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Clinical Bioethics:
Analysis of a Practice

by

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ABSTRACT

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This project is a philosophical analysis of the practice of bioethics consultation - what might be called the philosophy of bioethics. It assesses claims made about the purposes and appropriate aims of the field, in order to establish whether an identifiable conceptual unity underlies the practice. The conclusion is that no such unity exists.

The project begins by assessing the history of the field, in the hope that a historical analysis will explain why the field arose at all, which reason could then be used as a basis for claiming a particular purpose for bioethics consultation. However, it becomes clear that history has bequeathed diverse and sometimes conflicting goals to bioethics consultation. History suggests that the field exists both as a service to physicians and as a service to patients, though the interests of these two parties may be in tension.

This work also assesses contemporary accounts of bioethics consultation (including the recent Core Competencies for Healthcare Ethics Consultation) and shows that they are radically divergent and incommensurable, in addition to often being too vague to guide the practice. An investigation of possible philosophical arguments regarding bioethics consultation also fails to disclose a single coherent foundation for the
field. The project ends with a conceptual geography of twelve possible roles a bioethics consultant may play, and finds that though some are in tension, none may be ruled out of court on independent grounds in the absence of an overarching account of the appropriate aims of the field.

What this project demonstrates is that there is no conceptual unity underlying the practice of bioethics consultation. Instead, the enterprise must be understood as comprised of a plurality of roles serving a diversity of purposes and a heterogeneity of goods with no single uniting purpose.
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CHAPTER ONE: INTRODUCTION

The ethics committee aspect of the Quinlan decision is the subject of much confusion, disagreement, and concern. For example, would the role of such a body be solely advisory or would its determinations be mandatory? What should be its composition—totally professional or representative of various disciplines? Who should be its members? ... And of particular importance, is the requirement of committee concurrence in a termination decision reached by a physician and family or guardian constitutional? — Harold L. Hirsch and Richard E. Donovan, in ‘The Right to Die: Medico-Legal Implications of In Re Quinlan’ (1977)

I. WHY WORRY ABOUT BIOETHICS CONSULTATION?

Bioethics consultation is in ascendance, yet even 25 years after the Quinlan decision, there is no consensus about the aims and scope of the field. This dispute renders bioethics consultation especially susceptible to a number of criticisms. These criticisms fall into two main categories. Some criticize the field because it seemingly incorporates too much content, others because it seems to incorporate little to no content or because its purpose is unclear. Many bioethicists themselves are not sure which if any criticisms are correct.

Consider recent press articles on bioethics. In a 2001 New York Times article on ethics boards at research companies, one bioethicist observed that “Bioethics boards look like watchdogs, but they are used like show dogs.” The author of the article noted that “… critics, particularly conservatives, complain that bioethicists have anointed themselves society’s philosopher-kings and hold views out of step with those of most Americans” (Stolberg, 2001a). Elsewhere, she posits the question, “Why is society relying so heavily on bioethics – a profession that barely existed three decades ago – to resolve matters
traditionally reserved for personal conscience and faith?” (2001b). Later in the same article, she observes

...in today’s sound-bite world, where politicians want quick answers to validate their own views, and reporters have room in their stories for just one perfect, pithy quote, bioethicists are increasingly being called upon to make moral pronouncements. And that, some say, is dangerous territory. ... Religious conservatives, in particular, see bioethicists as relying on what Richard Doerflinger of the United States Conference of Catholic Bishops describes as ‘utilitarian reasoning’ and for being in ‘open rebellion against the idea of moral absolutes’. And the conservative journalist William Kristol recently founded The Bioethics Group ... to counter what he views as the prevailing liberalism of bioethicists, whom he calls ‘secular priests’ (Stolberg, 2001b).

The concern seems to be that bioethicists appear to be fairly ideologically homogeneous. Doerflinger and Kristol seem most alarmed at the preponderance of opinions based on utilitarianism, a rejection of moral absolutes and liberalism. These positions clearly are not shared by a considerable segment of society, yet the apparent consanguinity between ‘media’ bioethicists’ opinions implies widespread agreement. Such agreement can translate into public policies (via bodies like the President’s Commission) that have real consequences, but which do not accurately capture the extent of disagreement on bioethical issues.

*Reason Online* published a story in 1999 entitled ‘Warning: Bioethics may be hazardous to your health: The moralists’ attack on medical progress and patient freedom,’ which discussed the case of a young woman named Joy Simha. Simha had already survived one occurrence of breast cancer, and wanted to take the genetic test for BRCA1, the breast cancer gene. Since she faced very high chances (50-85%) of ovarian cancer or recurring breast cancer if she tested positive, she contemplated having her remaining breast removed. However, the physicians refused to give her the results of her test, claiming that the results might be “dangerous if they [were] revealed to [her] at the wrong
time” (Bailey, 1999). After she contacted the press regarding her story, Simha eventually won the right to know the result of the test. It was negative, and she decided against the mastectomy.

Bailey points out that

[b]y refusing to reveal such test results to their patient, Simha’s doctors believed they were practicing medicine at the highest ethical level; keeping patients in the dark in such circumstances has been recommended by such prestigious bioethics authorities as a 53-member panel of ethicists and lawyers chaired by Stanford University law professor Henry Greely (Bailey, 1999).

The grounds for the physicians’ refusal to tell her the results seemed to be the lack of evidence that any treatment in particular (including mastectomy) conveyed a decrease in the risk of cancer. Bailey cites a contrary finding in the New England Journal of Medicine (which suggested that mastectomy would in fact reduce the risk of cancer by 90%), but argues that “[e]ven in the face of medical uncertainty, such decisions should be up to Simha and other at-risk women, not a panel of imperious bioethicists” (Bailey, 1999). He notes too the large-scale effect that bioethics has on the choices of individuals:

Bioethics is a growth industry. During the past 30 years, more than 165 such centers and programs have sprung up, many of them associated with university medical schools. As Simha’s case shows, bioethical pronouncements have real consequences for real people. Increasingly, bioethicists are shaping the choices that you and your family will have for future medical treatments (Bailey, 1999).

Later in the article Bailey observes that “...many bioethicists are now rediscovering the virtues of paternalism. This time, bioethicists themselves want to determine what patients need to know and what treatments they should get – bioethicist-knows-best, if you will” (Bailey, 1999). Hence another perceived danger of the increasing power of bioethicists is the usurpation of an individual’s right to decide.
Though such criticisms are often made of the field of bioethics in general, bioethics consultation is especially susceptible to them. The bioethics consultant is uniquely situated to have an impact on decisions made in clinical settings, for the way in which he frames the issues at stake may play a role in the eventual action taken. Such a framework can stem from particular personal values or goals, or institutionalized political views, potentially validating the criticisms above. As will become clear in Chapter Three, there is reason to think that at least one prominent bioethicist (Benjamin Freedman) explicitly endorses the idea that personal views may— in fact, arguably should—guide bioethics consultation.

There is another cadre of critics that perceives bioethicists as ineffectual, meddlesome, bureaucratic overseers with no clear role definition and therefore no clear purpose. There is some evidence to support this criticism. A 1993 survey of bioethics consultants concluded that even in a much clearer hypothetical case than most consultants would ever face, there was wide variety in the recommendations offered (Fox & Stocking, 1993). Such diversity of judgment casts doubt on the criticism that bioethics consultants are attempting to wrest power from individuals, determine a national agenda, or propagate an insidious ideology. In fact, it suggests an opposite criticism: there is no substance or foundation to the practice at all. Another study designed to explore the reasons physicians give for not using ethics consultations services observed that some

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1 For example, the conclusion of a 1988 study on medical ethics consultations found that “ethics consultations appeared to have considerable impact on physicians in conducting patient care” (Perkins & Saathoff, 1988, p. 761). This of course makes no observations regarding the nature of the impact. There is a difference between impacting a physician by persuading him with rational argument and impacting him simply by being an ethical ‘rubber stamp’ which enables him to pursue a particular course with a clear conscience. The point is that there is evidence that bioethics consultants have an impact on clinical decision making. The authors note that “these results suggest that ethics consultations help physicians recognize ethical issues and think clearly about them, often change patient management, and almost always boost physicians’ confidence in the final management plan” (p. 764).
physicians do not use consultants because they perceive them as interfering with the doctor/patient relationship and possessed of no particular insight into moral matters (Davies & Hudson, 1999).²

While critics disagree about the extent of a bioethics consultant’s influence, many consultants themselves are genuinely uncertain about their roles and are searching for ways in which to define their practice. Richard Zaner describes the incursion of philosophers (himself included) into the hospital:

...many of us [philosophers] felt acutely out of place and recoiled in shock and dismay. Our reaction was that this is simply no place for a philosopher, whose training and disposition include nothing that could prepare one for rendering judgments, much less definitive, possibly irreversible, moral decisions. Even if one could begin to untangle some of the moral issues implicit to such cases, one had neither the time to do so properly nor the appropriately prepared audience to hear the discourse or participate in a philosophical discussion designed to clarify issues (Zaner, 1988, p. 7).

Zaner’s worry is that bioethics consultants (in his case, specifically philosophers) do not clearly possess the moral expertise required to participate in concrete decision making, and that even if they did, other limitations would prevent them from properly using that expertise. He seems to think both that bioethics consultants might have inappropriate power, or at least power inordinate to their abilities, and that they have nothing to offer.

In addition, some bioethics consultants worry that without some idea of the goals they ought to pursue, their services are in danger of being coopted. For example, in a recent survey, some physicians “stated they would use ethics consultation to strengthen their position when there were perceived to be legal issues” (Davies & Hudson, 1999; emphasis added). One effect of bioethics consultation may be that it serves to manage

² One physician said, “I think ethics consultation is in some situations laying the framework of the problem, getting people to work together, but it’s the same thing that I think we all try to do anyway when faced with these situations, so I’m not sure that’s [i.e., medical ethics is] bringing in any expertise to it” (Davies & Hudson, 1999).
risk for individuals and institutions. This may be an unintended and unavoidable side-effect of bioethics consultation, in which case it is arguably permissible. It may on the other hand indicate that physicians and institutions are making use of the ambiguity surrounding bioethics consultation for their own purposes. It is also possible that physicians may use a bioethics consultation as an imprimatur on whatever choice they favor personally. Bioethics consultants could in such a situation be used as an ethical facade behind which to pursue particular agendas or operate on the basis of particular personal beliefs, with a purported ethical stamp of approval.

Bioethics consultation is criticized both for having too much leverage and for having nothing to contribute. Moreover, even those who practice bioethics consultation are uncertain what service they provide or ought to provide, whether it is a useful service, and whether they are merely being used. All of these concerns stem from the fact that the role of the bioethics consultant is ambiguous. This project attempts to make sense of the purpose of bioethics consultation.

The need for the further definition of the field arises from at least three sources: first, the decisions in which bioethics consultants are involved have high stakes, so it behooves us to understand exactly what the goal of the activity is and when it is being conducted rightly or wrongly. In addition, however, proponents of the profession must give an account to critics who are suspicious of the field for an entirely different reason. If bioethics consultants are a befuddled group with little to offer, critics will suggest, why expend precious resources on their salaries? It may be the case that even with a solid philosophical justification, bioethics consultation is considered expendable. An account
of what the practice has to offer will at least ensure that that judgment has been made accurately.

Second, one of the valid points of the critics is that there are political ramifications to the profession of bioethics consultation. If a particular viewpoint becomes ensconced in institutional bioethics, the freedom of individuals to act in accordance with their own values may be in jeopardy. In fact, it is not simply the adoption of a political viewpoint that endangers individual freedom. Whenever bioethics consultants are given the latitude for bioethical paternalism by substituting their own judgment for the judgment of others, patient freedom is threatened. An account of the practice is required that demonstrates the potential source of such dangers and the precautions that should be taken to avoid them. After all, it would be ironic if the very field that arose partly in order to protect patients from paternalism itself became guilty of it. Moreover, if there are foundational principles that ground the practice of bioethics consultation, they must be identified and the implications clarified. Such an account will enable proponents of the profession to mount a defense against criticism stemming from disagreement over core values.

A third reason to provide an account of the goals of bioethics consultation is the genuine uncertainty of consultants themselves about their aim. Some may not be concerned with defining the profession or its standards. Others, however, wish to work in an important profession, with integrity, honesty, excellence, and clarity of purpose. Without an idea of what that profession entails, or even whether it is in fact important, this will be a futile desire.
Among the central puzzles in bioethics consultation are the following:

1) What are the limits of authority of the bioethics consultant? May bioethics consultants roam hospitals in search of ethical conflicts and problems, or must they await a consultation call? If a bioethicist encounters by chance some ethical conflict (for example, by overhearing it or having someone ‘unofficially’ report it to him), may he pursue it by reporting it to the hospital administration? Ought he?

2) Whose interests does the bioethics consultant serve? Is it the patient, doctor, institution, or society at large? May anyone call a consultation, or should this privilege be extended only to certain people (for example, physicians)? If the hospital has such a policy, do bioethics consultants have good reasons for demanding wider access to the services they provide?

3) Are there unique obligations (moral and other) that a bioethics consultant has which distinguish her job from that of other members of the health care team?

4) Is a bioethics consultant entitled, by virtue of some particular expertise, to give advice regarding the right decision in a particular case?

All of these issues revolve around where the boundaries of the practice lie and the relationship between the boundaries and the goals of the field. Until a particular interpretation of bioethics consultation is offered, such questions will be impossible to answer.

It is difficult in general to establish what constitutes a profession, and what obligations membership entails for its practitioners. In bioethics consultation, however, it is important to reach some resolution on this issue given the somewhat novel and extensive roles played by its practitioners. As just discussed, it is important for a
profession with integrity to answer reasonable and serious criticisms, such as whether or not the profession is useful or necessary, as well as whether and how it is susceptible to abuse. In addition, bioethics consultants themselves might desire a clear explication of where the boundaries and justifications lie, so as to be sure that they are practicing well and with integrity.

There are at least three additional reasons for desiring a clear definition of the field. First, bioethics consultants are becoming more prevalent, especially in hospitals, where one of the primary responsibilities of a bioethicist is clinical consultation. As consultation usually involves patients and their families, who may have no basis for evaluating bioethicists’ performance (nor, in all likelihood, an idea of what they do), there ought to be some established standards. The increase in numbers of practicing consultants means that more and more patients and families will be impacted by the profession, and potentially harmed if the field is held to no standards.

Second, bioethics is practiced by individuals from many different “home” disciplines, who may share little common understanding of what it is they do. Thus it cannot be assumed that at least the practitioners agree about their responsibilities, even if no one else is privy to such knowledge. A physician who has attended a two-week intensive bioethics course, for example, may hold a different standard of justification for moral positions than someone who has trained for a graduate degree in philosophy. The recommendations of each may be widely divergent. A theologian or resident minister may pay more attention to the existential or spiritual needs, while a lawyer might pay more attention to meeting legal standards. None of the three may pay any attention to other moral considerations. Patients would then be at the whim of whichever bioethics
consultant was on call when the request for consultation was made. A clear account of
the field's aims would mitigate this contingency by standardizing the profession.

A third reason for wanting a clearer definition of the field is quite practical, though it raises the stakes for other questions already aired. The Joint Commission on the
Accreditation of Healthcare Organizations mandates that in order for a hospital to be
accredited there must be some institutional means of addressing bioethical issues that
arise. The requirement is that "The hospital addresses ethical issues in providing patient
care" (JCAHO standard RI.1), but it offers next to no guidance on how it should be
fulfilled. Most often this requirement is satisfied by convening an ethics committee
which is in effect required to give itself goals and side-constraints if any are to be had.
The JCAHO standards suggest that "Patient rights processes may include a variety of
strategies, such as using an established ethics committee, a formalized ethics forum,
ethics consultations, or any combination of these or other methods" (Standards, Intents,
and Examples for Patient Rights, JCAHO Standards). The variety of strategies they
suggest include maintaining a full-time bioethics consulting staff, having 24-hour access
to an external consulting service or to the ethics service of a larger medical center, having
"staff members [who] are educated on recognizing ethical issues" or who "have access to
appropriate support mechanisms, such as an ethics committee."

The field of bioethics consultation is in need of an account of its aims if it is to
meet criticisms or offer a justification of the services it provides. The fact that the
numbers of consultants is growing exacerbates the uncertainty. The fact that such
consultants arguably affect health care decisions adds impetus to that need. The goal of
this project is to provide a philosophically grounded account of the field of bioethics.
II. HISTORICAL BACKGROUND

The profession of bioethics has existed for approximately 3-4 decades, though authors disagree considerably about “the roots” of the field. One commonly cited predecessor of bioethics consultation is the Dialysis Selection Committee in Seattle, Washington, which began in 1962 (Alexander, 1962). A group of predominantly laypeople, including a lawyer, housewife, minister and banker, came together to determine who should be the beneficiary of what was then a rare lifesaving technology: kidney hemodialysis. The publication of an article committee in *Life* magazine (Alexander, 1962) led to public outcry against choices being made by the ‘god squad’ or ‘life or death committee’ regarding who would have access to life-saving treatment. This outcry resulted in the Federal government’s decision to pay for kidney dialysis, which funding continues to this day, and eliminates the need for a dialysis selection committee.

Research scandals also profoundly influenced the development of the field. In the 1950s, pregnant women began taking Thalidomide in a drug trial for morning sickness, only later to discover that it could result in the birth of babies with limb deformities. Subsequently the Federal government began to require consent from research subjects in such trials, which over time evolved into the current informed consent standards in research. In addition, Henry Beecher’s publication in 1966 of a paper outlining egregious ethical violations in medical research (including injecting senile patients with live cancer cells and intentionally infecting retarded children with hepatitis) gave rise to the Institutional Review Boards whose approval for medical research is now mandatory. Momentum gathered over the next two decades with the formation of two national bioethics commissions responsible for studying and reporting on various bioethical
issues. The reports, especially *The Belmont Report, Defining Death* and *Deciding to Forego Life-Sustaining Treatment*, have set the terms of bioethical debate up to the present.

The 1976 Quinlan case decision, which turned on the request of parents to withdraw life-sustaining treatment from their permanently comatose daughter, also provided a significant impetus to bioethics consultation. After appeal, her family finally obtained permission to remove their daughter from the ventilator based on the invocation of a legal right to privacy (Supreme Court of New Jersey, 1976). The author of the Court’s opinion, Chief Justice Hughes, noted an article on ethics committees by physician Karen Teel (Teel, 1975). Teel suggested that many hospitals had ethics committees to review difficult cases, and that the use of such committees should be expanded. Justice Hughes endorsed the idea of ethics committees as a means of helping physicians and patients to make decisions that would be accepted by the courts and society. However, it was not clear that many of these committees existed at all, contrary to Teel’s claim. The result of the Quinlan decision was that more hospitals decided to establish ethics committees, yet none gave a clear account of the purpose such a committee should serve. This lack of clarity is an epiphany of the contemporary disarray in the field. The JCAHO requirements are another: in their endorsement of an ambiguously defined but seemingly good idea, they have continued the vague affirmation of bioethics committees by the Quinlan Court.
III. METHOD

Philosophers can address themselves to bioethics and bioethics consultation in two different ways. One might give a rational reconstruction of how bioethics consultants provide services. One might also argue for a particular position on a moral issue in health care. Alternatively, one might offer an account of how the practice itself ought to be conducted, including appropriate approaches, goals, methods, skills, knowledge, etc. This would lead to what might be called the philosophy of bioethics, the subject matter of this project. The philosophy of bioethics, as it is understood here, assesses the concepts, arguments and justifications involved in bioethics consultation. In part the philosophy of bioethics should involve the investigation of the ways in which cultural values as well as historical and social contexts are presupposed in accounts of bioethics. It should also assess how bioethics consultation is understood, practiced and defended. The purpose of the philosophy of bioethics is to assess the arguments for practicing in one way rather than another.

The practice of bioethics consultation involves a myriad of different tasks, goals, and abilities, including education, facilitation, mediation, counseling, etc. A significant part of the job description of many consultants is education. The education might concern new law in a particular field, new hospital policies, or new bioethics theories that impact clinical bioethical practice. Education might also focus on maintaining hospital staff’s current knowledge about law, policy and theory. Empirical matters such as the way in which a particular subgroup of a patient population (based, for example, on locally predominant religions or cultures) view particular bioethics issues might also be the focus of education.
Another task of bioethics consultation consists of rounding with health care teams for the purpose of investigating or discussing bioethics issues. These rounds might be on a regular basis, or they might be strictly by request, for the purpose of general education of the health care team or advice on a particular patient.

For bioethics consultants with no regular rounds, and even those who do round, particular consultation calls often arise. The call for consultation can arise from a physician, nurse, patient, family member, or other member of the hospital. The consultation itself might be as informal as a ‘curbside’ consult, where a physician stops the bioethics consultant in the hallway or visits his office. Often, however, it involves meeting with the patient, family and/or health care team in a more formal setting. The purpose of the meeting will vary from situation to situation. At root it almost always arises due to some conflict about decision making. This conflict may be an internal conflict, for example when a patient feels his values are in conflict and is uncertain about how to proceed. Or, it may be an external conflict, where at least two parties disagree about the course of action. On the face of it, the purpose of the consultation is to resolve the conflict.

