then we are irrelevant and wasteful. In the circumstance I find myself, embedded within a large research teaching hospital, it is not a matter of whether I think of myself as a professional because this is assumed by those who consult me. It becomes a matter of my comporting myself to the highest level of practice as a professional. The fact that the discussion of clinical ethics as a profession has raged for more than 20 years should not hinder us from adopting the highest level of service and quality.[1] Our academic debate and concerns about being co-opted should not be used as an excuse for lax personal standards for development. Just like the other professionals with whom I interact, I am expected to continually educate myself, improve the quality of my practice, and approach every case with a serious investment of time and energy.

In their article in this issue of *The Journal of Clinical Ethics,* Russell and Pape present a compelling discussion of basic obligations of clinical ethics consultants to perform well and to improve practice. In many ways, these compose basic elements of professional obligation. The authors provide an organization and analysis of three types of "knowing" that are relevant and useful to the actual practice of clinical ethics consultation. I applaud their use and application of the cases published in *JCE* in elucidating these themes.

When Denise Dudzinski and I organized the selection of cases cited in the article, and subsequently compiled an extended selection of cases in book form, we hoped that it would spark people to reflect on

complex practice.[2] Almost every experienced ethics consultant we approached to contribute a case immediately identified several cases that fell into the "haunting" category. It was clear that these cases were not just those with sad outcomes. As Russell and Pape point out, they were cases with "uncertainty, ambivalence, or ambiguity," difficulties in the "politics of engagement," and potential powerlessness of consultants. The discussion presented by Russell and Pape highlights our obligations to approach our activities of clinical ethics consultation in a professional manner. These approaches of "knowing" entail strong education, improvement in performance, and careful attention to the histories and contexts of each consultation.

The strength of Russell and Pape's analysis lies in their attention to parsing out the different types of activities. Too often, the activities of ethics consultation are lumped together as if we speak about a monolithic activity of clinical ethics consultation. We undertake a variety of roles and tasks that are dictated by the nature of the interwoven webs of social relations, medical facts, and values.[3] Although Russell and Pape do not, and could not, articulate all of these types of activities, they provide a basis on, framework for, or approach with which a consultant could select an appropriate practical approach(es) in a particular case. These approaches clearly emerge out of the contingencies of the case rather than superimposed on it by a rigid definition. As far as the authors are able to take their discussion in this article, I have very little to criticize. So, below I will simply point out aspects of "knowing why" that need to be further articulated in order to avoid being mislead or waylaid in cases.

A major challenge to the "knowing why" in any clinic ethics consultation case involves the limits of pursuing the history of a patient, social circumstances, or institution. Although I agree with Russell and Pape that understanding the robust context of patients, families, healthcare providers, and institutions compose a fundamental component of unraveling or deciphering the individual web or cipher that presents itself as a case, we can be mislead by an unrestrained exploration of the context. There are several competing values that may limit or offset the unlimited pursuit of background information, which is fundamental in knowing the why of any complex situation. I put the difficulties in four broad categories: (1) relevance, (2) perseverance, (3) time constraints, and (4) types of knowledge.

Although it is important to understand the family dynamics of a particular patient's situation to decipher the values involved, there are limits to relevance and helpfulness. For instance, a patient's ex-wife might give you the following account: "Years ago, his current wife swindled a company and spent time in jail. Then he got back with me. Even though in the end, he went back with her, she doesn't really love him. After all, she cheated on him just two years ago."

Pursuing a line of inquiry related to the issues of jail time, swindling, marital cheating, or love may be irrelevant to the decision at hand. Further, in raising these issues with other family members, the consultant risks cultivating distrust and generating anger that will not assist resolution of the situation at hand. Finally, pursuing these issues may make the consultant a pawn in ongoing conflicts between family members, which could reduce the chance of helping build consensus. However, the ex-wife's statement should not be ignored, since it tells us something very important; the ex-wife has an oppositional relationship with the current wife. This is relevant and important as we structure conversations with large groups and as we parse information. Again, as consultants we must actively recognize that hearing this statement may naturally negatively influence our perceptions of the current wife and/or the ex-wife. We explicitly and intentionally "bracket" in our minds these accusations and remind ourselves that the statement may not be true. Independent of the truth, the statement would not discount the current wife from making good decisions in this particular case. The past does not necessarily dictate the quality of decision making in the present. Our performance of consultation should judge the current discourse and decision making against the backdrop of history and not by means of history. This includes understanding family dynamics while not becoming embroiled in them. The knowing "why" continuously must pass a test of relevance.

