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Knowing About Others: On "The Role of Relational Knowing in Advance Care Planning"

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ABSTRACT

Kate Robins-Browne and her colleagues have written a conceptually daring, empirically grounded article that is rich in scholarship and just conceivably might have a salutary effect on the theory and practice of advance care planning. It is, alas, just as easy to believe that its appreciation will be restricted to like-minded theorists. Writing from a posture of great admiration for this article's agenda and achievements, I will consider why non-relationship-based understandings of deciding for others are so enduring, and what might be done about that.

INTRODUCTION

Robins-Browne and colleagues' conclusion is a small gem.¹ It unifies, clarifies, and even amplifies the chief themes of the piece. The last paragraph, for example, sketches what could well become a very telling internal critique, warning that honoring a patient's autonomy, individually understood, by restricting the range of values, concerns, insights, and information a patient's bonded intimates may provide, may ironically reinforce the very paternalism

that autonomy based understandings of healthcare ethics have sought to uproot.

The final two sentences strike me as particularly significant: "Ethicists and clinicians appreciate the relational component of people's lives. However, acknowledging this, and allowing it to be a part of care and decision making is one of the greatest challenges faced in medical care." If we take the thought expressed here not as a rhetorical flourish to usher our authors off stage, but in sober earnest, they suggest that the way forward for the relational cause involves getting a better handle on just why the entrenched understandings are so obdurate, and just what might be done about it.

Alone and with others (particularly Hilde Lindemann), I've worked on converging themes since the early 1990s. Although that work is sometimes cited (as it is generously by Robins-Browne and her colleagues), it has failed to excite even a murmur among the zealots, as Hume might have said. That may be perfectly fair—our articulations of and motivations for relational ideas may be simply unworthy of rational opposition. Yet my impression is that bioethics as a social institution has developed a going mainstream culture that is theoretically a bit staid, but with clout among clinician and policy makers, and a rich "para-culture" consisting *inter alia* of feminists, narrativists, queer theorists, race theorists, relational and family-oriented thinkers,

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more theoretically adventurous, but with less impact.

While there always seem to be promising inroads opening up—a new curricular innovation here, a conference there, a grant somewhere else, a sharp new article in *JCE*—the mainstream, preoccupied with more internecine debates, does not seem to take heterodox folks with sufficient seriousness to engage their arguments: to defend the premises and practices they dispute.

Some of the resistance may be rooted in what is plainly indefensible—resistance to change that goes beyond whatever degree of theoretical conservatism is warranted, possibly augmented by implicit biases of various sorts against some of the sorts of folks mounting the challenges. Yet some of the responsibility remains on us, the challengers, or so I hope. What is to be done?

THE NEED FOR MORE THEORY—AND LESS

One of my few reservations about the stress on “relational knowledge” as the foundation stone of the Robins-Browne and colleague’s project is that it may leave some people wondering whether relational knowledge is aiming, finally and fundamentally, at the same target as knowledge *sans phrase*. Is the goal of relational approaches to choose as the person who is now unable to decide would have chosen—that is to say, to elect the same course of action as she or he would have done? Does invoking the relationality perspective plug the clinical team into a “more information-rich environment,” less alienating to significant others, better able to help clinicians understand what the patient would have wanted in the first place? More voices in the choir, singing in more keys, but harmonized by that same goal?

Yet here we run into those pesky proxy accuracy studies liberally cited in Robins-Browne and colleagues. Would getting more unfettered voices in the mix improve those results? Possibly, but the primary impact of relational perspectives seems to be to encourage us to take them less seriously—to care about them no more than do (or did) the people actually facing such decisions and their consequences. (As those authors note, “maybe surrogates’ accuracy is not that important.”)

It’s well worth underscoring that not everybody seems to care as much about concordance as do some bioethicists—that it can matter more to some people who it is who makes the calls, than what the actual content of the decisions might be. If we need to develop a relational ontology and epistemology to drive

the point home, let us do so—so long as our theory can accommodate comfortably those patients who seem to care quite as much about specific decisions as the most rabidly pro-autonomy theorist on the block. While our relational constitution may help make certain choices more intelligible to those theorists—or would, if we could get them to pay attention—it plainly doesn’t entail anything about the specific content of our desires, which are broadly variegated.

So, how do we gain that attention? Relational thinkers might go all-in, claiming that there is something deeply confused about the very setup and the goals of the autonomy view, maybe enlisting thinkers with mainstream credibility to help make the case. For example, one might invoke the philosopher L.A. Paul, well known for her view that deciding to start a family, as an instance of a “transformative choice,” changes a person so thoroughly that she cannot make a rational decision about the matter.² If becoming a parent is transformational, surely one could say the same for becoming significantly disabled, demented—or dead.

Another route one might take is to soft-pedal the distinctive metaphysics a bit, and take a leaf out of the other side’s play book. Beauchamp and Childress have done themselves nicely by developing a theory that, as they claim, is compatible with many diverse deep conceptions of the good; we might enjoy broader engagement with mainstream understandings were we to emphasize that the recommendations for practice that come from relational perspectives are ontologically pluralistic—defensible from mainstream as well as relational assumptions. They may even, as Robins-Browne and her colleagues suggest in their lovely conclusion, make the world more secure from the predations of paternalism, as well as honor more adequately the relational component of people’s lives.

NOTES

1. K. Robins-Browne et al., “The Role of Relational Knowledge in Advance Care Planning,” in this issue of *The Journal of Clinical Ethics* 28, no. 3 (2017): 121-33.

2. L.A. Paul, “What You Can’t Expect When You’re Expecting,” *Res Philosophica* 92, no. 2 (2015): 149-70.