The philosophy of bioethics examines how these and other tasks are defined, defended, and justified. When a consultant aims at resolving a conflict, on what basis may this resolution be justified? Is it based on grounds for resolution in the literature of the field of bioethics consultation, and if so, is that literature coherent? Or are there different, incompatible accounts of the goal of resolution? Can the goals and assumptions of the field be philosophically defended?
The task of this project will be to assess arguments regarding the goals of bioethics consultation. Chapter two investigates the history of bioethics in order to demonstrate the lack of an accepted foundation in the history of the field for particular goals. In addition, chapter two shows that the many historical ancestors of modern bioethics consultation have given sometimes incompatible goals to the current practice.

Chapter three analyzes four main accounts of bioethics consultation in the professional literature in order to determine whether there is some consensus on the goals and justification of the field. I conclude that not only is there no consensus, but also the perspectives that are offered are a) relatively superficial and underdetermined (resulting in a failure to guide bioethics consultants in practice, and b) incommensurable. In addition, I claim that it is not merely a contingent fact of this profession that consensus does not exist regarding the foundations of the field (though it is not unusual that a field in the throes of self-definition would not find it easy to reach such an understanding). The lack of consensus is instead the result of the fact that no foundation of the field has been established and that in the absence of a foundation, the roles and goals advocated for bioethics consultation are susceptible to a wide variety of interpretations. Given the history and nature of bioethics consultation, it is reasonable to interpret the field in these diverse ways. Each possesses a degree of plausibility. However, the result is deep disagreement regarding the aims and scope of the field.

Chapter four addresses the first professional attempt to outline the goals of bioethics consultation, *Core Competencies for Healthcare Ethics Consultation* (American Society for Bioethics and Humanities, 1998). This document offers guidelines concerning the goals of consultation, the approaches that ought to be used, the skills and
knowledge required, and the standards for success. Though the Task Force responsible for its publication specifically rejects the idea that this document should standardize the field in anything but a voluntary way, it is a first step towards possible accreditation or licensing. In the final analysis, however, the document's suggestions are overly general and vague. They cannot provide concrete guidance in any but the simplest situations, much less address the philosophical uncertainties and concerns raised in chapter four.

After having established that the field as it currently exists is in disarray, due both to the existence of conflicting accounts of the field and the complexity of the philosophical questions at the heart of the practice, chapter five takes a meta-step. What are the philosophical arguments that might ground a conception of bioethics consultation? George Sher's investigation of the obligations of university teaching university serves as a template for considering the obligations of bioethics consultation. He argues that we must both establish what the obligations are and why they are obligations, but that no account is capable of answering both questions. The result is the same for bioethics consultation, so I take up two of his concluding suggestions regarding other possible sources. These are also unsuccessful, as is a third alternative. The result is that we do not appear to be able to deliver a coherent account of bioethics consultation which will yield the obligations of the field. Without this account, we are both unable to articulate the boundaries of the consultant's authority and unable to choose between competing accounts.

Despite this conclusion, there is more to be said about the profession. Chapter six turns to the examination of individual roles a bioethics consultant might play in the process of consultation. The arguments here do not depend on a particular conception of
bioethics consultation. Rather, they examine what considerations might mitigate against
the performance of a particular role. So, for example, the roles of counselor, risk
manager and spiritual guide (in an official capacity) should be approached with great
cautions and should never be the goal of bioethics consultation. Where there already exist
professionals who can perform such roles, it is better if they rather than a bioethics
consultant pursue these roles. This solution is more efficient, and in some cases less
dangerous (e.g., in the counseling role) if these roles are played by trained professionals.
In addition, however, the pursuit of such roles might draw the consultant’s attention away
from whatever is found to be the primary purpose of bioethics consultation. There are
other roles, however, that seem acceptable for a bioethics consultant to play, at least in a
minimal sense. Depending on how these roles are interpreted and what is determined to
be the goal of bioethics consultation, however, there may be constraints on the manner
and extent to which these roles are played by the consultant. Several of these roles also
conflict with one or more of the possible aims of bioethics consultation, so until we have
the fundamental account of bioethics consultation, it is not clear whether or not they are
permissible. The chapter ends with a discussion of roles played in combination, and
argues that one of the fundamental choices facing bioethics consultation is whether it
should play roles requiring neutrality (e.g., mediation) or partisanship (e.g., patient
advocacy). What becomes clear in this analysis is that even in its subsidiary roles, it is a
heterogeneous practice, determined in part by historical forces and shaped by the social
environment in which it finds itself.

Chapter seven concludes by evaluating the results of the forgoing analyses and
exploring the implications for bioethics consultation, including the question of the
standardization of the field, the education of its practitioners, and the standards of its success. It is important to note that even after a thorough examination of whether or not certain roles ought to be played in bioethics consultation, ambiguity may remain. This state of affairs is not, prima facie, the result of a weakness of the argument. If it is the case that at a very deep level there is ambiguity in the nature of bioethics consultation, then this is an important fact that must be addressed in any internal moral code of bioethics. For example, if there really is no answer to the question of what should count as moral expertise, then bioethicists need to examine what they owe to employers, physicians, patients and their families in terms of divulgence of this state of affairs.

Finally, a word about terminology. According to the American Heritage Dictionary (4th Ed.), “ethics” means either “a set of principles of right conduct” or “a theory or a system of moral values”. “Morality”, on the other hand, is understood as “the quality of being in accord with standards of right or good conduct” or secondarily, “a system of ideas of right and wrong conduct”. In this project I take no stand on a distinction between the terms “ethics” and “morality”, and use them interchangeably.
I. THE CONTEMPORARY PROBLEM OF BIOETHICS BY WAY OF ITS
HISTORICAL ANTECEDENTS

It is not simply in its current incarnation that bioethics consultation is a many-headed entity. The historical influences on the field of bioethics in general and on bioethics consultation specifically have been diverse and conflicting as well. In fact, the three main monographs on the history of bioethics—two by historians and one by a pioneer bioethicist—disagree about “the roots” of bioethics. Tina Stevens (a historian) argues in *Bioethics in America* that bioethics is merely a product of a “centuries-long cultural legacy of American ambivalence toward progress.” She locates the roots of the field in a movement of scientists in the post-atomic age to confront the moral issues involved in their various projects. In one of her more provocative claims, she argues that the bioethics movement actually subverted the desires of social activists:

...when bioethical concerns seemed not to dissipate but instead were institutionalized at the close of the 1960s, bioethics appeared to be historically exceptional. [I.e., it was an exception to the cyclical nature of embrace and opposition to new technology - what she calls the “tradition of ambivalence”].] Bioethics won this legitimacy, however, as a reward for functioning as a kind of cultural inoculation, an immunization that forestalled the more virulent attacks of radical critics, who were mistrustful of biomedicine’s undergirding role in a technological society (Stevens, 2000, p. 2).

Far from being a movement dedicated to the protection of society, she alleges, through its rapid institutionalization bioethics was co-opted, losing its salience and force as a cultural critique.
Albert Jonsen (a philosopher), on the other hand, initially located the starting point of bioethics in the Seattle dialysis selection committee in 1962 (Jonsen, 1990). He later argued in *The Birth of Bioethics* (1998) that bioethics had a much larger starting “point” stretching from the period immediately following World War II and the Nuremberg trials up to the mid-1960s. David Rothman, a historian and the first author of a full-length history of bioethics, *Strangers at the Bedside* (1991), locates the starting point slightly further back. He sees the time prior to, during, and immediately after WWII as demonstrating a utilitarian mindset which led to bioethical problems: the ends of research were medical success, and the means were justified, whatever they comprised.

The “real” historical influences of bioethics may be impossible to discern; they are wrapped up in over a half-century of profound and entangled social, political, and technological change. As a result, the examination of history will shed much light on the *question* of goals, but no answers. Even if we could establish the historical roots of the field, we would not thereby establish the normativity of that history.

Despite this, however, there are important features of contemporary bioethics consultation that become clear upon an examination of history, and more specifically, the history of bioethics committees. Three main historical influences will be addressed here, two of which can be directly credited for some current bioethical tasks and approaches: the first is medical research and federal involvement in it, and the second is the Karen Ann Quinlan case. The third is the short-lived dialysis selection committees, which raised interesting problems about the purpose of ethics committees that are deserve an extended look.
Each of these historical precedents focused on a particular set of concerns that would later help to constitute the field of bioethics consultation. What will become clear is that ambiguity in bioethics consultation is not new. It arises in part because the very concerns that gave rise to the field were themselves full of political and moral ambiguities.

II. DIALYSIS SELECTION COMMITTEES

Kidney dialysis began in 1944, when Dr. Willem Kolff developed the first workable artificial kidney in the Netherlands. It sounded like a frightening contraption, described as a rotating drum that had to be raised and lowered to let blood into and out of the system. He emigrated soon after this to the United States, bringing two of his machines with him. Unfortunately, the relief provided by the treatment was temporary: patients could not receive it repeatedly, as it scarred their veins, rendering them useless for dialysis. In the meantime, the first successful kidney transplant (between identical twins) occurred in 1954. More transplants were taking place around this time, but only approximately 10% survived due to rejection complications.

In the late 1950s, Dr. Belding Scribner was working on dialysis at the University of Washington in Seattle. As Albert Jonsen relates the history,

After a previous patient...had died because his successful dialysis could not be repeated, Scribner had awakened in the middle of the night with the idea of a permanent arteriovenous access.... Within a few weeks he and his colleagues had fabricated such a device from Teflon tubing [which incorporated silastic, invented only a few years before]. The shunt [the “Scriber shunt”, as we know it today] worked and [the second patient] lived, with dialysis twice a week, for another twelve years (Jonsen, 1990, pp. 17-18).
Unsurprisingly, this success led to a drive to treat more patients. The Seattle group (including Scribner) subsequently treated a number of patients successfully, but initiated a 13-month moratorium on the treatments when complications arose, the most odious of which was the shunt itself. It wore out too quickly, suffering from clotting and infection. The machines were delicate as well, and what was needed was something less like surgery and more an every-day procedure. The team continued to experiment on patients who had already begun treatment, some of whom went through a dozen shunts in as many months.

At this point, despite efforts to the contrary, word of the successful new treatment was spreading, and members of the dialysis team were besieged with requests from their colleagues to take on new patients even during the moratorium. This pressure prompted the team to establish both a medical board and separate lay committee to select patients for the limited spaces in the treatment.

The medical board was a group of doctors who selected the best medical candidates for the treatment, and passed those patients' profiles along to the lay committee. The lay committee, alternatively known as “The Admissions and Policies Committee of the Seattle Artificial Kidney Center at Swedish Hospital” and the “Life or Death Committee” was convened for the first time in the summer of 1961, and spent the first six months deciding how they would select patients. A fascinating account of the committee’s decision making was presented in a *Life Magazine* article by Shana Alexander in November of 1962. Alexander was able to interview members of the committee (all of whom wanted to remain anonymous), as well as the doctors and
patients involved in the dialysis project. Though she was not allowed to attend a meeting, she was able to view an account of one, and her resulting article provoked a public drive for wider availability of dialysis.

The committee worked as follows: the medical board determined who were good candidates for inclusion based on medical information, and recommended a few other somewhat *ad hoc* restrictions. For example, they suggested that the lay committee exclude those over 45 due to potentially greater complications with the treatment, and that they exclude children because of the potentially traumatic treatment and subsequent dietary restrictions. The doctors on the medical board also offered to sit in on the lay committee for medical inquiries, but otherwise the committee was independent.

The lay committee made a few initial decisions: they wanted to be anonymous, and they wanted the patients to be anonymous as well. They made a list of factors to be considered: age, income, sex, marital status, number of dependents, net worth, emotional stability, education, occupation and a few others. They also restricted candidates to the residents of the state of Washington, on the logic that the sponsoring institutions in which the treatment was being conducted were funded by state taxpayers. While these meetings were being conducted and the treatment center (consisting of three beds) was being readied, the odds of each candidate went from 1 in 50 to 1 in four – most other candidates had died.

In the most provocative section of the article, Alexander prints a partial transcript of one of the committee meetings. In it the committee is to choose two people from a list of five. Patient One, a housewife from Walla Walla, is eliminated because it is unlikely that she could find a way to move her family nearer to the treatment center due to their
economic status. A conversation regarding the other patients went as follows

(Alexander refers to the members by their occupations):

**Minister:** How can we compare a family situation of two children, such as this woman in Walla Walla, with a family of six children, such as patient Number Four - the aircraft worker?

**State Official:** But are we sure the aircraft worker can be rehabilitated? I note he is already too ill to work, whereas Number Two and Number Five, the chemist and the accountant, are both still able to keep going.

**Labor leader:** I know from experience that the aircraft company where this man works will do everything possible to rehabilitate a handicapped employee.

**Housewife:** If we are still looking for the men with the highest potential of service to society, then I think we must consider that the chemist and the accountant have the finest educational backgrounds of all five candidates.

**Surgeon:** How do the rest of you feel about Number Three - the small businessman with three children? I am impressed that his doctor took special pains to mention that this man is active in church work. This is an indication to me of character and moral strength.

**Housewife:** Which certainly would help him conform to the demands of the treatment...

**Lawyer:** It would also help him to endure a lingering death...

**Minister:** Perhaps one man is more active in church work than another because he belongs to a more active church.

**Banker:** We could rule out the chemist and the accountant on economic grounds. Both do have a substantial net worth...

**Lawyer:** Both these men have made provisions so that their deaths will not force their families to become a burden on society.

**State Official:** But that would seem to be placing a penalty on the very people who perhaps have been most provident...

**Minister:** And both these families have three children too.

**Labor leader:** For the children's sake, we've got to reckon with the surviving parent's opportunity to remarry, and a woman with three children has a better chance to find a new husband than a very young widow with six children.
Surgeon: How can we possibly be sure of that?....

(In the end, the aircraft worker and the small businessman were chosen.)

Alexander’s article provoked public outrage that humans should play God. As a result, in 1972 Medicare began paying for hemodialysis, and the short life of the dialysis committee was over. During its tenure, the areas in which bioethics was involved continued to grow. The Harvard Ad Hoc Committee on Brain Death published standards for declaring an irreversible coma, the first two Bioethics Centers were founded (Hastings Institute of Society, Ethics and Life Sciences and the Kennedy Institute of Ethics), and the Federal government was occupied with research scandals that demanded legislation.

There are no dialysis committees today, and though there are similar issues raised in transplantation, that field must contend with histocompatibility issues that prevent transplant teams from having to make such similarly stark choices. Nevertheless, dialysis selection committees introduced a host of possibilities and problems regarding the involvement of non-medical personnel in health care that continue to this day. What was the original purpose of the committees? As Alexander describes it, it was based on the “acceptance of the principle that all segments of society, not just this medical fraternity, should share the burden of choice as to which patients to treat and which to let die. Otherwise society would be forcing the doctors alone to play God” (p. 124). Note also the various tasks the members understood themselves to have. According to the Housewife, “The purpose of our committee is to protect the medical men from ... highly emotional situations. ... [I]t is only if we are truly unknown that we really can be a buffer for the medical profession” (Alexander, 1962, p. 117). As the State Official understood
it, “The central problem here is that medicine has moved forward so rapidly it has advanced beyond the community’s support. Our committee must try to bridge the gap” (p. 118). While this committee saw itself as supporting physicians by buffering them from emotional situations and sharing the burden of difficult choices, some contemporary committees understand themselves to be in place partly to watch doctors, to put it in stark terms, or more congenially, to help prevent oversights. As will become clear in the following discussion on medical research, there is good reason for that task as well.

The dialysis committee demonstrates some of the many conceptual roots behind bioethics consultation. Once a precedent had been set for involving ‘outsiders’ in medical decision making, it is easy to imagine that others also found it a worthy approach. Yet dialysis selection committees involved a particular sort of decision making help that was unlikely to be paralleled in other areas. It involved a very discrete context in which specific choices needed to be made, the results of which were literally life or death. Once the idea of including non-medical personnel in medical decision making spread, however, it became less clear what the purpose of including that outside help was. Even the purpose of the dialysis committee itself is not entirely clear: was its purpose to protect physicians or to share the burden of decision making? Which should it have been? The question of purpose will confront us repeatedly as we consider the field of bioethics consultation, and it is important to note that it is present from the earliest days of bioethics.
III. RESEARCH AND FEDERAL INVOLVEMENT IN BIOETHICS

Federal involvement in medical research gained momentum in the late 1950s. If Rothman’s history is taken as correct, medical research in the post-WWII era was imbued with the same spirit as it had been during the war: the ends were crucial, the means much less important. Congress was already beginning to take a look at FDA oversight (or lack thereof) by the time Thalidomide appeared.

A. Thalidomide

Thalidomide, a drug marketed by Merrell Pharmaceuticals, was in part designed to prevent morning sickness in pregnant women. Unfortunately, it became apparent that thalidomide could result in serious fetal defects, usually the absence or deformation of limbs. It had far more impact in Europe, where the drug had been prescribed widely, than it did in the United States, where Dr. Frances O. Kelsey, an officer in the FDA, kept it off the market despite intense pressure from Merrell. (She later received a Distinguished Federal Civilian Service Medal for this action.)

Unfortunately, Kelsey was unable to keep Thalidomide from being a subject of experimentation. Merrell began marketing its drug in the guise of a drug trial, and eventually was able to have it prescribed to over 20,000 women as a drug trial (Jonsen, 1998, p. 141). It later withdrew its application for approval in the light of the evidence that was surfacing. However, the Thalidomide events served as an illustration of the problems with FDA procedures, which in fact were already under investigation by Senator Kefauver’s Subcommittee on Antitrust and Monopoly.
The committee held hearings in 1959 that resulted in the 1962 Leaver-Harris amendment to the Federal Food, Drug, and Cosmetic Act, which gave the federal government a strong role to play in the approval of new drugs. More importantly for present purposes, though, it requested that the Health Education and Welfare Secretary compose regulations mandating that investigators obtain consent from subjects. However, this is not “full and free consent” as we might know it; the regulations required only that a physician inform a potential subject that the drug in question was “being used for investigational purposes” and that “[the pharmaceutical company] will obtain the consent of . . . [subjects] or their representatives, except where they deem it not feasible or, in their professional judgment, contrary to the best interest of such human beings” (Federal Food, Drug and Cosmetic Act, quoted in Jonsen 1998, p. 141). Dr. Kelsey had another role to play here, writing an article that highlighted the vagueness of the language in the new provision. The subsequent 1966 regulations clarified the notion of informed consent, based in part on Kelsey’s observations and the resulting discussion.

As Albert Jonsen points out in The Birth of Bioethics, this was a significant event in the history of the field. From this point on, the federal government began to involve itself to a greater degree in clinical investigations, and over the course of the next few decades, came to be the dominant determiner of how medical ethics committees conceived of their jobs.

B. The Henry Beecher article and NIH regulations

In 1966, physician Henry Beecher published ‘Ethics and clinical medicine’ in the New England Journal of Medicine an provoked a controversy. Here is how he begins:
Human experimentation since World War II has created some difficult problems with the increasing employment of patients as experimental subjects when it must be apparent that they would not have been available if they had been truly aware of the uses that would be made of them. Evidence is at hand that many of the patients in the examples to follow never had the risk satisfactorily explained to them, and it seems obvious that further hundreds have not known that they were the subjects of an experiment although grave consequences have been suffered as a direct result of experiments described here. There is a belief prevalent in some sophisticated circles that attention to these matters would "block progress." But, according to Pope Pius XII, "...science is not the highest value to which all other orders of values ... should be subordinated" (Beecher, 1966, p. 1354).

He goes on to list 22 different unethical clinical investigations, ranging from the injection of live cancer cells into senile patients, the suturing of mercury-filled gauges to the hearts of adult patients, and the intentional infection of retarded children with hepatitis.\(^1\) Some of the funding for these experiments came from the NIH and the US military, and involved leading medical schools such as Georgetown, UCLA and Duke. As Beecher points out, available research funding to Massachusetts General Hospital quadrupled between 1945 and 1955, and increased 17-fold between 1945 and 1965. In the meantime, NIH research funds had increased a staggering 624-fold -- from $700,000 in 1945 to almost $437 million in 1965. As he points out, "Taking into account the sound and increasing emphasis of recent years that experimentation in man must precede general application of new procedures in therapy, plus the great sums of money available, there is reason to fear that these requirements and these resources may be greater than the supply of responsible investigators" (p. 1355).

\(^1\) These were the Willowbrook experiments (Willowbrook State School for the Retarded); the Principal Investigator, Saul Krugman, later went on to win the prestigious Lasker prize in 1983, among his many other decorations.
Among the strongest points Beecher made was that the subjects in these experiments were often the underprivileged and marginalized. While some might maintain that such abuses were justified by the benefits derived from experimentation, he concluded that “[a]n experiment is ethical or not at its inception; it does not become ethical post hoc - ends do not justify means. There is no ethical distinction between ends and means” (1966, p. 1360). He makes a very strong case for the urgency of obtaining informed consent, for “moral, sociologic and legal reasons” (p. 1360), and even suggests that the medical publishing industry refuse to publish results obtained in an unethical manner as a way of discouraging initiation of such experiments. His article was not well received by many in medicine, but it was the subject of a great deal of discussion. Coming as it did only a few years after the Thalidomide scandal, it no doubt added a great deal to increasing citizen suspicion of medical research.

In the meantime, the NIH was already in the process of investigating the relationship between physicians and research subjects as it differed from that between physicians and patients. One of the main differences, it was becoming clear, is that many research subjects were healthy “normals” who were volunteering for the trials. The physician had an interest in enrolling these patients (for study results) but no concomitant clinical responsibility to them. And, as Beecher’s article made clear, the traditional reliance on physician self-monitoring was potentially insufficient to protect research subjects, both “normals” and the marginalized upon whom Beecher focused.