The usefulness of listening repeatedly to a story also has its limits. There are times when no matter how long or how often we listen, the patient or family demonstrates an inability to move to the present situation and circumstance. Long after the initial prompt for background information, the person perseveres in a retelling. We might hear things like: "But if my mother had received antibiotics two months ago, she might

have been a surgical candidate today," or "I need to start at the beginning. Five years ago. . . ." In the first example, the family is stuck in the "what if" and cannot get to the decision at hand. Beyond the potential of wanting to know "who's responsible" or a legal suit, this behavior can be a coping mechanism to avoid a horrible decision that must be made in the present. By continuing to allow the past to be explored, the present can become obscured. As consultants, we need to be sensitive to when the past interferes with the present and redirect the conversation. In the second example, a person continues for hours in a meandering story that provides a very low yield of information. The performative aspect of consultation requires clipping, strong redirection, or pruning of these conversations when they begin to dominate the time and attention of those involved. When combined with the time-limited nature of consultation, discussed at more length below, these conversations can become a trap for the consultant. We must recognize that not all retellings of histories lead to better understandings of the "why," even if at first they have relevance.

The time constraints on both decision making and professional work hours mean that there are limits to the amount of knowing "why" that can be achieved. The ambiguities that necessarily pervade clinical ethics consultation force us to balance the maximal reduction of ambiguity with efficiency and timeliness of advice. Although consultants would always like to have a full understanding of the "why" in a situation, decisions usually must be made before fully knowing. This should not create paralysis for giving advice, since our practice is as imperfect as clinical medicine is.

To maintain transparency, clinical ethics consultants must provide advice in consultation, with the caveat that some facts have been assumed. We live with the fact that, in retrospect, the advice may have been wrong. If there is error, however, it should accrue from the use of incorrect information, not from poor reasoning. Due diligence should be used to check facts, and the consultant should not make quick judgments to serve simple expediency or the convenience of the healthcare provider, the family, or the consultant. At the same time, practical time limits must be respected and acknowledged in the knowing "why."

Finally, the types of knowledge on which a consultant bases the knowing "why" are fundamental. We should always prefer firsthand accounts. In their stead, we often attempt to triangulate or find definitive proof for the "why" of a situation from multiple sources and references. In doing this it is easy to get caught up in the question of motivations in the "why." Given that motivations are usually mixed, we should seldom judge individuals on suspected motivation. Rather, our analysis must be centered on values and likely outcomes for the patient and the team. Again, before providing advice, we should carefully evaluate the level of knowing that we have for each of the facts in the case. Actually talking with the patient and/or surrogate is usually fundamentally important, rather than just relying on the filter of the healthcare providers. After all, it is not just family members who may supply less-than-reliable information. For instance, it may be important to talk with or read the note of the surgeon, rather than taking the word of the intern. We need to weigh each bit of information not only by relevance, as previously discussed, but also weigh information for certainty of coherence with known events, opinions, and facts.

These various challenges in the knowing "why" compose only one aspect of the rich activities we undertake as clinical ethics consultants.

Although there are many difficulties found in clinical ethics consultation cases, Russell and Pape remind us of the need for careful evaluation of our activities as consultants in complex clinical settings. My exploration of the limits and challenges of the knowing "why" points to complexities of our tasks as ethics consultation professionals. These are not practices that we can perfect through a brief weekend course. We need continuing ethics eduction, quality improvement, and investment in individual cases. These parallel some of the basic elements expected of our peers in other healthcare professions — physicians, nurses, social workers, and so on — and should be equally applied to clinical ethicists.

NOTES

1. R. Branson, "Bioethics as Individual and Social: the Scope of a Consulting Profession and Academic Discipline," *Journal of Religion and Ethics* 3, no. 1 (1975): 111-39.

2. P.J. Ford and D.M. Dudzinski, ed., "Cases that Haunt Us," Special Section, *The Journal of Clinical Ethics* 16, no. 3 (Fall 2005): 193-222; P.J. Ford and D.M. Dudzinski, ed., *Complex Ethical Consultations: Cases that Haunt Us* (Cambridge, U.K.: Cambridge University Press, forthcoming, 2008).

3. R.D. Orr, "Methods of Conflict Resolution at the Bedside," *American Journal of Bioethics* 1, no. 4 (2001): 45-6; P.J. Ford and A.R. Boissy, "Different Questions, Different Goals," *American Journal of Bioethics* 7, no. 2 (2007): 46-7.