In 1962, the NIH surveyed institutions to which it gave grants, and found that “only nine of fifty-two departments of medicine had any policy regarding rights of research subjects; sixteen stated that they used written consent forms” (Jonsen, 1998, p.
143). In 1964, the NIH director appointed a committee to investigate the ethics of human experimentation. The Livingston Committee, as it was known, came to the conclusion that "in the setting in which the patient is involved in an experimental effort, the judgment of the investigator is not sufficient as a basis for reaching a conclusion concerning the ethical and moral set of questions in that relationship" (Jonsen, 1998, p. 143). In other words, the physician's judgment was not automatically to be trusted. The NIH director (James Shannon) decided that peer review was necessary prior to any investigator carrying out human research, and his position was supported by the National Advisory Council of the NIH in December, 1965. On July 1, 1966, the NIH created the guidelines for federally funded human subject research that gave rise to Institutional Review Boards, or IRBs, one of the precursors of the ethics committee. There were three main points addressed to the IRBs. First, the research institution was responsible for "obtaining and keeping documentary evidence of informed consent"; second, the institution must conduct a "review of the judgment of the investigator by a committee of institutional associates not directly associated with the project"; and finally, the regulations defined the committee's review standards: "This review must address itself to the rights and welfare of the individual, the methods used to obtain informed consent, and the risks and potential benefits of the investigation" (quoted from Rothman, 1991, p. 89). As Rothman summarizes the regulations,

for the first time and in direct response to the abuses of discretion, decisions that had traditionally been left to the individual conscience of physicians were brought under collective surveillance. Federal regulations, a compulsory system of peer review, assurances by universities and hospitals that they were monitoring the research, specific criteria that investigators had to satisfy, and a list of proscribed activities replaced the reliance on the researchers' goodwill and ethical sensibilities (Rothman, 1991, p. 90).
It was the end of self-oversight.

At almost the same time, the FDA was struggling with its own regulations on human experimentation, part of the ongoing struggle since the 1962 amendment. In August of 1966, the FDA released its “Statement on Policy Concerning Consent for the Use of Investigational New Drugs on Humans.” Not only did they clarify their 1962 terms, they also devised, unlike the NIH, a relatively clear and detailed description of what “informed consent” meant: a patient had to have the ability to exercise choice and had to have a “fair explanation” of the procedure, its purpose, its possible side-effects, and alternatives to treatment. (However, it still allowed for the waiver of consent if the investigator deemed it appropriate in exceptional cases.)

In the course of three months, the face of medical research changed drastically, both in the public’s perception, through publicity surrounding Beecher’s article, and in reality, through regulations by both the NIH and the FDA. The IRB was born. The appearance of a 1972 article in the Washington Star about the 40-year syphilis experiments in Tuskegee, Alabama, can only have confirmed the need for these regulations (Jones, 1981).

C. The National Commission and the President’s Commission

Walter Mondale was an early and ardent advocate for bioethics, convening hearings three separate times (1968, 1971 and 1973) before garnering sufficient congressional and public interest in the subject. In 1974, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created under Public Law 93-348 to “identify basic ethical principles” and their applications for human subject
experimentation. In 1979 they finalized *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, which they recommended be adopted in its entirety as a statement of departmental policy on the conduct of research involving human subjects. Publication and dissemination of this policy will provide federal employees, members of institutional review boards and scientific investigators with common points of reference for the analysis of ethical issues in human experimentation. While the principles cannot always be applied so as to resolve beyond dispute particular ethical problems, they provide an analytical framework that will guide the resolution of ethical problems arising from research involving human subjects (National Commission, letter to the President [accompanying the report], 9/30/1978).

The report delivered to the public three ethical principles that should guide human subject research: respect for persons, beneficence (understood as an obligation to do no harm and to maximize possible benefits and minimize possible harms), and justice.

Having completed their mission, the National Commission was disbanded as planned in 1978, and the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research was appointed. The President’s Commission published *Defining Death* in 1981 and *Deciding to Forego Life-Sustaining Treatment* in 1983. The former defined death as “The irreversible cessation of cardiorespiratory functions or the irreversible cessation of all functions of the brain, including the brain stem.” The latter addressed many of the issues that bioethics committees have come to confront on an ongoing basis: competency, ideal decision-makers, the value of the durable power of attorney, and code status. They also advocated the formation of hospital ethics committees: “The medical staff, along with the trustees and administrators of health care institutions, should explore and evaluate various formal and informal administrative arrangements for review and consultation, such as ‘ethics committees’, particularly for decisions that have life-or-death consequences for
incompetent patients" (National Commission, 1981, p. 5). Though their recommendations were not binding, the publications of both committees had enormous impact. Almost anyone with a passing involvement in bioethics is familiar with the principles of bioethics, although they have changed somewhat since 1978. The topics raised by the President’s Commission are still much discussed and have shaped the field for more than 20 years.

D. Baby Doe Regulations

Among other federal involvements were the Baby Doe regulations, which were initially proposed in 1982 after a controversial legal case in Indiana focusing on an infant referred to as ‘Baby Doe’. The infant was born with Down’s Syndrome, esophageal atresia, and perhaps other various anomalies which the parents declined to have treated. A circuit court upheld their right to do so and the U.S. Supreme Court did not take up the case on the grounds that it was moot (the baby having died in the interim). Ronald Reagan responded to the story as it was reported in the news services and ordered the Secretary of the Department of Health and Human Services (Richard Schweiker) to see that such decisions not to treat did not occur again. Secretary Schweiker notified hospitals receiving federal funds that it was unlawful not to treat a handicapped infant (via withholding of nutrition or surgical or medical treatment) if that decision is made on the basis of the infant’s handicap and the treatment is not contraindicated by the handicap. Such failure to treat would be met with the loss of Federal funding. Shortly thereafter,

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2 Data in this section on the legal development of the Baby Doe Regulations is drawn from Gardell & Engelhardt, 1987.
the 1983 Baby Doe Regulations required that this notice be posted on a 17- by 14-inch sign in all maternity, delivery, and pediatric wards as well as all nurseries and neonatal intensive care units. The notice included a “Handicapped Infant Hotline” through which a “Baby Doe squad” could be reached for response to illegal failures to feed and care for handicapped infants.

The subsequent history of these regulations is tortuous, and includes a reduction in the required size and posting of the signs as well as a gradual retreat from the hard line against the non-treatment rule. The 1984 iteration of the regulations, for example, decreased the sign size (for the third time), and now required that “nourishment and medically beneficial treatment (as determined with respect to reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of the presence of anticipated mental or physical impairments” (italics added). In addition, the rules encouraged (but did not require) hospitals themselves to instigate Infant Care Review Committees (ICRCs), and charged them with developing policy, reviewing current cases, and reviewing former problematic cases.

The ICRCs were not meant to make moral judgments regarding treatment decisions, but instead to insure that decisions were made in conformity with the Baby Doe Regulations. Nevertheless the decisions involved issues of analysis regarding such crucial terms as “virtually futile” and “inhumane”, since the 1985 regulations recognized three exceptions to the general requirement to treat. Treatment was not required when:

(i) The infant is chronically and irreversibly comatose;
(ii) The provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant’s life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or
(iii) The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane (Department of Health and Human Services, 1985).

This obviously meant that the ICRCs had the latitude within which to render morally freighted decisions about provision or withholding of treatment by particular interpretations of ‘virtual’ futility and ‘inhumane’ treatment. As Nancy King points out,

[the final regulations do not use examples to elaborate on their discussion of treatments that, according to reasonable medical judgment, are ‘futile’, or ‘virtually futile...and...inhumane’, in terms of the infant’s survival.... But any attempt to present such terms as ‘purely medical’ or objective determinations must fail; it seems undeniable that value factors and net benefit determinations play some role in defining certain treatments as futile or as merely prolonging the act of dying in these cases (King, 1987, p. 109).

Federal involvement in the issues surrounding the care of handicapped infants contributed to the spread of bioethics committees. As in the Quinlan case, the institution of an ethics committee was recommended as a way in which to address complicated medical decision making. And also as in the Quinlan case, the bases upon which these decisions were to be made were underdetermined.

E. Conclusion

Beginning in 1962 with the Leaver-Harris amendment, the federal government became increasingly involved in biomedical ethics, requiring the formation of Institutional Review Boards and introducing requirements for informed consent in NIH-funded research and FDA drug trials. In its establishment of informed consent requirements, institutional review boards and the Baby Doe requirements, the government assigned to bioethics the role of patient protection. It also at times required them to make moral judgments: what principles should guide human subject research? When does death
occur? When does a baby’s right to live outweigh a parental right to make treatment decisions? How should “virtual futility” and “inhumane” be interpreted? The legacy of federal involvement in bioethics has been to imbue it with the responsibility to protect patients and make moral judgments.

IV. IN RE: KAREN ANN QUINLAN

The case of Karen Ann Quinlan is often cited as helping to instigate ethics committees. Karen Quinlan was admitted to a New Jersey ICU in a comatose state on April 15, 1975, and placed on a ventilator. Doctors were unable to ascertain from either physical exam or medical history why she was comatose, though it is thought that a combination of alcohol and barbiturates may have been the cause. Over a week later, there was no change in her condition, and she was described by her attending physicians as being in a persistent vegetative state (PVS). Her family was devoutly Roman Catholic, and after consultation with the family priest and a discussion of Karen’s previously expressed wishes not to be hooked up to a machine, her father Joseph Quinlan applied to the New Jersey Superior Court to become her guardian in order to authorize discontinuation of treatment.

Instead, the judge named a guardian ad litem, after which the Quinlans filed for trial. The trial was held in October of 1975, and the court granted Joseph guardianship of his daughter’s property but not of her person. The guardian ad litem became the guardian of her person and did not authorize discontinuation of treatment. The Quinlans appealed to the New Jersey Supreme Court, and the case was accepted. The trial was held on January 26, 1976, and the decision was rendered on March 31, 1976.
The facts of the case were not in dispute in either court proceeding: doctors agreed that Karen was in a persistent vegetative state and extremely unlikely to recover. (All parties also agreed that she did not meet the criteria for brain death laid out by the Harvard Ad Hoc Committee in 1968.) However, the physicians were unwilling to remove Karen from the respirator (perhaps in part from a very justified fear of legal repercussions). The Quinlans wanted treatment stopped, citing the ordinary/extraordinary treatment distinction in Roman Catholic theology.\(^3\) Karen’s treatment at this point was deemed extraordinary.

The issues upon which the Quinlans based their case were 1) the free exercise of religion, 2) cruel and unusual punishment; 3) the right of privacy, 4) the medical factors, and 5) alleged criminal liability. Chief Justice Hughes wrote the Court’s opinion, in which they found the consideration of the free exercise of religion and cruel and unusual punishment to be inapplicable. However, they did uphold the right to privacy, broke ground on the medical factor issue, and then addressed the alleged criminal liability.

With respect to the right of privacy, the court held as follows:

We think that the State’s interest contra weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual’s rights overcome the State

\(^3\) Roman Catholic theology holds it to be a moral obligation to accept ordinary treatment but not necessarily to accept extraordinary treatment.

As regards various hospital procedures, the [Roman Catholic] theologian would say that ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience. ... In contradistinction to ordinary are extraordinary means of preserving life. By these we mean all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit (Kelly, 1959, p. 129).

Treating an otherwise healthy patient with a lobar pneumonia with penicillin and oxygen, for example, would be deemed ordinary, since the patient is likely to recover fully. On the other hand, treating someone with an advanced form of melanoma by subjecting them to a surgery with the risk of death and which has a small chance of curing her would be considered extraordinary (Kelly, 1959, p. 129).
interest. It is for that reason that we believe Karen’s choice, if she were competent to make it, would be vindicated by the law. ... We have concluded that Karen’s right of privacy may be asserted in her behalf by her guardian and family under the particular circumstances presented by this record (Supreme Court of New Jersey, In Re: Quinlan, Vol. II, p. 306).

Joseph Quinlan was granted guardianship of his daughter, and the Court deemed that no physician who disconnected Karen from the ventilator would be prosecuted for “criminal homicide in the circumstances of this case.” What they said about the medical factor is also interesting. They recognized that medical practice responds to legal reality, and that while it was appropriate for the lower court judge to rule as he did, and for the doctors to behave as they did, it was also appropriate for courts to reexamine particular cases. As Justice Hughes states, “...we are required to reevaluate the applicability of the medical standards projected in the court below.” Although the court had no interest in granting physicians complete immunity in such cases, it also held that “there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients” (Supreme Court of New Jersey, 1976, p. 311). This is where ethics committees became involved.

Justice Richard Hughes favorably cites an article by Dr. Karen Teel (1975), which suggested that ethical decision making ought to be shared by a group of people, rather than conducted by an individual. Teel indicates that at the time she writes,

Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make. We are not always morally and legally authorized to make them. The physician is thereby assuming a civil and criminal liability that, as often as not, he does not even realize as a factor in his decision. There is little or no dialogue in this whole process. The physician assumes that his judgment is called for and, in good faith, he acts.
Someone must and it has been the physician who has assumed the responsibility and the risk. I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, ... which serves to review the individual circumstances of ethical dilemmas and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital settings and their official status is more that of an advisory body than of an enforcing body. The concept of an Ethics Committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point (Teel, 1975, pp. 8-9).

In citing Teel, Justice Hughes notes that

The most appealing factor in the technique suggested by Dr. Teel seems to us to be the diffusion of professional responsibility for the decision, comparable in a way to the value of multi-judge courts in finally resolving on appeal difficult questions of law. Moreover, such a system would be protective to the hospital as well as the doctor in screening out, so to speak, a case which might be contaminated by less than worthy motivations of family or physician. In the real world and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent (Supreme Court of New Jersey, 1976, Para. 143).

In addition, he says:

If there could be created not necessarily this particular system but some reasonable counterpart, we would have no doubt that such decisions, thus determined to be in accordance with medical practice and prevailing standards, would be accepted by society and by the courts, at least in cases comparable to that of Karen Quinlan. The evidence in this case convinces us that the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed (Supreme Court of New Jersey, 1976, para. 146-147).

The Quinlan case, concluding years before the National Commission convened, was the first forum in which the existence of ethics committees was addressed. Therefore, it is worth analyzing the ruling in further depth as it represents a fundamental historical ancestor to modern ethics committees and methods of ethics consultation.
A. Bioethics Committees as a Means of Sharing Legal Responsibility

Note that the language of Teel’s statements indicates that one of the primary concerns is the sharing of legal responsibility. Teel holds that the physician acting alone assumes a "civil and criminal liability" about which he may not be aware, and that it would be better "to allow the responsibility of these judgments to be shared," perhaps by an Ethics Committee "which [can provide] much in the way of assistance and safeguards for patients and their medical caretakers." Justice Hughes states that an appealing part of Teel’s suggestion is the "diffusion of professional responsibility for the decision" (which would likely include legal responsibility) that such a committee could provide. But there are a number of problems with the idea of taking this suggestion of "diffusing legal responsibility" as a goal of bioethics consultation.

First, as a practical issue, adding bioethics consultants to the decision making process is unlikely to result in any differences in how physicians and their responsibilities are treated. There is currently a trend toward using individuals (rather than committees) for bioethics consultation, as independent contractors. Such a trend would mean that responsibility in a particular case would be diffused only to one other person. This does not seem as if it would significantly impact the responsibility of the physician.

Moreover, given the heterogeneity of the field, not to mention the availability of jobs more relevant to (and lucrative than) their respective training, it is unlikely that a significant percentage of such consultants would be, for example, physicians or lawyers. Would a judge or jury be likely to divide the attending physician’s responsibility with a chaplain- or philosopher-bioethicist? It seems unlikely that such a consultant would even be sued, given the relatively small salaries that such individuals earn and the fact that
they lack “ethical malpractice insurance” (at least currently). Additionally, the present lack of standards in the field of bioethics consultation means that it would be relatively easy for lawyers to find expert witnesses willing to support a very wide variety of consulting activities as being “within professional standards”.4

A second problem with focusing on sharing legal responsibility as one of the goals of the bioethics consultant is that the shared decision making doesn’t actually diffuse responsibility. It multiplies it by making available to the plaintiff one more party to the suit. If in fact bioethics consultants were added to the list of potential candidates for lawsuit, it is plausible that a plaintiff or his attorney would increase (rather than merely divide differently) the settlement requested. Were criminal penalties to result, they would be meted out to any party to the crime; ten criminals means ten sentences rather than one sentence divided ten ways. If we understand legal responsibility to be whatever damages a judge hands down, this scenario implies that rather than diffusing responsibility, including bioethics consultants potentially inflates the total amount of responsibility to go around.

Finally, given the existence both of legal counsel and a risk management department in the hospital, the bioethics consultant qua bioethics consultant is not guaranteed to add a layer of legal protection. To the extent that she does, it may be either a) unwarranted or b) accidental. In the first case, if a bioethics consultant acts so as (that is, intentionally) to alleviate a physician’s or an institution’s legal responsibility, he or

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4 In fact, one of the most interesting sessions at the 2001 meeting of the main professional association of bioethicists (the American Society for Bioethics and Humanities) consisted of a mock trial against a bioethics consultant for malpractice. As became evident during the mock trial and in the question and answer session following, it was highly dubious that the field contained enough rope to hang itself.
she is in fact acting as a risk manager. The argument against playing such a role is merely that if this is a goal of bioethics consultants, it is a redundant goal. Since both risk management and legal departments exist in the hospital, calling someone who engages in these activities a bioethics consultant as a result of such activities\(^5\) is merely equivocating on the terms “risk manager” and “bioethics consultant.”\(^6\) Whatever is intrinsic to the role of bioethics consultant, if it were merely risk management, then we would not need the extra term “bioethics consultant.”

Additionally, however, there is reason to think that risk management is not one of the core elements in bioethics, currently understood. First, the term “ethics” and the term “risk management” might be opposed at times, since law and ethics are not identical. Second, as this chapter demonstrates, there are many other roles the bioethics consultant might play that are more patient-oriented than physician- or institution-oriented in the way that risk management is. For example, it is hard to imagine a risk manager being brought into a family conversation in order to help make treatment decisions, or being asked by a patient to help resolve his value questions. At this point I do not wish to make the argument that risk management is a prohibited activity for a bioethics consultant,\(^7\)

\(^5\) It is worth keeping in mind that in the end, we may or may not find it appropriate for someone who is called a “bioethics consultant” also to engage in risk management activities. At the moment, however, I am trying to establish what it is that we think is at the core of “bioethics consultation.” If the core activity were risk management, I argue, there would be no need for the extra term “bioethics consultant” and at least some arguments against it, as I will proceed to show in Chapter six.

\(^6\) Despite what I have said, however, it may be that simply by performing under the rubric “bioethics consultant” instead of “risk manager”, the same person might have more success in actually averting legal risk. If a patient or family member meets with a bioethics consultant, he might be more willing to appreciate another perspective, share his own perspective, or simply feel that his wishes are being taken seriously, which might in turn result in less likelihood of suit. See note 7 below.

\(^7\) After all, studies have shown that the more patients feel that they have communicated with their physician and institution, the less likely they are to sue (Shapiro, Simpson, Lawrence et al., 1989). It is clearly possible that the time a bioethics consultant spends with patients or families might add to the sum total of communication that they perceive themselves to have had with the institution. In such a case, the
only that it is not one of the “core” goals or defining activities for which we are looking. To the extent that management of risk is a side-effect of some of the activities of bioethics consultation, it may be beneficial to the hospital but need not be taken as compromising the bioethics consultant’s activities (whatever they are) provided he has throughout been pursuing the legitimate goals of his profession.

In addition, it is very interesting to note, as Ross et al. claim (1993), that Justice Hughes had the impression—mistaken, as it turns out—that there were many ethics committees in existence at the time of his ruling.\(^8\) But if it is the case that few or no bioethics committees existed at the time, and those that did had no explicit goals, where lies the history of bioethics committees and consultants? The edifice of bioethics consultation may have been built in part on a chimera, which is partly to blame for the fact that we now have a hard time discovering or establishing our foundations. This is not to argue that there is no reasonable niche that bioethics consultants can fill. It is merely to observe that if this “pseudo-existence” is in fact our history, we must examine our profession and find a center or foundation that does not rely on “what has been done in the past.” To prefigure this chapter’s conclusion, the history of bioethics suggests that there is in fact no single set of canonical historical events or social trends upon which we can build an understanding of this field. The result of that conclusion is that we must investigate the roles that have historically been associated with bioethics and bioethics consultant has perhaps engaged in risk-management behavior, but as a byproduct of another goal-directed activity (whatever that turns out to be) rather than as the goal itself.

\(^8\) As they note, “The [Teel] article incorrectly implied that many such committees existed, and perhaps the court thought it could simply add this prognosis confirmation function to the committee’s other activities” (Ross et al, 1993, p. 2).
consultation more philosophically in order to understand which of them have stronger claims as foundations for our field.

\textit{B. Bioethics Committees as a Means of Sharing Moral Responsibility}

The second observation to be made about Teel’s and the judge’s comments is that there is a concern with \textit{moral} responsibility. Teel says that doctors often have the “responsibility of making ethical judgments which [they] are sometimes ill-equipped to make. [They] are not always morally and legally authorized to make them.” Resolving whether bioethics consultants can take on or share in the moral responsibility for a particular case requires establishing the possibility of possessing the moral authority and/or expertise that could confer upon one such responsibility. Moreover, the field would have to be redrawn significantly in order to give bioethics consultants the power \textit{vis-à-vis} the hospital to enforce decisions for which the consultant must bear responsibility.

Responsibility must be accompanied by some authority.

Third, the judge notes that an ethics committee could come up with a decision that “would be accepted by society and by the courts.” If \textit{this} is the standard for a bioethics consultant’s decision, a code of ethics for the field of bioethics consultation would need to offer a rationale and standard for acceptability by society (i.e., is it majority rule, or is unanimity required?), with guidelines regarding the appropriate ways in which such a consensus can be achieved. As will become clear in the next chapter, the idea of proposing decisions that are acceptable to society (implicitly included in Terrence Ackerman’s model of bioethics consultation) has grave problems. The judge’s other
criterion, "acceptability to the courts", returns us to the issue of sharing legal responsibility.

Fourth, the judge in the Quinlan case observes that for an ethics committee, "the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed." This seems to provide for ethics committees in cases similar to Karen Quinlan's, where the issue at stake is whether treatment will return a patient to "cognitive and sapient life". In short the 'ethics committee' is to function as a prognosis committee. Since this is a task for medical experts to perform, establishing a separate committee for this purpose seems redundant.

The precedent set by the Quinlan decision suggests four aims for bioethicists, at least as assembled in a committee (at present no distinction is being made between committees and individual consultants). First, it suggests that they act as risk managers, offering legal protection to the physicians party to controversial decisions; second, that they collectively might constitute a body with the authority to make moral decisions; third, that they function as a fiduciary of society's interests in seeing that physicians do not overstep their bounds (as a sort of "moral watchdog"); and fourth, that they act as prognosis committees (i.e., medical staff committees whose job it is simply to determine whether a patient has a chance of returning to sapient life (see Ross et al., 1993, p. 1). These roles simply return us to the challenges with which we began: which is the appropriate goal of bioethics consultation? Ross et al. observe that "there is some irony in finding that the only ancestor actually called an ethics committee was given no task of
ethical analysis” (1993, p. 2). With this history of having a new function tacked onto a virtually non-existent function, can bioethics help but be conflicted about its purpose?

Aiming at the diffusion of legal responsibility may at times conflict with pursuing the morally appropriate treatment; allowing for consensus decisions does not give us guidelines regarding appropriate ways in which to achieve them. Taking these suggestions from the Quinlan case does not give us a clear delineation of the goals of bioethics consultation, and certainly gives us no priority ranking of the goals it does offer. What is required is a deeper analysis of the various roles bioethicists can play and the justification for each.

V. CONCLUSION

At least part of the intent of both the dialysis committees and the Court’s decision in the Quinlan case was the protection of doctors. The Seattle Committee wanted to help doctors make difficult decisions and “buffer” them from emotionally charged situations. The Quinlan case’s court wanted to help diffuse the moral (and perhaps legal) responsibility of doctors. The Federal government’s involvement in bioethics, on the other hand, arose in large part as a way of ensuring patients protection from doctors by establishing informed consent and research requirements, and the Baby Doe hotline. The precedent set by both dialysis committees and Federal involvement also consisted of allowing people other than the doctor and patient to become part of decision making. Moreover, this decision making involved taking moral positions on issues such as the
comparative worth of lives, the point at which a life is not worth living, and medical futility. This deep schism between potential roles for the ethics consultant echoes today.

Of course there are many other events that contribute to the contemporary nature of the bioethics committee - the Nuremberg trials, the upheaval of the 1960s, the Catholic medical-moral committees that had been fairly widespread even before the President’s Commission, and the general challenging of authority taking place in American society. Medicine itself was also changing, as Rothman points out, and both the doctors and the institution became ‘strangers’ to patients, losing the close ties that fostered trust and shared decision making (Rothman, 1991, Ch. 6). In addition, specialization increased, the practice of house calls ended, the monitoring of patients became technologically sophisticated (so that physicians might find themselves reading dials and lab results more than touching patients), and the training and hours became more intense (Rothman, 1991, Ch. 7). It is not surprising, then, that outsiders became involved in bedside ethics. Their involvement, however, did not clarify matters.9 As the next chapter shows, even those who have devoted considerable time and effort to reflecting on bioethics consultation have deep differences of opinion about its nature and goals.

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9 Therefore those who argue, as does Joseph Fletcher, that “[i]dentify crises or confusion about what roles are appropriate for ethics committees to play can be minimized if one understands the functions performed by such committees in the past...” are mistaken (Fletcher, 1991, p. 860).
CHAPTER THREE:

INTERNAL AND EXTERNAL MODELS OF BIOETHICS CONSULTATION

I. INTRODUCTION

The historical roots of bioethics give many potential roles for bioethicists to play, but none that is paradigmatic. While history does not offer a definitive answer, might bioethics consultants themselves suggest a solution? And if so, have they arrived at a consensus definition of bioethics consultation? In the first section, I examine four accounts of bioethics consultation, giving primary attention to the following authors selected for their importance in framing the field: Terrance Ackerman, Benjamin Freedman, John LaPuma and David Schiedermeyer, and Jonathan Moreno.

There is no resolution to be found here, either. While there is some overlap in suggested roles, there are also significant differences between the accounts. They point to very different understandings of the normative roots of the field. For example, one author (Freedman) argues that bioethicists ought to be “heroes,” resisting institutional cooptation whenever necessary, even to the point of losing their positions. Ackerman considers bioethicists as consultants to physicians, to be dismissed once the physician considers the consult sufficient. In addition to the fact that there is conflict between many of the roles these authors suggest, each has problems of its own that would prevent it from being coherently adopted as the aim of bioethics consultation. Ackerman, for

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1 The philosophical justification of such a consensus is a different, and larger, question. However, since I will argue that such a consensus does not in fact exist, I will not explore the justification and normative claims of consensus on this question further.
example, suggests that the bioethics consultant may give advice regarding what decision is "capable of evoking a share and stable social commitment," but does not sufficiently describe on what such a commitment depends. LaPuma and Schiedermayer's main concern is to give practical guidance for the profession, which among other things includes how to bill for one's services. To the extent that they give any philosophical justification, it is usually brief and ambiguous. What it implies for the actual aims of bioethics consultants is therefore unclear. Freedman argues that the bioethics consultant exists to give concrete moral guidance. Notwithstanding the fact that the content of such guidance is disputed, he roots his account in Judaic sources, claiming that it "has much to recommend it" even to those who do not share that faith. Moreno's account seems most concerned with explaining how the recommendations of bioethics consultants can possess moral authority. There are philosophical problems with his argument for this moral authority, but more salient for the issues being considered here is the fact that there is nothing binding about these recommendations. Moreover, very little can be implied from his argument about the permissible and impermissible roles or activities of a bioethics consultant. The results of this chapter point the way to Chapters 5 and 6, which, respectively, examine the normative arguments for the tasks of bioethics consultants and investigate their subsidiary roles for bioethics consultants.

Prior to moving to Chapter 5, however, one task remains. The primary professional organization of bioethics, the American Society for Bioethics and Humanities (ASBH) has published a document focusing on bioethics consultation. This document will be investigated in depth in Chapter 4 for its suggestions regarding bioethics consultation. One might also argue that a viable conception of the field can be
found in an examination of how others view and utilize the profession. Notwithstanding the fact that part of what I want to determine is how bioethics consultants can have a self-understanding independent of how other professions views of the field, I will also in Chapter 4 briefly examine how the American Medical Association, American Pediatric Association and American College of Obstetricians and Gynecologists understand the role of bioethics consultants. I argue that these external understandings of the profession give even less detail regarding bioethics consultant than the other accounts I examine.

This chapter and the following set the stage for later chapters by arguing two points. First, there is no consensus, either within our outside of the profession, to be found on the role and function of a bioethics consultant. Second, many of the goals advocated by different models are incommensurable, and therefore further analysis is required in order to determine appropriate roles for the bioethics consultant. To the extent that one would like to maintain bioethics consultation as a legitimate profession, then, it is necessary to investigate further the limits and scope of its functional role.

II. INTERNAL MODELS OF BIOETHICS CONSULTATION²

A. Ackerman’s Model

Terrence Ackerman recommends a model of bioethics consultation based both on straightforward consultation (i.e., awaiting a call for consultation from a physician, who determines the focus and purpose of the consultation) and on mediation or facilitation. To understand his proposal for bioethics, however, it is necessary to examine briefly his understanding of a) the nature of moral problems and b) the methodology for resolving

² By ‘internal’ I mean models of bioethics consultation that arise from those within the profession.
moral problems that he believes follows from (a). He understands bioethics consultation to be an example of how this methodology is applied to practical moral problems.

1. The nature and resolution of moral problems

Ackerman’s position is laid out in two papers, ‘Moral problems, moral inquiry, and consultation in clinical ethics’ (1989) and ‘The role of an ethicist in health care’ (1987). Noting that the deductive model of ethics (where it is presumed that one can deduce practical guidelines from overarching normative theories) has been widely discredited, he asks, “If the deductive model is bankrupt, how shall we avoid reverting to reliance on moral authority or admission of a paralyzing relativism in matters of moral concern?” (1989, p. 142).

His answer is to suggest that the resolution of these problems depends upon the nature of the problem. His first step is to delineate the three distinctive features of practical moral problems: 1) “at stake is the determination of the conditions we will observe in our interactions with one another under specified circumstances” (1989, p. 144); 2) different plans of action will achieve or frustrate different values or states of affairs; and 3) initially there is a lack of consensus about which plan of action ought to be pursued. As a result, “[t]he purpose of moral inquiry is to formulate norms of behavior that evoke shared and stable commitments among the members of the moral community. ... Thus, resolution of a moral problem involves a broadening of our shared interests or common moral bonds” (1989, p. 146). This may, he notes, require that some revise their values in order “to take fuller account of the moral concerns of others” (p. 147).³

³ It is ironic that while Ackerman points out that there are “no normative theor[ies] generally accepted as valid” (p. 141), he assumes that the principle requiring social consensus is valid. Of course, one might
According to Ackerman, shared social commitment to realizing particular states of affairs should also be stable. So, he concludes, "[t]he methods appropriate to moral inquiry consist in the analytic procedures useful in achieving stable and shared commitments" (1989, p. 148), which has four components: 1) identification of the states of affairs that members of society value; 2) understanding of relevant data; 3) identification of alternative solutions; and 4) comparison of how the alternatives succeed or fail in achieving valued states of affairs.

Ackerman’s moral philosophical grounding is somewhat difficult to pin down, unless one loosely names him a pluralist: at various points he seems to argue for consequentialism or pragmatism, either a hypothetical or actual social contract, and casuistry as philosophical justifications. It is therefore not clear to what else his foundational account may commit him.

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4 He does not say why, but since in this article he is discussing moral inquiry in a broad context (rather than in bioethics consultation), presumably he thinks the commitment should be shared and stable so as to prevent domestic unrest.

5 "...lack of complete success in resolving moral problems does not in itself undermine the usefulness of a methodology. Rather, the crucial question concerns which conceptualization of the methods of moral inquiry permits the most effective resolution of moral problems" (1989, p. 151, italics original).

6 "...this view of moral inquiry ... as an inherently social process ... means that when engaging in moral problem solving, we commit ourselves to identifying a plan of action that is capable of evoking a shared commitment. Since moral problems involve an initial lack of social consensus, the plan of action chosen must be supportable by others who would engage in the same process of thorough reflection" (1989, p. 150, italics added); "[My view] makes the moral justification of a plan of action hinge upon its capacity to evoke a shared and stable social commitment among the members of the moral community" (1989, pp. 151-152).

7 "Through the comparison of solutions to various kinds of moral problems, recurrent features of justified plans of action get identified. These recurrent features are formulated in moral principles ... [I]nsofar as they summarize the wisdom of past moral experience, moral principles provide critically important methodological tools in constructing solutions to moral problems" (1989, p. 152).
2. Ackerman’s understanding of “society”

Ackerman also does not describe in detail who the “members of society” are who share values. Such an account will have a significant impact on how “shared social commitment” is to be understood and achieved. Some headway in understanding his meaning may be made by inference from his 1980 article, ‘What bioethics should be.’ In it he suggested that moral evaluation is concerned with acceptability (he focused on policy making in this article, but the general point is the same), and expands on to whom it should be acceptable: “The answer is: accepted by persons i) who have aims or values which bear upon the choice of a policy, ii) who have engaged in thorough examination of the probable consequences of available policy options, and iii) who genuinely desire to revise the set of aims in a way that allows for the establishment of a unified policy” (1980, p. 265). However, as Basson later observes (1983), this a) offers no justified standpoint for criticizing each party’s goals, b) does not explain how we are to choose among mutually exclusive goals, and c) has no provision for treating similar cases similarly. His account is therefore problematic at the outset.

3. The role of the bioethics consultant

With this description of practical ethics, Ackerman assesses the role of the bioethics consultant. He claims that consultation begins with the reason for the consult: “The physician is faced by a moral problem and needs help in resolving it. Thus, we may propose that the basic function of the ethics consultant is to facilitate the process by which reflective resolution of a moral problem may be achieved” (1989, p. 153, italics original). In his view, facilitation can involve 1) “the classification and diagnosis of the
moral problem presented by the situation”; 2) the identification of alternative plans of action; 3) helping others to understand better the facts of the situation by the consultant’s sharing his understanding of social science; 4) the elucidation of how various plans of action will help to achieve or frustrate various desired states of affairs; and 5) recommending a proper solution.

There are a number of observations to be made. First of all, “facilitation” is an ambiguous term. Etymologically, it means “to make easier.” If we take this to be the goal of ethics consultation, it implies no answer to many of the questions I raised in the introduction about what bioethicists ought to do or for what goals they ought to aim. In addition, it is merely an umbrella term representing other possible activities of the bioethicist. For example, the first four activities of facilitation that Ackerman suggests are really clarificatory roles: the consultant’s purpose is to ensure that the issues, values, consequences and facts are made clear. This does facilitate discussion among the concerned parties, but it actually gives the bioethicist a proactive role to play in the clinical setting. With no direction about what he is to “facilitate,” he can go to work and judge his success based on the goal of clarification, a role that will be discussed in more depth in Chapter Six.

Ackerman’s fifth observation is that the bioethicist may be asked to make recommendations. However, he says,

[1]his role must be carefully circumscribed. It is not the function of the ethics consultant to deliver ‘right answers’ to the moral quandaries of physicians. This role makes sense only if a) there are moral truths independent of moral choice, and b) these truths are able to be discovered and applied to morally problematic situations by philosophers using their special investigative skills. By contrast, we have seen that moral inquiry is a reflective process in which we seek to identify plans of action capable of evoking shared and stable social commitments. Appropriate norms of behavior cannot be identified apart from the input of other
members of the moral community. Since justified norms of behavior are socially produced outcomes, the ethics consultant cannot claim to know what is morally right independently of participation by others in the investigative process (1989, pp. 155-156).

He takes a firm stand against the idea of moral expertise, but this stand depends on his assumption that such expertise can only exist if “there are moral truths independent of moral choice” which “are able to be discovered and applied to morally problematic situations.” However, some argue that there certainly are right answers that a bioethicist can offer which do not stem from “moral truths independent of moral choice” (see, e.g., Moreno’s position later in this chapter; Agich & Spielman, 1997). In other words, “right answers” to moral inquiries are not necessarily equivalent to “moral truths independent of moral choice”.

Additionally, if Ackerman is taken to defend a hypothetical or actual contract as the basis of morality, he is also implicitly arguing that the bioethicist can offer a “right answer” when he suggests that bioethicists can help determine what answer would be “capable of evoking shared and stable social commitments.” In Ackerman’s opinion, any moral recommendation by the bioethicist should be taken to be an hypothesis to the effect that the plan of action is capable of evoking a shared and stable social commitment, because it will effectively realize the states of affairs that members of the moral community will cherish after thorough reflection. In making a recommendation, the consulting ethicist must underscore the fact that it does not merit acceptance independently of the confirmatory reflection of the persons consulted (1989, p. 156).

In short, Ackerman views the bioethics consultant as someone with a) an accurate idea of what is capable of evoking a shared and stable commitment, and b) the ability to judge whether such a decision is capable of realizing valued states of affairs.
Before summarizing and analyzing Ackerman’s conception of ethics consultation, it is worth noting additional recommendations he made in his 1987 article. Overall, the model is the same as it was in the 1989 article, but in the earlier article he specifically mentions roles that the bioethics consultant ought not to play:

1) “One is the function of ‘moral policeman’ - identifying instances of immoral behavior by health professionals” (1987, p. 315);

2) “A closely related, but more subtle, mistake is ascribing a ‘patient advocate’ role to the consulting ethicist. A patient advocate represents the patient in efforts to correct a situation in which the latter’s interests or rights may be violated” (1987, pp. 315-316);

3) “A third mistake confuses the role of the ethicist with a task traditionally assigned to the clergy. ... The ethicist is sometimes thought to be a ‘secular clergyperson’” (1987, p. 316);

4) “Another inappropriate role conceives the ethicist as a modified psychologist or counselor for health professionals” (1987, p. 316).

In his view, these four mistakes have something in common:

Each conceives the ethicist’s activities as focusing upon the rectification of particular circumstances that result in failure to treat patients according to commonly recognized norms of conduct. ... Thus, proper conceptualization of the role of the ethics specialist requires a clear understanding of the type of moral problem to which his or her professional skills are applied (1987, p. 316).

Ackerman, in other words, sees bioethics consultation as almost purely reactive; a bioethicist should come and go on the request of a physician, and should not represent independent parties or ideas. Notice here the fundamental difference between his conception of the consultant’s task and the conception suggested the historical precedents discussed in chapter 1. The most striking is that he specifically suggests bioethics consultants ought not to be patient advocates, which he describes as follows: “A patient advocate represents the patient in efforts to correct a situation in which the latter’s interests or rights may be violated.” Given the historical fact of the rights violations of patients (for example, in many research projects) that helped to bring bioethicists into the
hospital, it is rash to make such a claim without argument. As will be seen below, one prominent bioethicist (Freedman) argues that patient advocacy and a form of moral policing (bioethicists as ‘heroes’) should be part of bioethics consultation.

4. Problems with Ackerman’s model

Ackerman’s model of bioethics consulting has problems independent of the fact that his account conflicts with historical precedents and Freedman’s view. The philosophical foundations of both his positive recommendations and his argument against bioethics consultants playing particular roles are left unexamined. (In three of the roles that he forbids, the justification for prohibition seems to be simply that they are not in harmony with the facilitation model that he suggests (1987, pp. 315-316).) In addition, as Freedman argues,

Since [in Ackerman’s view] the doctor is the decision maker, anything the doctor judges as assisting the decision did in fact assist it, and if that is right, then the measure of an ethicist’s effectiveness is the satisfaction of the physician requesting the consultation. What if the physician is pleased with the consultant because he or she has provided an ethical imprimatur on behalf of the corrupt course of action that was planned? What if the physician is displeased with the consultation because its resolution, though beneficial for a patient, complicated his or her life? It matters not (1994, p. 111).

... under this conception, the health care ethics consultant is a slave (p. 112)

Freedman points out that the implication of Ackerman’s view is that success or failure of a consultation depends entirely on the doctor’s satisfaction. The question of whether the patient’s interest was served, or justice observed, or ethical standards met is simply not germane. The ethicist on this conception is a wax seal on a doctor’s choice.

Another problem with Ackerman’s view is his understanding of ‘shared social commitment’. Most fundamentally, there is the question of whether he means it to be
hypothetical or actual, the choice of which has serious implications for the conduct of consultations. For example, if he advocates hypothetical contract, it might be the case that all parties to a particular consultation choose B, but since “members of society” (those who have a ‘shared moral commitment’) would in a hypothetical situation choose A, A would be the right decision. On the other hand, if he means to base his model on actual contract (i.e., actual shared social commitment), different problems arise: who is the “society” in a particular consultation who must contract with each other? It is far from obvious that only the doctor and patient count; families, nurses, social workers and hospital administrators might all have an interest in a particular case. Nothing in Ackerman’s account gives any basis for including or excluding anyone in particular.

Furthermore, there is the problem of what to do if the parties cannot reach mutually satisfying conditions to the contract. Does one party have veto power? Once Ackerman starts to answer these queries, he is forced to rely on the content of specific moral commitments that may be in conflict with the stated goal of achieving ‘shared social commitment’. His conundrum is that offering a particular conception of what counts as a shared social commitment means that that conception itself is not a shared social commitment.

Additionally, there is a problem with the normative scope of a shared social commitment. Which values are more or less important to be shared, and why? Even if Ackerman attempts to limit the range to values involved in health care, problems remain. It is hard to see how such a limit can be justified, since it is easy to imagine that most ‘social’ values, defined broadly enough, would impact health care choices in some way. If so, then the limit is trivial because it excludes almost nothing. For example, the
diversity of aversion to risk among members of society will dictate great discrepancies in what kind of health care each member is willing to subsidize.

The depth of commitment is at issue as well; we might all share a superficial commitment to limiting the experience of pain in ourselves and others, but when resources are reallocated from some areas of medicine to others in order to reduce pain for some patients, we may quickly find ourselves beyond the depth of such a shallow commitment. As Engelhardt has argued (1996; 1991) we simply do not have the same values. Additionally, his account does not establish how one ought to incorporate rigidly-held views (see footnote 3). Unwavering commitment to a value or belief is held by some in the highest esteem. It is therefore not obvious that consensus is the only desirable goal of bioethics consultation.

Finally, the facilitation view yields only minimal standards of success for the bioethics consultant. It might depend entirely on the physician’s opinion. It might also depend on whether the consultant is right that a particular decision is capable of evoking a shared social commitment. This standard, however, seems difficult to establish. The questions remaining are which commitments are salient, who counts as society, and how deep the commitment is or ought to be. Assigning such discernment ability a priority in importance for evaluation seems relatively contingent and arbitrary. If some of the critics of bioethics consultation are to be answered, the field should have some way of evaluating its practitioners. Ackerman’s model gives no provisions or basis for this.
B. LaPuma & Schiedermayer’s Model

The model of bioethics consultation suggested by John LaPuma and David Schiedermayer bears a family resemblance to Ackerman’s, with its focus on clinical consultation, but presents a conception of ethics consultation rooted in entirely different premises. These authors offer a “clinical model” — one based on understanding the ethicist’s role as primarily clinic-centered, requiring substantial clinical knowledge, and best performed by a physician or nurse with additional ethics training. Repeatedly, they stress that the optimal candidate for the position of ethics consultant is a clinician, or at least someone with extensive clinical training.8

Their position is discussed in two papers (1991a and b), and most fully developed in their 1994 book, “Ethics Consultation: A Practical Guide.” Practical it is indeed, with chapters on “Training, Skills and Certification” and “Setting Up Practice” (sections here include, among others, ‘compensation and billing’ and ‘malpractice prevention’). Almost no attention is given to a philosophical justification of the job or its roles, and indeed, this seems to hold almost no weight. Yet this philosophical justification is vital, as proposed models of bioethics consultation (both those of LaPuma and Schiedermayer and others) actually fail to provide guidance when the premises are not made explicit and justified. For example, the evaluation of Ackerman’s ‘shared social commitment’ shows that the goal of “facilitation” does not guide the consultant at all when she asks towards what purpose or goal she ought to direct her mediation or facilitation activities. If a justification were offered for why mediation or facilitation is important, however, the reason given would help to guide one’s activities.

8 “Skill in clinical judgment underlies effective consultation, enabling the consultant to make the medical distinctions that are technically and morally relevant in each case” (LaPuma & Schiedermayer, 1991a, p. 156).
I will discuss the general issue of justification in Chapter Five. At present it is sufficient to note the paucity of LaPuma and Schiedermayer’s justification for their account of bioethics consultation. Throughout, they focus on the details involved in ethics consultation. The book delivers on its promise of practical guidance, at least for setting up a practice: there is an entire chapter on “Setting Up Practice”, which includes arranging coverage for ethics call if one must be out of town, preventing malpractice problems, “establishing credibility”, and “compensation and billing”. Unfortunately, guidance on what one ought to do in an actual consultation is relatively meager.

One line in LaPuma and Schiedermayer’s volume captures a focus of my project: “Ethics consultants should help write their own job descriptions” (1994, p. 70).

However, in their account, immediately following this line is a discussion about hours spent in fulfilling each responsibility, whether hourly or percent-of-time accounting is preferable, and the possible need to request more resources from the hospital if one finds oneself without sufficient time to accomplish these responsibilities. Obviously none of this satisfies the need to examine the goals of bioethics consultation in more detail, and indeed begs the question of the premises and justification of the role of a bioethics consultant. However, there are claims and implications to be found in the volume, which will help to outline the model they propose.

The minimal moral justification La Puma and Schiedermayer offer for bioethics consultation “derives from the mandate to protect the patient and foster shared decision making in the clinical setting” (p. 41), which originates in the President’s Commission recommendations (President’s Commission, 1982). Additionally, “[t]he primary clinical justification for ethics consultation originates in the doctor-patient relationship” (p. 42).
They also suggest that the fact that bioethics consultations can be helpful is itself a legitimization of the practice.⁹ Among the challenges facing the profession of bioethics consultation, the first is whether there is even a need for their services. Since a precondition for a consideration of the goals of bioethics consultation is that there is such a need, here I will merely take La Puma and Schiedermayer’s justification as prima facie reasonable. However, even if it is a needed profession, their argument is not helpful in giving any specificity regarding its goals.

The underspecification of their model extends to the purposes and goals of ethics consultation as well. Here is what they say about purposes: “...a central purpose of ethics consultation is to help effect an ethical outcome [which is one that] is commensurate with the patient’s good, given the medical facts and personal circumstances” (1994, p. 28). Again, this is an unexceptionable goal, because it says next to nothing about what actions are permissible and impermissible in pursuit of the consultation. For example, in what ways may an ethics consultant “effect” the outcome, and how far does his authority to do so extend? May he attempt to convince a patient and family to change their minds?

Additionally, as is discussed below, if only physicians may instigate an ethics consultation, there will be limits to what the consultant can achieve in the absence of such permission.

LaPuma and Schiedermayer are somewhat more specific about the possible roles a bioethics consultant may play: “The consultant’s possible roles include those of

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⁹ “Ethics consultants’ demonstrated ability to help resolve ethical dilemmas in patient care legitimates the use of ethics consultation. ... The physician’s need for analysis and advice in individual cases, the institution’s need for counsel in patient-related policy issues, and the patient’s need for an advocate further legitimates the use of ethics consultation” (La Puma and Schiedermayer, 1991a, p. 155). (Interestingly, they add: “Physicians’ concerns about liability and payers’ concerns about the costs of care have fueled the search for special expertise” (p. 155). This implicitly recognizes the perceived usefulness of bioethics consultants from a risk management standpoint.)
professional colleague, case manager, patient and physician advocate, negotiator, and educator” (p. 52); and “[w]hen a patient’s situation mandates it, the consultant is a patient advocate” (p. 53). They mention ‘case manager’ mostly to disregard it; the only time a bioethics consultant should be a case manager is “[w]hen a patient’s medical interests are threatened or when the primary physician is unavailable or cannot attend to the patient” (p. 53). Relative to the other roles that bioethics consultants play, the role of educator is unproblematic. Certainly there are questions that could be raised about being an educator, but at root this role consists in conveying information about factual matters, in this case matters such as existing bioethics law, moral theory and hospital policy. If there are issues to be raised about education, they involve much more than bioethics consultation, and the questions about consultation itself appear much more pressing. As a result, I leave this role aside at present, to return to it in Chapter Six.

The discussion of the role of “professional colleague” is worth notice. It is an interesting suggestion, revealing in La Puma and Schiedermayer’s work a preoccupation with the consultant’s “fitting in” to the clinical milieu. A few quotes are demonstrative of this concern:

Earning credibility is especially difficult because it is both personal and professional. Besides the skills previously suggested...the clinical ethics consultant must demonstrate the four A’s: affability, accuracy, availability, and affordability (p. 69).

Without a sense of understanding the particular distinguishing traits of a clinical setting, the consultant risks being viewed as an outsider. Moreover, the ethics consultant may be viewed as someone with a negative or condescending attitude toward requesting physicians. Doctor-bashing ethics consultants will fare poorly – their knowledge will be seen as peripheral and their recommendations as overarching and irrelevant. To earn credibility the consultant should try to attend and, when possible, participate in morning report, mortality and morbidity conference, grand rounds, and attending rounds (p. 70; italics added).
What these lines imply is that the authors are concerned that the bioethics consultant be kept under control, in a sense. Though affability is a pleasant trait to have in a colleague, it also implies someone who will not disturb the peace with outrageous proposals or challenges to the status quo. Availability is another safe trait in a colleague, and one especially attractive to busy doctors. Affordability is a curious trait to have to demonstrate, and at this point in the development of bioethics consultation, seems to put the cart before the horse: there is no consensus that bioethics consultants even ought to bill for their time. Finally, accuracy is a trait that might appeal to empirically minded doctors, but here it is not at all clear about what bioethics consultants ought to be accurate, as Judith Wilson Ross has observed.10

The curiosity of the role of ‘professional colleague’ stems from the fact that the role of ‘professional colleague’ should seemingly be played by everyone in the clinical setting: why single this out as a specific role for the bioethics consultant to play? Here again is a suggestion that bioethics consultants ought to be a fairly domesticated group, steeped enough in the ways of the hospital that doctors can “get along” with them. Implicit in these suggestions of appropriate roles for bioethicists is the assumption that physicians, a particular hospital or hospital policy, or the medical establishment itself, are never the source of bioethical conflict. There is no need for bioethicists to “speak truth to power”; on this account power is not the problem. The onus is on the bioethics consultant to “fit in” and learn the language and customs of the hospital, regardless of the job he or she is there to do.

10 “My problem with ethics consultation and its evaluation parallels one that haunts the practice guideline movement: How can you give authoritative guidance to physicians about practices when you have insufficient data about outcomes upon which to base that authoritative guidance? ... With ethics consultation...the data are not simply ‘insufficient’: There are no data, there is no evidence” (Ross, 1999, p. 32)
Obviously La Puma and Schiedermayer do not see ethics consultants as Socratic gadflies on the institutional conscience. They, like Ackerman, insist that ethics consultations be called only by the primary physician, although they temper this later with the insistence that the primary physician at least *assent* to the consultation. They speak disparagingly of the possibility that others might request a consultation:

In their wish to serve all members of the health care community, some ethics consultants accept requests from persons other than the attending physician. While this view is understandable and appears egalitarian, the consultation risks failure without the assent of the attending physician. For the consultation to be effective, the attending physician must at least agree with the request (1994, p. 3).

The reasons for this insistence include possible discourteousness or arrogance on the part of the consultant, the fact that the physician's assent facilitates the consultant's job, and that the final responsibility for the patient rests with the physician. Additionally, astoundingly, they say: “even if another member of the medical team wants an ethics consultation, the attending physician does not always want or need such a consultation” (p. 5). In an earlier article, they state: “the primary physician engages and dismisses the consultant. ... Uninvited consultants should not intercede in cases: Ethics consultants should not be moral policemen” (1991a, p. 158). In light of the important history of bioethics with respect to patient protection, it is not at all clear that ethics consultation ought to depend on the physician’s desires, and good reason to think that it should not.

This has repercussions for a consideration of their suggested role of advocating for the physician or the patient. Interestingly, to my knowledge this is the only account of bioethics consultation in which it is suggested that the consultant is a *physician* advocate as well as a patient advocate. There is tension in the work over this issue. In one place, they note that “[w]hen a patient’s situation mandates it, the consultant is a
patient advocate. The ethics consultant’s primary duty is to the patient, although he or she also has duties to the requesting physician” (1994, p. 53). Yet if the consultant can only be called by the physician, the first line of defense for patient advocacy is circumvented. They do acknowledge that sometimes cases arise where the problem is with the primary physician himself. In a case in which someone asks for an ethics consultation because of a problem with the attending physician, they suggest, the ethics consultant should point out to the person requesting the consultation the appropriate procedures for resolution of the problem. As they see it, “[t]hese options encourage action to prevent harm to the patient but also acknowledge that an actual ethics consultation cannot occur unless there is an invitation from the attending physician. ... The consultant cannot hope to survive the role of an uninvited moral troubleshooter” (1994, p. 5). There is a procedure to be followed in the hospital which even the bioethics consultant must respect.

Finally, they suggest that a consultant might function as a negotiator. In what ways may a consultant play such a role? La Puma and Schiedermayer note that reasonable people can disagree about moral values, but also suggest that “[t]he role of negotiator may include using persuasion, as ethics consultants have a professional obligation to effect ethically permissible outcomes in their case” (p. 53; italics added). Again, what counts as ethically permissible and where the lines beyond which persuasion is inappropriate lie are not discussed.

The model La Puma and Schiedermayer advocate is clinical, meaning that the entire activity of bioethics consultation is focused on the clinical setting. This focus results in a model that recommends visiting the patient who is the subject of the
consultation, including conducting a physical examination (which incorporates evaluation of “mental status, central nervous system, major organ systems, lines, catheters, tubes, and drains, presence and effects of mechanical restraints, pressure sores and ecchymoses” (1994, p. 16)). When this is combined with their conception of the roles of the bioethicist, it is not surprising that they recommend that only clinicians (whether nurses or physicians), or at least non-clinicians with extensive clinical experience, serve as ethics consultants.

It is legitimate to suggest that ethical issues can be missed or misinterpreted when one lacks clinical experience. Despite this, however, a cynical mind could easily conclude that the authors mean to defend the purview of physicians by excluding non-physicians from medical decision making. Alternatively, they might mean by taking the initiative in defining the scope of the bioethics consultant’s activities to maintain at least some control over the field. On a more charitable reading, however, LaPuma and Schiedermayer, in their concern that the clinical aspect of bioethics consultation not be lost, are simply overcautious regarding this point and insufficiently attentive to other requisite knowledge for bioethics consultation. Consider the other “home” disciplines of bioethics: philosophy, religious studies, medical humanities, etc. Often such bioethics practitioners have earned a Ph.D. that involves an amount of schooling comparable to medical training. It seems unduly quick to suggest that while a non-clinician bioethicist might require extensive clinical training in order to be an adequate consultant, a clinician bioethicist might not require similarly extensive training in other areas such as moral philosophy. It is much more reasonable to suppose that there are talents and fields of expertise that both bring to an ethics consultation, and that absent a consultant who is an
MD/PhD (though surely he or she would have other gaps in knowledge), physicians and non-physicians must work together on ethics cases.

Additionally, however, there are those who suggest that specific reasons exist regarding why a bioethics consultant ought not to be a clinician. Jonathan Moreno gives several. He notes, for example, that there is no issue of ‘turf’ when a consultant is not a physician; “there are no grounds for professional jealousy between a philosopher and a physician” (1991c, p. 193). In addition, however, it is a non-clinician’s very ignorance of clinical medicine, with which La Puma and Schiedermayer are concerned, that might prove to be advantageous. Moreno recounts the fact that frequently, as an “outsider” ignorant of technical details surrounding a case, he is able to ask naive questions that others would be afraid or unwilling to ask, upon which an entire case may turn. It is not obvious that ethics consultants must be clinicians, and many reasons to view the outsider role as both historically important and theoretically preferable.

Finally, the standards of success La Puma and Schiedermayer suggest provide no further substantive clarification regarding the consultant’s job:

Performance evaluation criteria might include whether the consultant demonstrates in a quantifiable way the roles of professional colleague, negotiator, patient and physician advocate, case manager, and educator. ... Secondary evaluative standards include achievement of institutional goals and the consultant’s personal goals. If the consultant’s skills and roles can be defined clearly in behavioral terms, the evaluation might be conducted in these terms ... The institution may be able to assess the consultant’s demonstration of the four A’s.... Criteria that should not be used for evaluation ... include the amount of money he or she has saved the hospital, the length of written consultations, or the number of references provided per consultation (1994, p. 82).

In other words, having defined the roles that a bioethics consultant ought to play, the only way of assessing whether a person is good at the job is whether they have demonstrated these roles. Since these roles are underdetermined and vague, however, it is not clear
what it would mean to perform them well. Their “secondary” standards actually complicate the situation, for they give no account of whether the content of the institution’s or individual consultant’s goals matter at all. An important challenge to bioethics consultation concerns the degree to which an individual might abuse his position in order to advance his own personal goals (whatever their nature), yet LaPuma and Schiedermayer include this advancement as a potential standard of success. And again we see the “four A’s”; the authors suggest that a consultant’s affability, availability, affordability and accuracy might be hallmarks of success. Yet one can still ask: Availability for what? Accuracy in what? Affordability compared to what, and why? And why is affability a central trait?

They also suggest the following “Potential Quality Indicators for Ethics Consultation”:

consultant is personally involved in the case; the process supports patient’s goals and values; alternatives are described; the consultant is perceived as useful; requesting physicians describe increased knowledge; requesting physicians perceive collaboration; there is a reduction in futile and excessive treatment; there is an increase in desired and useful treatment (1994, p. 31; italics added).

These criteria highlight again the passive, conciliatory nature of the clinical ethics consultant as these authors see it: several of these criteria stipulate that the physician’s perception of the consultant’s success is the actual determinant of success. One criterion is vague: is the consultant “personally involved”? It is not clear why personal involvement should be an indicator of the quality of an ethics consultation. After all, such involvement might lead to grievous problems. There are good reasons for professionals to maintain a certain level of detachment. It is as well unclear what they understand to be futile, excessive or useful treatment.
This model is far too underdetermined to answer the questions I have posed for the job description of the clinical ethics consultant. There is also tension within the work over the question of patient versus physician advocacy and their requirement that only physicians may request ethics consultations. I have not yet made any claims regarding what bioethics consultants ought to do, but it is important to note the prima facie intuition that more independence ought to be granted to the ethics consultant if there is any hope that the job can be conducted with integrity. An additional problem in adopting this model is that it is quite opposed to other reasonable models suggested in the literature. Absent a philosophical defense, there is no prima facie reason to adopt LaPuma and Schiedermayer’s account instead of another.

C. Freedman’s Model

Benjamin Freedman has written extensively about many aspects of bioethics consultation, including his personal experiences and cases (1981b; 1998; 2000), the working conditions consultants ought to expect (1989; 1994), and the foundation of bioethics consultation (1978; 1981a; 1999). After the earlier portion of his career devoted to considering professional morality (see, for example, his 1978 and 1981a papers in the journal Ethics), followed by his participation in ethics committees in Canada (see his 1981b for an early description of his experiences), it is natural that bioethics consultation would come to be a focal point of his research. A reading of his papers in chronological order gives one a sense of both his personal development and the development of the field of bioethics consultation. Early papers indicate a hesitant philosopher, unsure of his purpose but sure that he has something to offer the field (though what that was seems to
have been unclear); later papers offer the voice of a seasoned practitioner who has some
clear ideas for the field, with some qualifications about his expertise. One of Freedman’s
later articles (1998) offers concrete guidance in a particular sort of case, and his final
work is a normative theory meant to guide the field and correct some of what Freedman
perceives to be misconceptions of the job (specifically including Ackerman’s
conception). Likewise, when literature on bioethics consultation, or “ethics at the
bedside” began to appear, it was very tentative. Authors often relied on anecdote and
personal narrative to explain their experience in a new field. Soon papers appeared
which took a more theoretical stance on the clinical situation. As more people entered
the field, the literature evidenced a growing sense of engagement in a legitimate, shared
pursuit (perhaps legitimate because shared), and confidence in offering opinions seemed
to grow.

Interestingly, while his 1994 paper argued that no internal morality of bioethics
consultation exists,\textsuperscript{11} in his 1999 volume he offered an account of an internal morality
that can inform bioethics, the model of duty. He contrasts this model with two other
models: the model of rights, and the model of the ethics consultant as expert consultant.
Freedman sees the rights model as rooted in the patients’ rights movement, and considers
bioethics consultation to be the “second stage” in this development. On the rights model,
a consultant’s job is to help resolve issues that arise in the clinical setting, often by
clarification of the rights at stake, and sometimes by a determination of the “winner” in
the rights conflict. It is attractive in part, Freedman notes, because of the place of

\textsuperscript{11} “The task of delineating a profession’s internal morality relies on a prior specification of purpose. There
is no canonical description of the purposes a health care ethics consultant should satisfy to be found within
the literature” (1994, p. 116). The remainder of the article goes on to define the minimal working
conditions a clinical bioethics consultant might require, given the context of uncertainty about the job itself.
litigation in our society: given the repulsion many feel to the money and time consumed by legal rights battles, bioethics consultation offers “the justice of the courtroom without the courtroom” (1999, p. 37). And in fact, exactly some of this reasoning lay behind the Quinlan ruling: “We consider that a practice of applying to a court to confirm such decisions [i.e., regarding medical care] would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession’s field of competence, but because it would be impossibly cumbersome” (In re Quinlan, Vol. II, p. 312). Instead, the Court suggested the use of bioethics committees. One of the major goals of bioethics consultation on this model seems to be realizing justice without involving the burdens that actual legal proceedings would involve.

His arguments against this model focus on its insufficiency rather than its inherent incorrectness. As he points out, in both his experience and that of every other consultant that he had spoken to,

cases...which center around questions of personal morality... are overwhelmingly more common than those posing gritty social ethical questions of irreconcilable conflict. One central task for a model of consultation is the provision of perspective, and in this the model of rights seems to me notably lacking: It places at the periphery those cases that experience shows constitute the core of ethics consultations (1999, p. 39).

To the extent that the field of bioethics consultation focuses predominantly on rights and irreconcilable conflict, then, Freedman would argue that it belies important and more pervasive issues.

The expert counselor model assigns a passive role to the bioethics consultant; he comes only when called, and specifically, in several models (e.g., Ackerman’s and LaPuma and Schiedermayer’s models), only when called by the physician. The goal of the consultation on this model is to be appropriately helpful to the physician who called
for the consultation. This help can be provided in many ways, by clarification of issues, identification of alternative courses of action, presentation of the literature on the subject, etc. In the end, though, the bioethicist’s advice need not be heeded; the physician makes the final choice of action.

Freedman has two main arguments against this model. First, he suggests, it amounts to censorship:

whether these restrictions [e.g., that only physicians can call consultations] are exercised or not, they profoundly undermine the credibility of each consultation, just as there is never any reason to believe a newspaper whose contents must be approved by the state before publication. And so I believe that hospitals rarely, if ever, begin an ethics consultation service motivated primarily by the desire to counsel their perplexed physicians... (1999, p. 41).

The implication is both that individual bioethics consultants would be wrong to practice under such strictures and that a conception of a profession that thus makes its practitioner subservient merits no respect. Presumably this is undergirded by a presumption that bioethics consultants have something important to offer, namely ethical advice, in the way of which nothing should intervene.12

Second, Freedman thinks that this model misses the point of some reasons for ethical consultation: that, for example, the doctor “wanted to know if what he was thinking and how he was acting were wrong.... He wanted to do right by his patient, and he wanted to know what I thought that might involve” (1999, p. 42). In other words, the doctor wanted moral guidance, a guidance that cannot necessarily come simply from clarification of alternatives. Freedman’s implication, therefore, is that bioethicists can be

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12 However, one need not make quite so strong a statement. One might also hold that though it is not clear exactly what bioethics consultants offer, it is clear that under certain circumstances institutions or individuals might use them as rubber stamps. For some this may pose no problem, but for others who want to maintain a sense of independence and integrity, it will be unwelcome. Moreover, a professional organization who wanted to protect the value (moral and financial) of the profession by warranting its independence might refuse to license members to practice under such circumstances.
moral authorities, fit to guide the perplexed and well-meaning physician regarding issues more subtle than a bare conflict of rights. This point is of central importance in the discussion of bioethics consultation.

Freedman takes his duty model from Judaic sources, including the Talmud and historical interpretations of it, but he argues that its appeal is not restricted to those of a Jewish tradition. At the base of his theory is the intuition that the reason for bioethics consults is often a desire for moral guidance – someone is sought to help determine what the right thing to do is, not to help clarify what, given one’s particular values, one might think is the right thing to do. For Freedman, the point of the activity is to make a determination and act according to an independent moral truth, and the bioethics consultant’s job is to guide the parties involved towards that truth. According to this duty model, both the rights model and the expert consultancy model miss the point of perhaps the majority of requests for consultation: someone desires to do the right thing, but is uncertain about what it is or how to achieve it.

Freedman summarizes three differences between these models. First, when asking what the purpose of the consultation is, the rights model construes it as “the resolution of a defined conflict” (1999, p. 49); expert consultancy also asks “what shall the consultee, or consultees, do?” The model of duty, on the other hand, asks, as he puts it, “What is to be done?”

A second difference between the models is the issue of who should participate in a consultation. The model of rights “will require the participation of the parties claiming rights in this matter, as well as input ... from those who can shed light upon it.”

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13 “I shall describe a nonparochial Jewish understanding that has much to commend itself on its own merits to those with no commitment to the Jewish tradition per se” (1999, p. 44).
Consultancy is more flexible, “although it will always ... begin ...with just the single person requesting the consultation.” The model of duty, on the other hand, is broader. In this model, many different people may request consultation, and they may do so for a much wider variety of reasons than either the rights or the expert consultancy model stipulate.

Finally, Freedman argues, the focal point of attention in the duty model of bioethics consultation is the individual stories of the persons involved. He acknowledges that, to a certain extent, the other models allow for this, but argues that there is a central place for it under the duty model; in it another dimension is added, for the biographies of the participants shape the very moral question posed. ... We need to know things about these people to understand the moral dilemmas they face: not, as in the model of rights, the basis upon which they make their assertions; not, as in the expert consultancy model, how they themselves understand their dilemmas; but rather, the nature, force, and outlines of the obligations themselves (1999, p. 52).

Again, Freedman is invoking the existence of an independent moral truth that provides the foundation for such obligations. Under his duty model, the bioethics consultant is an expert regarding such concrete obligations, and can communicate to the parties involved in a consultation the reasons for and descriptions of such obligations. He is, to them, a moral guide or wise man.

Some of these obligations result from the particular personalities or relationships in a situation. For example, in the case he describes, a doctor and his patient have had a relationship for 20 years. When the patient requests that she not be treated (and nontreatment will lead to her death), the doctor knows that it is her right to make that choice, but still feels ethical turmoil about the decision. Freedman points out that in this case, any attempt to offer guidance must take this long relationship into account as
informing the very basis of the ethical dilemma. Were the doctor a stranger, he might have no serious problem honoring this patient’s choice, and might never call an ethics consult. The duty perspective can take these individual features of persons and their relationships and help to discover what one’s duty might be in this particular circumstance.

Moreover, Freedman observes, duties can arise without our having chosen them or specifically accepted them: “As your life is shaped by forces, only some of which are subject to your influence, so is your moral life shaped” (1999, p. 53). His point is that we cannot always know in advance all the ramifications of the choices we make, but that this ignorance is no excuse. Moral duty nevertheless can arise from circumstance. This helps to explain why the duty model fills a gap left by the rights and expert consultancy models: ethical issues are often the result of uncertainty that remains once the relevant rights and values are identified. In a model of duty, therefore, room is made for an exploration of the sometimes vague, uncertain and unidentified duties that apply to a particular case. As he notes, “such a consultation is of no use to one determined to be proven right,” but on the other hand “the other models are of no use to one perplexed as to the right thing to do under the circumstances” (1999, p. 57).

Under the model of duty, Freedman advocates a number of roles for the bioethics consultant. Consider the following: “If there is a single duty that is the glue holding together ethics consultations that begin in conflict, it is the duty to seek the right course of action in treating the patient” (1999, p. 45). We might draw from this statement at least two roles: patient advocate, whose job it is to see that the patient’s needs are met, and moral policeman, whose job it is to ensure that the right thing is done. In his
suggestion that the bioethics consultant is the one to identify these duties, Freedman also
suggests that the consultant is in the position of moral expert.

At the outset of this chapter I argued that each of the models of consultation I
would discuss were incompatible and imply very different tasks for the bioethics
consultant. It is clear that Freedman and Ackerman offer different and incompatible
conceptions of the role of the bioethics consultant. Freedman considers Ackerman’s
model as a representative of the rejected expert consultancy model: “According to many
accounts, most baldly expressed by Terrence Ackerman, a health care ethics consultant’s
task is to assist others – especially physicians – in making decisions. Along with this
account goes the belief that there is no, and could not be any, independent measure of an
effective consultation” (1994, p. 111). Ackerman, as we saw earlier, specifically
disavows two of the roles Freedman favors: the patient advocate and the moral
policeman. In some senses, Ackerman and Freedman represent the poles of possibilities
regarding models of bioethics consultation.

Freedman’s position is persuasive. It makes a great deal of sense to think that a
mere statement of rights and clarification of values and options does not help in many
cases, because after a thorough consideration of law and policy, one can be left in a state
of moral uncertainty. The problem is that as reasonable as this account sounds, it is not
clear what it requires a bioethics consultant to do in the process of consulting. It is not
sufficient simply to state that there are duties to be done. Everyone may agree to this
point yet still be unclear what actions should be taken. More importantly, people may
(and often do) disagree about their duties in a particular case. Since normativity requires
a particular moral framework, and there are many different possible frameworks, there is
nothing uniquely informative about his understanding of duty without reference to such a framework. Freedman’s model therefore fails in distinguishing which duties are most important.

There is also reason to suspend judgment regarding the other roles that Freedman favors, such as patient advocate and moral policeman or moral expert. He gives no arguments for these roles – indeed, he never specifically states them, though they are implied by many of the things he says. For example, he repeatedly says in his work that parties in an ethics consultation want guidance regarding the right thing to do. This suggests that bioethics consultants can be moral experts in the sense that they can tell others what the right thing to do is. However, any modest moral philosopher must acknowledge the real, lasting disagreement regarding conceptions of the right and the good. Asserting that bioethics consultants can provide an account of the right and the good, without specifying their source of authority or expertise, is simply begging the question.  

Freedman also suggests that bioethics consultation is in a sense a means to an end: bioethics is a forum for expressing moral commitments, as other professions may provide a forum for expressing intellectual, aesthetic, utilitarian, or other commitments.... I suspect my own experience is usual: choosing bioethics at a time of rising social demands that the academy be socially and politically relevant, under the spur of a need to fulfill personal moral commitments and needs without abandoning academic interests and predilections (1994, p. 123; italics added).

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14 Edmund Pellegrino also seems to suggest that bioethics consultants can determine the morally right decision: “An orderly analysis – followed by a resynthesis – of the ethical, legal, and psycho-dynamic realities should begin with a discussion of what is the morally right and good thing to do, follow with a delineation of the legal implications of what is morally proper, and end with an assessment of how best to implement the morally proper decision, given the socio-psychological relationships between decision makers” (Pellegrino, 1999).
Can he really be suggesting that bioethics consultants should be moral activists? The possibility for bioethical paternalism looms large in such a conception. It would be ironic if bioethics-consultation, whose historical roots originated in part out of a reaction to the repressive paternalism of the medical establishment, became a means for consultants to “express their moral commitments” independent of patients’ wishes. Freedman might be working from the idea that with the existence of an independent, knowable moral truth, and the existence of trained experts in the field (i.e., bioethics consultants), a bioethics consultant’s personal moral convictions would express this truth. However, such a view of bioethics consultation flies in the face of abundant disagreements regarding proper bioethical choice as well as in the face of a multitude of arguments defending an individual’s right to decide for himself in moral matters. One can easily perceive the good intentions and moral sincerity in what Freedman writes, but it is exactly those good intentions on the part of benevolent physicians that helped to spark the bioethics movement. If there is a common root at all in bioethics consultation, it is the defense of a patient’s wishes against the wishes of a battalion of experts who may disagree. The bioethics consultant is no exception.

Finally, at times Freedman suggests that sometimes bioethics consultants ought to sacrifice their jobs for the right reason – for example, when an institution persists in doing something grossly unethical. It does seem true that there are times in one’s life, in both personal and professional situations, where the moral requirement to be a whistleblower or in some other way to “stir up the pot” overrides even the need to maintain one’s employment. This implies that a bioethics consultant might, on occasion, need to be prepared to lose his job (by termination or resignation) if this is required in order to
stand up for what is right. However, the duty stems not from one’s job as a bioethicist, but simply from one’s status as a moral agent, who perhaps is in the right position to observe something wrong and who may subsequently become complicit in whatever results. This could apply as well to physicians, nurses and hospital cleaning staff.

Freedman, however, implies that it is uniquely part of being a bioethicist: “... in my view persons working under this constraint [of not acting on their own consciences] defraud themselves, their employers, and the patients by claiming to act as ethicists...” (1999, p. 127).

In what way would bioethics consultants working under this constraint be guilty of defrauding? Many people do not stand up for what’s right; this merely makes them (perhaps) immoral. What additional consideration would make ethicists guilty of fraud (rather than immorality or weakness of will)? It can only be one of two possibilities: either 1) it is inherent in the very notion of the word “ethicist” that one act morally, or 2) it is part of one’s job description to act morally. The first option is unacceptable, unless we argue that all unethical ethicists are in fact not really ethicists (i.e., provide the advice sought from ethicists). This becomes a word game whose subject is a word most admit they can’t define to begin with. Option one is therefore not tenable. Freedman must, therefore, draw on the second option. This option certainly seems to account for the intuition that there is something wrong with someone who calls herself an ethicist and yet is willing to work under a gag order which might prevent her from voicing any objection to immoral behavior. She would be saying at the same time both that she is and is not concerned about doing the right thing.
But is accepting a job as a bioethics consultant tantamount to saying “I have the special role of caring about the right thing”? At this point, the answer must be “no”, simply because, as I have argued, there is no established fact about what constitutes the job in the first place. There is as well controversy regarding which conception of the right and the good has the best claim to our agreement. I will return to the question in Chapter Six, when I discuss the roles of moral policeman, moral guide and moral activist. It is sufficient at present to note that it is not obviously the case that being a bioethics consultant is everything that Freedman has suggested.15

15 Another interesting point arises here: how far would the institution have to go in protecting a bioethics consultant’s ability to act on her conscience? After all, Freedman argues,

By engaging a health care ethics consultant, an institution is making a new commitment to humane and just care. This is more than a perception shared within the hospital community; it is a perception fostered by advertising of the position, and by announcements of its having been filled, in public relations releases and hospital newsletters. Absent the intention to protect that ethics consultant’s freedom of conscience, this is all a lie (1994, p. 127).

The extreme version of the relationship might yield an institution held hostage by the views of a radical bioethics consultant. Freedom to express and act on one’s beliefs and opinions seems to be different in the hospital setting than in the university. In the case of tenure, there is merely an opinion that is voiced, one that in fact might be countered within the very same institution. A bioethics consultant, in the role of moral activist (and, moreover, often the only one hired by the institution), might rage for days about a particular decision. “Protecting her conscience” might mean, for example, allowing her to intrude upon an abortion procedure in the hospital, attempting to stop it. This is, after all, exactly what acting on one’s conscience means for some people.

Additionally, it is not clear what this implies practically. After all, certain questions about deeply-held moral views and beliefs are forbidden during interviews in this country. Employers who ask questions about one’s beliefs regarding abortion might be subject to anti-discrimination lawsuits. Moreover, their being asked would quickly imply (probably accurately) that institutions were merely shopping for the right set of ethical views. Yet in what other way could an institution protect itself from a moral extremist if it were believed that bioethics consultants all potentially will protest when they perceive ethical violations? In some cases asking such questions may be entirely legitimate: a Catholic hospital, for example, may (and perhaps should) look for a bioethicist who is at least informed about Roman Catholic views and willing to consult on the basis of them. Such an institution may even go further and look for a consultant who himself actually holds Roman Catholic views. Likewise, an institution may ask questions of prospective consultants designed to ascertain whether the candidate was likely to be an affable colleague, amenable to compromise. Freedman himself describes being interviewed and not hired, according to confidential information, because of his answer to an interview question concerning what he would do if faced with a hypothetical unethical practice he was unable to resolve internally. He said he would “go to the newspapers and generally make as much noise about this as [he] could in an effort to get external pressure to change what internal pressure hadn’t budged” (Freedman, 1989, p. 135).
**D. Moreno's Model**

Jonathan Moreno's model of bioethics consultation is somewhat more difficult to articulate. His concern is not to give a complete account of what bioethics consultants ought to do, but rather, to explain how the judgments they offer might have moral authority. He does list a few skills consultants ought to have, but much of the real point of their practice must be inferred from his work, especially *Deciding Together: Bioethics and Moral Consensus* (1995). In addition, these roles are undergirded by his metaphilosophy. Once we have a perspective on his theory, it will be easier to describe what he advocates for bioethics consultation.

The impetus for his book was the observation that consensus played (and still plays) a large role in bioethics, yet the concept of and justification for consensus had not yet been sufficiently articulated. The bulk of the book addresses these questions and their relationship to the institution of bioethics. As he puts it, "much of the burden of this book is to develop a conceptual framework in which bioethics is understood as grounded in actual social practices" (1995, p. 11). He assumes at the outset that insofar as they are involved in actual cases, bioethicists may not maintain a merely theoretical stance. They must be involved in cases and must be useful, which most importantly includes giving positive recommendations. Because his argument for this claim relies on the fact that if bioethicists are not useful, they will not be appreciated (or perhaps even tolerated) in the clinic, it skips over the important question of whether giving positive advice is justified by a conceptual account of the role of bioethics consultation.

Moreno offers no rigorous defense of the *necessity* of consensus, making it somewhat more challenging for opponents to find points of specific weakness. This
stance is undoubtedly a result of his moral philosophy, derived from American pragmatism, which he calls "bioethical naturalism": "Resisting a simplistic fact-value dichotomy, bioethical naturalism takes actual moral experience as primary data for ethical inquiry ... [it] recognizes that a novel moral consensus can proceed only from the intellectual and societal context in which we find ourselves, and [it] must engage social processes" (1995, pp. 11-12). That is, it rejects the claim that morality derives from a transcendent source. His purpose is to give an account of how the phenomenon of moral consensus can be explained, as well as how it can be non-arbitrary. Importantly, he does not suggest that it is a goal to be sought, or a "regulative ideal". He instead considers consensus "to be a 'lubricant' for the activities of men and women in civil society, something that is often but not always desirable" (1995, p. 12).

Bioethical consensus for Moreno is fundamentally politically based. To begin with, he repeatedly situates bioethical discussions socially, and points out the importance of somehow capturing enough of a shared view in a decision that "as many people as possible are brought under its rubric" (1995, p. 50). He also takes bioethics to be situated in a liberal pluralistic society, with its attendant challenges. For example, he readily acknowledges the problems to which consensus decisions are subject in this context. The doctrine of liberal neutrality requires that the state take no 'official' position on the good life, yet a consensus decision (especially one resulting from a committee appointed by the government) seems blatantly to override this requirement. Moreno explains the dichotomy resulting: "either all the allegedly consensus-based conclusions of modern bioethics and its organs have no moral authority in a pluralistic environment when they have even minimal content (with the exception of panels authorized by and serving
monocultural groups), or we must find some way of supplementing Millian liberalism” (1995, p. 59).

What he seems concerned to do is simply provide for the possibility of consensus that is non-arbitrary, occurring voluntarily among a group of individuals for a variety of reasons: “What is needed is a device that can conveniently characterize the latent possibility of a valid consensus, even on elaborate moral principles, in a liberal and pluralistic society” (1995, p. 60). First, he endorses Rawls’ idea of the overlapping consensus both as a way of articulating the context within which bioethics is situated and as a model for an overlapping consensus in bioethics. At least in the American society on which Rawls and Moreno (and for that matter, the other authors here discussed) focus, that context includes a liberal pluralist society and a desire for social peace, with the preservation of room for individual dissent. Moreno suggests that bioethics contains fairly ramified principles about which there is overlapping consensus. For example, he states, the focus on autonomy in bioethics can be understood as part of the precondition for the political conception of justice. However, in bioethics it can be much more precise, including a consensus on the rather specific principle that competent patients may refuse life-sustaining therapy. But, Moreno notes, at this point what has hitherto been a political defense of consensus can move us no further. The demand that subjects of overlapping consensus preserve “reasonable opposing doctrines likely to persist over generations” is unable to be accommodated in the process of consensus.

In order to understand why this is the case, it is important to explain what Moreno understands by “consensus”. Contrary to the ordinary conventions of English grammar, he does not use it as a noun, but rather more like a verb. Consensus, he points out, has a
great deal more to do with the process the members of a group undergo than where they arrive, since consensus requires communication, thought, inquiry, etc. It is at least as much (if not more, at least in bioethics) in the process rather than the product that the moral issues must be confronted and in which the moral authority inheres. A consideration of "a" consensus decision sheds virtually no light on the validity of the decision itself, unless one holds the view that consensus is either a) indicative of the good or b) constitutive of the good. Moreno holds neither of these beliefs, at least not as they are understood metaphysically or transcendentally. His position, bioethical naturalism, sees morality as arising from human experience rather than from some transcendental source. Therefore, it is important to him to consider the consensus process. A consensus decision involving one powerful member's domination of the committee is not a valid consensus in Moreno's view, because such a consensus has not respected the process of consensus, in which the real moral justification inheres.

Moreno recognizes that it is difficult to come to a decision which honors "the values that are held in a stable balance within the framework of overlapping consensus" (1995, p. 61). Bioethical decisions, whether made by a panel or in the clinic, often result in positive actions, and it is much more difficult in this case simultaneously to respect opposing values. Moreno therefore sees the rest of his task as "extending a valid moral consensus in a liberal and diverse society, a problem that forces us to look beyond the political rationale to actual consensus processes" (1995, p. 62). His conclusion is that "so long as the small group's particularized consensus upholds liberal values such as respect for the personal autonomy of those who disagree and a willingness to consider alternative
points of view, then the panel’s consensus has all the moral authority that a deliberative process can be accorded in a liberal society” (1995, p. 63).

The way in which the autonomy of individuals, for example, is to be respected in a group is by ensuring that the process of consensus evidences that respect. The qualities of the process would include “nonviolent methods, mutual respect, and a willingness to entertain new evidence and alternative points of view” (1995, p. 64). The results of this process are not held to be transcendentally true; they are not meant to impose a vision of the good life. Thus this model can accommodate those who disagree, since the consensus process is not legislative but rather, deliberative and persuasive (1995, p. 71).

It is important to be clear about Moreno’s argument:

1. Moral values are not transcendental, but rather, arise from and must be understood within human experience (this is his version of naturalism).\footnote{He notes many similarities between what he calls American philosophic naturalism and the naturalism of Willard van Orman Quine, but also significant differences. According to Moreno, Quine’s epistemological naturalism “is too closely associated with causal theories of observation, such that causal processes are said to produce true belief-states.” In contrast, American philosophic naturalism “stresses the dynamic interaction of the knower with that which is to be known.... To use Dewey’s phrase, the stimulus-response relation is not an arc, but a circuit” (1999, p. 7).}

2. Human moral experience in this country is based on generally liberal values, such as respect for autonomy.

3. Bioethical decision making must be based on the same values, which include consensus decision making.\footnote{Without consensus, he points out, “how could any view, including that which is right, prevail in human affairs except by coercion?” (1995, p. 39).}

4. However, there is a potential for consensus decision making to conflict with the important value of autonomy, so it is necessary to give an account of how consensus might have moral authority while simultaneously honoring the value of autonomy.
5. The moral authority of consensus inheres in the fact that it follows from a process that respects uncontroversial liberal values (such as respect for personal autonomy and "a willingness to consider alternating points of view" (p. 62)).

There is one more aspect of Moreno’s account that merits attention. The title of Chapter 9 of Deciding Together is “Bioethics as Social Reform”. This brings to mind a typical picture of bioethicists as meddlesome moral activists or policemen. In a sense, Moreno does make room for this. However, the moral reform he mentions does not consist of evangelical pronouncements and demands. In fact, I would argue that the social reform he mentions is incidental to the real goal: logical reform. By this is meant not a reform of logic itself, but rather, social reform on the basis of pointing out logical inconsistencies. The kind of social reform Moreno suggests is that of bringing coherence to the stated values found in overlapping consensus. So, for example, the patients’ rights movement and the attendant focus on autonomy in bioethics takes a stated principle of our society, the right to self-determination, and highlights areas in medicine in which that principle is not respected. This "bringing into alignment" is the social reform he means.¹⁸ Obviously, in practice this might be very difficult, since some overlapping values and principles only overlap when examined superficially, and fall apart when more precision is called for.

Finally, Moreno distinguishes his sense of social reform from advocacy. Social reformers, he argues, have an organizing principle which informs their actions. At the same time, however, "the bioethicist maintains an intellectual distance from the single-minded promotion of self-determination" (1995, p. 146). An advocate, on the other hand,

¹⁸ This point is somewhat difficult to piece together from the book itself, but in personal communication (July, 2002) Moreno has confirmed that this is in fact what he intended.
turns a commitment to a principle into a social agenda that is not (publicly, at least) amenable to criticism. So, for example, both the Hastings Center, a non-profit bioethics research institution, and the Hemlock Society, which advocates laws granting terminal patients a choice in the manner and time of death, are concerned with the right to self-determination. However, the Hastings Center focuses on discussion of the issues (including dissenting voices) while the Hemlock Society agitates for specific change. As Moreno points out, “one implication of this account ... is that the roles of bioethicist and advocate are not only distinct but incompatible” (1995, p. 146).

It is both easy and difficult to critique this argument. It is easy because its claims are not absolute and thus can be taken to question-beg by offering ad hoc moral values. On the other hand, it is difficult: if one believes that moral claims cannot be absolute, the charge that moral claims are ad hoc has less purchase. Moreno in fact argues that the dichotomy between absolute and ad hoc moral values is a false one, and that there is room for other options (in his model, bioethical naturalism). In the end, it may seem difficult to oppose such a common-sense view: good thinkers gather together and deliberate on a puzzling issue, hearing each other out in an open-minded fashion, then together make a recommendation regarding what decision would best comport with widely-held societal values. Societal values could be misguided, but if there are dissenters, their voices are heard, and if the dissenter is the patient, the recommendation is not binding on him anyway. This simply seems like a good fact-gathering operation.

However, dissent will be valid from those who may have to pay the price of the societal “tendency” that gives rise to overlapping consensus. For example, taxpayers who oppose abortion may be forced to be complicit in a system that provides public
funding for it. Those with Parkinson's or other degenerative diseases will not benefit from treatments deriving from research banned by the government. However, these are arguments for political philosophy to address; though bioethics consultation is situated in this milieu, it is also subject to it. Over time bioethical considerations may help to change the political system, but for now they cannot.

What results from Moreno's theory for bioethics consultation? One of the most important issues raised by his defense and requirements for a particular process of bioethics consensus is whether bioethics consultation must always be done by a committee and not by an individual consultant. It may be a moot question, since even an individual consultant never acts alone; the physician (often more than one), nurses, social worker, family and others are usually party to any decisions made. Additionally, certainly some issues a bioethics consultant might encounter do not really call for a consensus decision. Fact-finding and clarification, which comprise a great deal of the consultant's job, can be done by a single person.

Consideration of another of Moreno's works may help to establish his vision of bioethics consultation. In "Ethics consultation as moral engagement" (1991a), Moreno notes three capacities a bioethics consultant should have: 1) he should be a "skilled participant-observer, able to identify informal social structures and arrangements and to assess his or her developing role in them"; 2) he should be able to "understand the dynamics of small group behavior"; and 3) he should possess competent mediation techniques, familiarity with negotiation strategies and sound interpersonal skills. The third set of skills is one common to most accounts of bioethics consultation. Like most accounts, however, there is little mention of the goals or side-constraints of such activity.
The first two goals demonstrate the wholly different slant of Moreno's work: a micro-political endeavor focused on consensus and the sociology of small groups. Ackerman's model, by contrast, positions the bioethics consultant in service to the physician; no one else need be involved.

It is Moreno's overall focus, though, that makes his model of bioethics consultation different from the others I have discussed. While it is true that there is some contrast between Moreno's suggested goals and the goals of others, the larger contrast with the other authors I have discussed becomes clear with an examination of the theory in which those goals are embedded. For Moreno, the morally important feature of bioethics consultation is the process of consensus. The roles and goals are somewhat incidental to that overarching principle, and their suitability might be measured by the extent to which they inhibit or further the process. Ackerman, Freedman, and LaPuma and Schiedermayer simply address the issue of individual roles, without the larger context Moreno offers.

Moreno's model, because of its focus, does not offer concrete goals for the process of consultation. The skills that he suggests consultants ought to have are those that help the forging of a consensus that is not binding on any party. However, he makes no normative claims about what consultants ought to do in a consultation. What his model seems to indicate for bioethics consultants is a relatively passive (or at least undetermined) role in which they steer conversation and try to understand the dynamics of the group. Implicit in his model is the idea that at least a consultant ought to avoid authoritarianism that would thwart the consensus process, but beyond that, there are no real points of navigation. Perhaps since consensus decisions are not binding, there is no
need for a consultant to play any particular role or pursue any particular goal. In this
respect, it is hard to explain why a trained mediator would not be just as suited to
bioethics consultation as, for example, a physician or philosopher. This conclusion
would presumably not bother Moreno; as he said in private communication,

As for the source of authority in ethics consultation, as a pragmatist I don’t
worry about the source of authority until it is actually challenged. When it is
challenged, as a naturalist I look to the ways that people normally come to the
conclusion that someone “in authority” is actually “an authority”. At that point
I defer to the social scientists, whose job it is to tell us how these things work. I
do not believe that philosophers have any special insight into these questions
(2002).

Bioethics consultation, on his account, is benign suggestion and guidance.

E. Conclusions

As I have shown, each of these accounts leaves many problems unanswered regarding the
roles of the bioethics consultant. We are returned to many of the questions with which
we began: What are the goals of bioethics consultation? What is required, forbidden or
permitted in the pursuit of these goals? What is the order of priority among goals in the
case of a conflict between goals? The conflict between and internal problems with these
accounts prevents us from answering these questions on the basis of bioethics
consultants’ own understandings of what they do. For example, Ackerman’s suggestion
that bioethics consultants await a consultation call from a physician resembles that
feature of LaPuma and Schiedermayer’s model, but contrasts with Freedman’s suggestion
that bioethicists have a moral activist role to play. Moreno’s model, meanwhile, takes no
stand on the appropriate manner in which a bioethicist may be called. Freedman seems
to suggest that the purpose of consultation is to pursue the right answer, while Ackerman
claims that the physician’s satisfaction is the end of the consultation. At times LaPuma


and Schiedermayer suggest that a bioethics consultant ought to be a patient advocate, and at other times suggest he should not. Moreno and Ackerman reject it. There is no agreement in the profession about what the bioethics consultant ought to avoid or pursue in the course of his activities. As the next section will show, there is in addition ambiguity in the conceptions those outside the profession have of bioethics consultation.

III. EXTERNAL UNDERSTANDINGS OF THE PROFESSION

A profession at the beginning of its self-definition, as bioethics consultation undoubtedly is, might derive guidance from a consideration of the ways in which it is perceived from outside. Certainly the results of such a reflection are not binding, and perhaps may not even lead to coherent results, but may still be worth undertaking since other people may be able to articulate why they find bioethics consultation valuable. In this section, I examine the description of tasks for bioethics consultants found in three statements by major medical associations.

A. The American Medical Association

Section 9.11 of the American Medical Association’s “Opinions on Professional Rights and Responsibilities” (AMA, 1994, reprinted in Brody et al., 2000) concerns ‘Ethics Committees in Health Care Institutions.’ It begins with a rather clear statement of their perception of bioethics consultation’s goals:

Ethics committees in health care institutions should be educational and advisory in purpose. Generally, the function of the ethics committee should be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution.
Recommendations of the ethics committee should impose no obligation for acceptance on the part of the institution, its governing board, medical staff, attending physician, or other persons. However, it should be expected that the recommendations of a dedicated ethics committee will receive serious consideration by decision makers (AMA, 1994, 9.11, #1).

Obviously the AMA appears concerned to limit interference by ethics committees, while establishing the fact that the committee’s recommendation will be considered seriously. Taken together, this implies that whatever moral authority the committee possesses, it is not binding. Unlike a hospital’s general counsel, or a policeman, or even perhaps a religious official, the ethics committee is seen as strictly an advisory group. Its authority is circumscribed.

The AMA’s description also addresses the character its members ought to have: “Committee members should be selected on the basis of their concern for the welfare of the sick and infirm, their interest in ethical matters, and their reputation in the community and among their peers for integrity and mature judgment” (9.11, #2). In addition, members ought not to have responsibilities that might conflict with their membership on the committee. It is also recommended that in religious hospitals where particular moral values will guide the committee, this fact should be publicized to the hospital staff and patients and their families.

While the AMA’s recommendations might be reasonable, they offer very little aid in defining the goals and side-constraints of ethics consultation. They do, however, point to an important tension regarding the authority of the ethics committee. While most physicians and hospitals seem concerned to limit the authority of bioethics committees and consultants, many consultants themselves (chief among them Benjamin Freedman) are concerned that they not be co-opted by the institution and that their integrity not be
compromised by the institution preventing them from doing what needs to be done to pursue the ethical solution to a problem. This highlights again the importance of providing a justified answer to the question of the authority of a bioethics consultant.

B. The American College of Physicians

The American College of Physicians' *Ethics Manual* provides similar recommendations. The section of the 1998 version of the *Manual* (American College of Physicians, 1998) that deals with ethics committees and consultants reads as follows:

Ethics committees and consultants contribute to achieving patient care goals by facilitating resolution of conflicts in a respectful atmosphere through a fair and inclusive decision-making process, helping institutions to shape policies and practices that conform with the highest ethical standards, and assisting individual persons with handling current and future ethical problems by providing education in health care ethics.... Although it is generally agreed that neither ethics committees nor consultants should have decision-making authority, they can advise clinicians, patients and family members on ethical matters (1998, p. 588).

Interestingly, some of the unclarity marking the 1989 version of the *Manual* (ACP, 1989) has been removed.¹⁹ An appendix has also been added to the *Manual* on “A Case Method to Assist Clinical Ethics Decision Making.” Most of it addresses the queries that ought to be asked in a consultation in order to bring relevant facts to light:

Define the ethics problem as an ‘ought’ or ‘should’ question; List significant facts and uncertainties that are relevant to the question; Include the benefits and harms of the treatment options; Give understandable, relevant, desired information to the decision maker and dispel myths and misconceptions; Solicit values of the patient that are relevant to the question; Identify health professional values; Propose and critique solutions; Identify and remove or address constraints on solutions (such as reimbursement, unavailability of services, laws, or legal myths (1998, pp. 592-593)).

¹⁹ The 1989 version noted that “neither ethics committees nor ethics consultants have been adequately evaluated prospectively to know whether they can serve a useful advisory function”, and that “the legal status and potential legal liability of ethics committees remain unclear” (ACP, 1989, p. 334).
One statement indicates some direction regarding the resolution of the controversy:

"Identify a decision maker." Like the AMA guidelines, however, the ACP guidelines
give no help in answering the more pertinent questions surrounding bioethics
consultation, such as who may call a consult, what bioethicists are permitted to do while
carrying out their function, or whether a bioethics consultant may advance his or her own
moral agenda by attempting to persuade patients and their families in favor of a certain
decision.

C. The American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists has gone further than most
organizations, publishing an "Endorsement of Institutional Ethics Committees" (ACOG,
1985, reprinted in Brody et al., 2000). Like the AMA and the ACP, the ACOG
advocates that the ethics committee help develop institutional educational programs, act
as an information resource, help to develop policy, and offer counsel in individual cases.
In addition, however, they suggest another function: "To foster awareness of ethical
issues and create an environment of ethical concern" (ACOG, 1985; in Brody et al., 2000,
p. 475). Arguably the other four functions they cite would have the effect of fostering
ethical awareness, but there is also room here for more proactivity by bioethics
consultants and committees. For example, it might help to create "an environment of
ethical concern" for the ethics committees to go on rounds regularly with teams, partly in
search of ethical problems.

Specific mention is made of the ethics committee helping to achieve agreement:

"With the ethics committee serving as a catalyst, every attempt should be made by the
primary decision-makers to reach agreement about treatment” (ACOG, in Brody et al., p. 476). This would seem to place the focus on a *commonly acceptable* rather than a *right* decision. The ACOG also concludes that the ethics committee’s decisions are advisory only, though “authority exists within hospital systems to enforce hospital policies and standards and to assume appropriate legal responsibility for practices within the hospital” (p. 476). The goals offered by this committee are no more helpful in delineating the field than were the goals of the previous two.

**D. Conclusion**

All three of these perspectives leave the profession of bioethics consultation underdetermined. Again the need for a well-articulated, rationally justified conception of the profession is highlighted: bioethics consultants must be able to define for themselves and for others what their purpose is, how their actions are constrained, and in what way they ought to be evaluated. Such conclusions will not come from outside the field, in part because external perspectives are motivated by the needs and values of those working to define and domesticate the role of bioethicists.

**IV. CONCLUSION**

This chapter has demonstrated that interpretations of bioethics consultation arising both from within and outside of the profession fail to yield a definitive account of the aims of the profession. Each of the internal accounts has philosophical problems. They also conflict with each other, and some belie the historical motivations for including consultants in medical decision making in the first place (i.e., patient protection).
Ackerman and LaPuma and Schiedermayer suggest that consultants serve at the whim of physicians, while Freedman argues they should be free of such constraints. The first two accounts also reject Freedman's interpretation of bioethics consultants as upholders of morality and as patient advocates. Moreno's model suggests that what is important about bioethics consultation is that it oversees the consensus process to ensure that it is conducted appropriately. However, each captures something initially plausible about the aim of bioethics consultation. This combination of the plausibility and unclarity of aims accurately reflects the current state of bioethics consultation. Accounts of bioethics consultation arising from outside the field also fail to guide the consultant.

Unfortunately, as the next chapter makes clear, the most comprehensive effort to date to provide a description of the field, the *Core Competencies for Healthcare Ethics Consultation*, is likewise vague, underspecified, and insufficient to the task.
CHAPTER FOUR:

THE CORE COMPETENCIES DOCUMENT

I. INTRODUCTION

Recently the main professional organization of bioethicists, the American Society of Bioethics and Humanities, published a document which attempts to define the practice of bioethics consultation, *Core Competencies of Healthcare Ethics Consultation*. It described its impetus as follows: "...the mission of the Task Force was to explore standards for health care ethics consultation. The work of the Task Force was motivated by the belief that when patients, health care providers, or others seek the assistance of health care ethics consultants, ethics consultants should be competent to offer that assistance" (*ASBH, Core Competencies*, 1998, p. 1; hereafter referred to as "CC").

The Task Force focused on five main topics: (1) "the nature and goals of ethics consultation"; (2) the core competencies required to achieve these goals; (3) the new field of "organizational ethics"; (4) evaluation of ethics consultation; and (5) special obligations of institutions and consultants. Topics (3) and (5) fall outside the scope of my project; the main focus in this chapter will be on topic one, and on what they say about evaluation (topic (4)) insofar as it has implications for defining goals. Topic (2) will also be discussed insofar as it helps to clarify topics one and four.

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1 The Task Force that authored the document was appointed by the Society for Health and Human Values, which was subsequently folded, with two other bioethics organizations, into the American Society for Bioethics and the Humanities (ASBH).
Preliminary Comments

The fact that these guidelines exist by no means implies that all bioethicists do or will comply with them. That there are many understandings of the practice seems to be acknowledged by the Task Force when they specifically state that they do not mean for the guidelines either to serve "to establish a legal national standard for competence to do ethics consultation" or as a basis for accreditation or certification. This caution is warranted. Attempting to establish legal guidelines in the face of the disagreement demonstrated in the previous chapter seems, at the very least, unpromising.

Another reason offered for this rejection of legal or credentialing standards is that "certification [or accreditation] could lead to the institutionalization of a particular substantive view of morality, a certain view of the relation between ethical theory and practice, or one conception of the relative importance of skills that are important for ethics consultation" (CC, p. 31). However, it is not clear that accreditation or certification would pose more of a risk of "institutionalization of a particular substantive view of morality" (what might be termed "moral imperialism") than does the de facto standard this document proposes. If it is possible to suggest standards of competence that do not enshrine a particular moral view, why can these same standards not serve for

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2 By 'moral imperialism' I mean the imposition, backed by power of one sort or another, of a particular moral view on those who have differing values. In the case of bioethics consultation, the power involved might stem from several sources. First, there is clearly power asymmetry whenever a bioethics consultant is permitted to override a patient's wishes. The Task Force rightly condemns this and takes it as an inappropriate role for the bioethics consultant. However, there are more insidious ways in which this kind of imperialism might be manifested. If a bioethics consultant is deemed by the parties to a consultation to possess the moral high ground, an inappropriate deference to his opinion might result. This can be encouraged by the use of phrases like "The right (or moral) thing to do in this case is ...."

An additional source of moral imperialism might result if bioethics consultation became professionalized and subject to legal examination on the basis of that professionalization. If, for example, a professional, certified or licensed bioethics consultant made a recommendation in a chart, and a doctor chose not to follow it, he might be subject to legal sanction on the basis of contravening a recommendation by a licensed professional. As a result, the bioethicist's opinion might be backed by implicit legal force.
accréditation? If the document is meant to set a standard, the danger of moral
imperialism could be just as present in a de facto standard as it is in a de jure standard.
One might argue that in fact the danger is even more insidious, as de facto standards need
not be voted upon, published, or promulgated. If the document is not meant to set a
standard, then why publish it with the stated goal of standardizing health care ethics
consultation?3

Presumably the suggested voluntariness of the standards is meant to respond to
this criticism. The Task Force offers four reasons for proposing voluntary standards
rather than mandatory standards for accreditation (p. 31): (1) voluntariness "reflect[s] the
complexity and lack of data" in the field; (2) voluntariness allows for diversity according
to institutional context; (3) giving guidelines, even temporary ones, can "encourage
gradual change and stimulate public discussion"; and (4) voluntariness allows for
examination of the guidelines' merit. The Task Force's sensitivity to complexity and
lack of data is appropriate and to be appreciated, but if the field is so complex, it seems

3 Judith Wilson Ross criticizes the report on similar grounds:
After all, just because the Task Force says that it doesn't want people/agencies to use them other
than voluntarily doesn't do anything to keep others from using them mandatorily. Indeed, the
Task Force members encourage employers to use them mandatorily (but only if they agree with
them) insofar as the report says that they should use them to gauge the competence of new- and
old-hire ethics consultants. [...] The Task Force could have discouraged (and perhaps stopped) the
move toward certification solely by saying that certification is not possible because we don't know
what we are certifying; by saying that the best they could offer was a description of the kinds of
skills and knowledge that they themselves possessed and found useful for whatever it is they do
(Ross, 1999, p. 31; italics original).
There is already evidence to suggest that she is right about the adoption and promulgation of the CC
standards. Albany Medical College-Union College began offering an MS degree in Bioethics in 2001.
They describe their program as follows:
The 12 course (three-year) MS curriculum is designed to serve the needs of working health
professionals and to meet current or prospective requirements of such accrediting and funding
bodies as the Joint Commission on Accrediting Healthcare Organizations (JACHO) and the
National Institutes of Health (NIH). It is also designed to impart the advanced skills and
knowledge recommended in the report on Core Competencies in Clinical Ethics Consultation
(http://www.asbh.org/events/announce.htm) issued by the American Society of Bioethics and
Humanities (ASBH), the field's professional society (italics added; online link accessed February
2003: www.union.edu/Academics/Bioethics/Academics/).
worth investigating why this is so and whether it can be made less so before proposing even tentative standards. If the result of the investigation is that the complexity stems from deep, irresolvable value differences, the conclusion might be that there is no basis for standardizing the profession. Regarding the second point, it is not clear how standardized the practice can be while simultaneously allowing for institutional diversity which surely spans a wide variety of values. Either it cannot be standardized, or the standards must themselves specifically accommodate moral diversity, which the *Core Competencies* does not do. Either way, it does not go far enough in specifying and investigating such issues. While it is true that this document can stimulate public discussion, it seems more to the point to discuss publicly the *goals* of consultation prior to defining competencies to achieve them.\(^4\) Finally, even those who are predisposed to conforming to those standards voluntarily may want justification for adopting certain areas of competency or in order to understand their goals more clearly. These concerns indicate a need for deeper analysis, as the Task Force itself suggests with the last two reasons (reasons (3) and (4) above) for proposing voluntary standards.

A main problem in the document is that it nowhere discusses what is understood to be the relationship between the goals, model, methods or roles of bioethics consultation. The discussion below therefore focuses on each individually.

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\(^4\) Ross offers a related criticism: “My problem with ethics consultation and its evaluation parallels one that haunts the practice guideline movement: How can you give authoritative guidance to physicians about practices when you have insufficient data about outcomes upon which to base that authoritative guidance?” (1999, p. 32). Her point is based on the lack of evidence about ethics consultation’s standards and guidelines. Whereas medicine has specific goals such as reduced mortality and morbidity, and increase in activities of daily life, etc., bioethics consultation as yet has no such assessable end points.
II. THE CORE COMPETENCIES MODEL OF HEALTHCARE ETHICS

CONSULTATION

The Task Force argues that the context of bioethics consultation is the most important consideration in a description of the practice. That is, bioethics consultation takes place within a context framed by societal values (such as individual rights, the law and institutional policy). This is interestingly different from the models of bioethics consultation discussed in the previous chapter, which began with a particular premise about the goals of bioethics. The CC report, on the other hand, begins by looking at bioethics consultation as a situated practice, and deriving goals from the situation.

Given this context, they ask, “What is the most appropriate approach to health care ethics consultation...?” (CC, 1998, p. 5).

The report understands ethics consultation to be “a service provided by an individual or a group to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict [which may have both affective and cognitive dimensions] regarding value-laden issues that emerge in health care” (CC, 1998, p. 3). As they explain, “The defining characteristic of the authoritarian approach ... is its emphasis on consultants as the primary moral decision makers at the expense of

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5 However, what they do not do is justify or identify in anything but a superficial way exactly what the present societal values are, whether some values are more important than others, and also which values are most important in specific situations. This oversight creates problems later in the report when it attempts to define “morally acceptable options” as those “normally set by the context in which ethics consultation is done”. Although the report acknowledges the fact of value pluralism in contemporary American society, it still seems to believe in a common morality that would ground bioethics consultation. Though it may not be definitive, they allow, this context does provide a range of morally acceptable options. More is said about this facet of their model below, but it is important to keep in mind the starting point of this model.

6 Although Moreno’s model also considers the context of bioethics consultation, it is towards an entirely different end. For Moreno, the context helps to explain the moral authority that bioethics consultant’s recommendations possess. For the CC document, the context delivers the goals of the practice.

7 They acknowledge that organizational ethics consultation is a related and growing field, but only focus on clinical ethics consultation in this report (with a brief discussion of the relationship between the two).
the appropriate moral decision makers ... [it] can be authoritarian either with respect to
process or outcome” (p. 5). On the other hand, “the sole goal of the pure facilitation
approach is to forge consensus among involved parties” (p. 6). There are problems with
their arguments against both positions.

A. Problems with the Argument Against the Authoritarian Approach

According to the Task Force, authoritarianism can occur relative to outcome or process.
Authoritarianism about outcome occurs when a bioethicist becomes “the primary moral
decision maker and displaces the appropriate moral decision maker, in this case the
patient” (p. 6)—for example, by overriding a Jehovah’s Witness’s desire not to have
blood treatments on the basis that the patient’s moral beliefs are wrong. Authoritarianism
about process occurs when relevant parties are excluded from moral decision making.

Authoritarianism about outcome seems justifiably rejected; a foundational value
in bioethics is that a patient has the right to accept or refuse a particular treatment.
Additionally, of course, there are philosophical and legal foundations for such refusal.
However, the argument concerning authoritarianism about process is not convincing.
They argue against this possibility predominantly on the basis of the following case
element:

Consider a case in which a family and health care team disagree over continued
treatment of a critically ill adolescent. Suppose that the health care team believes
that continued treatment is futile, while the family hopes for the patient’s
miraculous recovery. Imagine that the ethics consultant, after talking to the
attending physician and reviewing the chart, sides with the health care team, and
recommends that treatment be discontinued. The consultant does not reach this
decision based on personal moral views, but rather from an understanding of the
controversial concept of ‘futility’ as discussed in the bioethics literature. This
process is authoritarian in its process because it excludes relevant parties from
moral decision making. It fails to open lines of communication between the
family and the health care team in order to work toward a consensus that falls within the boundaries set by societal values, law and institutional policy (p. 6).

Why this case is inappropriate is unclear. First, the Task Force might be suggesting that the invocation of the academic concept of futility made this decision egregious. However, they offer no argument for why doing so would be a mistake. Since professionals are usually informed about and often guided by the literature of the field, it is not immediately obvious why citing this literature would be problematic. Second, the case describes the concept of futility as “controversial”, which seems to suggest that the consultant’s recommendation is authoritarian because it draws on a controversial concept. If that is the reason such behavior is inappropriate, the implication is that the bioethics consultant should almost never base a decision on current bioethics literature (since, after all, most issues are controversial in bioethics; recall especially the recent backlash of conservative bioethics writers discussed in the introduction against their perception of ‘mainstream’ bioethics) or perhaps not give positive recommendations.

Third, the Task Force might mean that the decision was wrong because relevant parties were excluded. However, by the Report’s own account, the family’s views are known, so at least they were heard and understood. Those views may not have been respected (though we cannot know this from the example, which only stipulates that the bioethics consultant agreed with the health care team), but surely the Task Force cannot be suggesting that any failure to follow the views of the family is authoritarian. The only point that might reasonably be meant is that the ethics consultant failed to speak with the family herself. However, again they provide no argument for the requirement that a consultant speak with the family. In many cases, where there is trust between a
bioethicist and a health care team, the family’s arguments and position might be conveyed to the bioethicist by the physician.

Of course, there are good reasons for bioethics consultants to speak directly with patients and their families, whose position may be distorted (intentionally or unintentionally) by the health care team. The team might also have overlooked important facts of the case (e.g., interpersonal family relationships) that help to determine the family’s position. In the end, we may take it as required for a bioethics consultant to speak directly with the family, but this report does not argue for such a requirement. Also, without an argument about why it is important to do so, it would be hard to know how to conduct such a conversation correctly.⁸

Fourth, they suppose that “the consultant does not reach this decision based on personal moral views, but rather from an understanding of the controversial concept of ‘futility’ as discussed in the bioethics literature.” Presumably by ‘personal values’ they mean values the reference point of which are strictly their acceptability to he who holds them.⁹ The implication seems to be that if the consultant had reached her decision based on personal moral views, the decision would have been acceptable. Many would want to resist such a possibility even more fervently than the possibility that academic arguments

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⁸ For example, if the point is simply to let the family air their views, it seems patronizing without further stipulation of what such airing might accomplish. If on the other hand the point of airing is that the consultant might actually be convinced, it is a weak argument. It would require a conversion on the bioethicist’s part to believing in miracles, which seems unlikely. There is no reason automatically to assume this process was authoritarian unless the reason for bioethics consultants’ speaking directly with patients and families is established.

⁹ Such ‘personal’ values may in fact accord with a metaphysical Truth, the views of a particular religion, or with a widely-held moral consensus. However, they need not have any such relationship. The implication seems to be that basing one’s decision on personal values might be preferable to basing such a decision on academic arguments. It should be noted, however, that for academicians, it is sometimes (perhaps often) the case that their personal values accord with and are influenced by discussions in the professional literature.
can be used to reach such a decision; “personal values” represents a considerable range of possibilities, some of them far from benign.

Although the report’s argument against authoritarianism about process is unclear, there are other ways in which they might have argued against it. For example, they might have contended that there is an obligation to consider all points of view, especially of those who have a stake in a particular discussion. There are implications of such an argument for the practice of bioethics consultation. For example, if the basis of the argument were that there is value in hearing all sides of an issue, it would require that bioethicists always speak directly with all parties in a conflict. Depending on the source and nature of the value, different consultation activities might be legitimated. If, for example, the value is derived from an airing of views that makes each person feel validated, then the bioethicist need only allow each person to speak his piece in a way that allows this person to feel respected.\footnote{10} If on the other hand the value lies in the fact that by discussion, mistakes are avoided, then discussion must be conducted as long as it seems mistakes are being avoided (this will also require a delineation of exactly what counts as a mistake).

Lacking further argument, with this example the report neither establishes the case against authoritarianism about process (though of course this does not rule out the possibility of another case being made) nor acknowledges to what else adherents to the Core Competencies document might be committed by such an argument. One might be

\footnote{10}{Obviously such a possibility is compatible with the person airing his views being in the equivalent of Robert Nozick’s ‘experience machine’ (Nozick, 1974), where the point of the consultation is, by playing the appropriate role, to elicit a particular feeling in the speaker (\textit{viz.}, “My views are respected; I can see that from the thoughtful looks on these people’s faces”) rather than to change anything about the world, such as the views of the listeners.}
persuaded that authoritarianism ought to be rejected, but it would take a more developed argument to define the nature of authoritarianism and the character of its impropriety.

B. Problems with the Argument Against the ‘Pure Facilitation’ Approach

There are also problems with their argument against the pure facilitation approach. The Task Force states that “the sole goal of the pure facilitation approach is to forge consensus among involved parties” (p. 6). In their opinion this is dangerous because it could lead, for example, to a violation of a patient’s rights when he had previously expressed a preference for treatment A, but is now unconscious and his family and doctors reach consensus on treatment B. This example does not prove their point, however; one could simply stipulate that any consensus must include, or be limited by, the previously expressed wishes of the patient (i.e., those expressed when he was still competent).

Despite the above attempt at salvaging the pure facilitation approach, there are other problems with this approach that the Task Force does not mention. First, it leaves no philosophical space for any justifiable inclusion of the word “ethics” in the title of one who helps forge a consensus; consensus is either reached or not, and its binding force is

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11 On this point, note that a pure facilitation approach might be an ideal way of avoiding the authoritarianism they declaim in the first model of bioethics consultation (the authoritarian approach). They have construed “pure facilitation” to mean only the facilitation of consensus at any cost. (For example, the egregiousness in the case they cite of achieving consensus is that “by merely facilitating consensus, consultants risk forging a consensus that falls outside acceptable boundaries.”) However, someone wary of authoritarianism might actually strive for a “pure facilitation” approach, where “pure” means pursuing the ‘appropriate’ outcome of the case (i.e., achieving the patient’s good) without the infusion of the consultant’s own values except where that facilitates the primary pursuit. In other words, the desire is to pursue the patient’s idea of the good, and the process of doing so—whatever that involves—is pure facilitation. In some respects this resembles their preferred model of “ethics facilitation,” with one potentially important exception: their model provides for the “building of consensus,” which I will argue below (see footnote 15 and section II.B) has potential for authoritarianism in a way that the Task Force does not acknowledge.
strictly based on the existence of consensus, not (in this example) on any moral reasons or explanations about consensus. As such, the job could be done well by trained mediators. In addition, the relentless pursuit of consensus might easily serve to ignore problems, concerns or dynamics with profound moral implications. For example, a consultant following the pure facilitation approach may (depending on the justification held for the moral validity of consensus) fail to treat family members’ oppositions or misgivings seriously, or even fail to pursue a line of thought which might dissolve a current consensus. In other words, if consensus is taken to be constitutive of the good, some of what is otherwise held to be morally valuable might have no purchase on the group’s consideration; what matters is the final result, not its particular content. If consensus is taken to be indicative of having reached the good, there are no guidelines or side-constraints on how a group might arrive at consensus. The Task Force is right, then, in rejecting the pure facilitation approach, at least under the rubric they offer.

C. The ‘Ethics Facilitation’ Approach

The Task Force favors the “ethics facilitation approach”, which is “informed by the context in which ethics consultation is done and involves two core features: identifying and analyzing the nature of the value uncertainty and facilitating the building of

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12 One might, however, argue that in fact pure facilitation which results in a consensus is either constitutive of the good or indicative of having reached the good. The Task Force’s arguments against the pure facilitation approach would need to be more substantial to rule this interpretation out of consideration.

13 Edmund Pellegrino seems to make such a suggestion: Anyone familiar with actual consultation processes knows how widely the knowledge and skills of those acting as ‘consultants’ today vary. Many have natural talents for conflict resolution but lack ethical expertise; many have the technical knowledge but are woefully lacking in interpersonal skills. The ideal consultant would possess both sets of skills, but reality makes this unlikely for most consultants. Are there not two different roles here? (1999, p. 12).
consensus” (p. 6, italics added). This requires a number of different tasks: gathering data, clarifying concepts and normative issues, and helping to identify acceptable options (p. 6). In addition, consultants should help to address the value uncertainty or conflict by facilitating the building of consensus among involved parties ... [which] requires them to ensure that involved parties have their voices heard, assist involved individuals in clarifying their own values, [and] help facilitate the building of morally acceptable shared commitments or understandings within the context (p. 7).

Since their understanding of the model of ethics facilitation is more completely presented by considering these other goals, I move now to a discussion of the report’s goals for bioethics consultation.

III. THE GOALS OF HEALTHCARE ETHICS CONSULTATION

In a section entitled ‘What are the goals of health care ethics consultation?’ , the Task Force states: “The general goal of health care ethics consultation is to ... improve the provision of health care and its outcome through the identification, analysis and resolution of ethical issues as they emerge in clinical cases in health care institutions” (p. 8).

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14 By ‘value uncertainty’, the Task Force means that conflict exists about “value-laden issues that emerge in health care”. They delineate two dimensions of uncertainty: the cognitive dimension, which they do not define but which must involve the epistemological claim that one cannot be certain of the justifiability or truth of values one holds, and the affective dimension, which seem to involve in part something more like *akrasia* or weakness of will. “These affective dimensions will sometimes involve cases in which parties seeking consultation know what ought to be done but find it very difficult to do so for either intrapersonal or interpersonal reasons. This could occur because the choice the parties face is so daunting (e.g., agreeing to have life support withdrawn from a loved one) or because they find themselves in a difficult interpersonal relationship” (p. 3).
A. "Improving the provision of health care"

According to the report, when there are unaddressed value uncertainties or conflicts, health care provision and outcome is not as good as it might otherwise be. However, this is not an obvious conclusion. First, one might want to resist it on the basis of a definition of health care provision. It seems possible, after all, that one could be the recipient of the best care available and still experience conflict. Resolution of the conflict might make the health care experience less stressful, or more respectful of one’s autonomy, but these are not inherently medical considerations. Improving health care provision and outcome is arguably the province of medicine rather than of ethics consultation.

Second, resolution of the conflict might be diametrically opposed to a certain conception of “health care outcome”. For example, if a conflict between a patient and provider is resolved by establishing the patient’s right to refuse a recommended therapy, the outcome might be death or increased morbidity. Third, bioethics consultation is understood as fundamental to health care, it might be considered necessary to the functioning of any health care facility. More than that, it might dictate certain spending decisions or insurance provisions. Bioethics consultation must defend its usefulness on its own terms rather than simply taking advantage of the success of an existing practice if it is to have a standing as an independent moral practice. In any event, perhaps a case can be made for the suggestion that bioethics consultation improves health care outcomes, but that case has not been made in the Core Competencies document. In what remains, therefore, I will discuss the document’s recommendations without addressing further the ability of bioethics consultation to improve health care outcome.
The general goal of improving “the provision of health care and its outcome” is, according to the Task Force, “more likely to be achieved if consultation accomplishes [some] intermediary goals.” Four intermediary goals are offered: (1) identifying and analyzing the underlying value uncertainty or conflict; (2) facilitating resolution of such conflicts (“with attention to the interests, rights, and responsibilities of those involved”); (3) “inform[ing] institutional efforts at policy development, quality improvement, and appropriate utilization of resources by identifying the causes of ethical problems and promoting practices consistent with ethical norms and standards”; and (4) “assisting individuals in handling current and future ethical problems by providing education in health care ethics” (p. 8). Goals (1) and (2) are the focus of attention in the report, and given this and the fact that goals (3) and (4) are not as central as (1) and (2) to a definition of bioethics consultation, I will focus on the report’s discussion of the first two goals.

B. Identification and Analysis of Underlying Value Uncertainty

The first goal of identifying and analyzing the underlying value uncertainty or conflict itself has four subsidiary goals, which they describe in the context of the ethics facilitation approach. According to the Task Force, “to identify and analyze the nature of the value uncertainty or conflict underlying the consultation” the bioethicist ought to (p. 6; my numbering):

(a) “gather relevant data” (of many types, for example, medical data, values of involved parties, institutional policy, etc.);

(b) “clarify relevant concepts (e.g., confidentiality, privacy, informed consent, best interest)”;
(c) "clarify related normative issues (e.g., the implications of societal values, law, ethics, and institutional policy for the case)"; and

(d) identify a range of "morally acceptable options within the context".

Careful analysis of each of the goals mentioned above shows that without further argument or foundation, these goals are too vague to give sufficient guidance for the profession. First, different accounts of which data are relevant (goal (a)) may yield different foci of a bioethics consultant’s attention and different training requirements. Second, goals (b) and (c) do not make clear to whom the concepts or normative issues ought to be clarified. If such clarification involves the consultant becoming clear herself, it simply implies self-education. However, clarification to the patient implies a good deal more conversation and education. It might involve, for example, a deeper explanation of the philosophical underpinnings of concepts such as "futility" or "best interest". Depending on how one construes this goal, considerable energy might need to be expended by the consultant, affecting both what else she may do with her day and what she can accomplish with a particular patient. Insofar as we are interested in establishing guidelines for behavior or standards for success in bioethics consultation, the goal of clarification, as the Task Force describes it, is underdetermined, and so does not help to specify the appropriate activity of the bioethics consultant. Thus the stipulation that a consultant ought to pursue clarification has, in the absence of further argument regarding what that might constitute, no concrete implications for the practice of bioethics consultation.

Additionally, as Edmund Howe points out, one of the ways in which bioethicists work towards clarity is by identifying the rights in question and the possessors of
decision-making authority. However, "[w]hen an ethics consultant identifies either, it may influence an outcome" (Howe, 1999, p. 14), giving bioethics consultants considerable decision-making power. He further argues that with such power, bioethics consultants might engender distrust and suspicion among patients and their families as well as health care teams.  

Goal (d) requires the consultant to identify a range of "morally acceptable options within the context." By way of clarifying what constitutes moral acceptability, the Task Force offers a number of ambiguous modifiers. It "emphasizes an inclusive consensus-building process" (a description that can probably be found in many corporations' vacuous mission statements or human resource manuals), while respecting patients' rights to live by their own values, always within the context of "societal values, law, and institutional policy, often as discussed in the bioethics literature" (as though agreement were readily located there), which "have implications for a morally acceptable consensus" (p. 7). The claimed virtue of the ethics facilitation approach is that it "is

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15 In a response to this criticism, three members of the Task Force correctly note that this accusation implies that any way in which a bioethics consultant might affect an outcome is inappropriate. "...[H]is view is so broad that facilitation itself, independent of ethical analysis, claims a type of 'decision-making authority' since it surely has the ability to 'affect the outcomes' of a case, and so runs the risk of engendering distrust and fear in patients" (Aulisio, Arnold & Youngner, 1999, p. 51). Howe's suggestion seems to be that bioethics consultants should take pains to avoid any decision-making authority (desired or undesired), while Aulisio et al. downplay the problem as a result of Howe's over-broad interpretation of the consultant's role.

There is an important point that ought not to be lost here between these two positions: If Howe is right that sometimes bioethics consultants possess some form of decision-making authority, the problem is not dissolved by observing that he casts his net too widely. Aulisio et al. fail to pursue Howe's critique to the next step: are there dangers in this kind of authority? Of course the driving intuition that it is impossible (and perhaps inappropriate) scrupulously to avoid having any effect on a consultation is correct. (Moreover, it would beg the question about why anyone should call bioethics consultants in the first place.) However, it is likely that some forms of consultants' authority are inappropriate and/or should be explained to patients and their families. This applies both to clarificatory and other roles the consultant could play. These kinds of unspoken authority are ways in which the building of consensus in the Report's favored ethics facilitation model has the potential (mentioned above in footnote 8) of being authoritarian in ways the Task Force does not acknowledge.
fundamentally consistent with the rights of individuals to live by their own moral values and the fact of pluralism” (p. 7).

However, this is still too sparse and vague a foundation for bioethics consultation, and does not answer the questions raised in the Introduction regarding such issues as permissible interventions by bioethicists, prohibited actions, and goals of the practice. For example, there is no argument regarding what justifies a consensus, which would give guidelines regarding both the appropriate process of achieving it and who ought to be included. Law and institutional policy are certainly matters of fact (although sometimes their interpretation may not be), but one of the implicit goals of consultation, according to the Task Force, is that such law and policy ought to be challenged when appropriate. Obviously there is a tension here. One of the grounding principles of bioethics consultation, under this model, requires that decisions should be considered within the context of such laws. This model also suggests that these laws and policies ought to be challenged when required, but it does not stipulate what constitutes an appropriate challenge.

Finally, how is one to determine ‘societal values’? It is controversial to claim that society shares values in common (cf. Engelhardt, 1996). Even if this were demonstrated to be the case, it would not prove that there is anything normative about common belief simpliciter which justifies overriding an individual’s choices. Barring further development of what constitutes a “morally acceptable” option, this goal fails to guide the bioethics consultant.

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16 “...though ethics consultation must be informed by law and institutional policy, challenges to these two domains may be appropriate at times” (CC, p. 5).
C. Helping to Address Value Uncertainty

The second main goal in the ethics facilitation approach is that bioethics consultants “should help to address the value uncertainty or conflict by facilitating the building of consensus among involved parties.... This requires them to:” (p. 7; my numbering continued)

(e) ensure that everyone has a voice;

(f) help clarify values (“identify and analyze the nature of the value uncertainty or conflict that underlies the consultation”; p. 8); and

(g) facilitate the building of consensus (“facilitate resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of those involved”; p. 8).

Goal (e) states that the consultant ought to “ensure everyone has a voice.” This might consist simply of calling on all parties to the consultation in order to hear their views. It might alternatively consist of something more proactive, such as advocating for persons who have trouble voicing their own opinions clearly or at all, or who are consistently overridden by other participants. Or, it might mean that the bioethicist ought to search out the relevant parties and ask for their opinions. Moreover, it is not clear what “voice” means. It might be equivalent to “vote” when a poll is taken to determine whether consensus has been reached. If this is the case, it is not clear what follows when there are one or more persistently dissenting voices. Goal e is a pat and empty expression without some explanation of exactly what is involved.

Goal (f), the goal of clarifying, has already been discussed above in goal (b), but there is a slight difference here in wording. Whereas in goal b above the
recommendation was “clarify relevant concepts (e.g., the implications of societal values, law, ethics, and institutional policy for the case)”, goal (f) states that bioethics consultants ought to “assist involved individuals in clarifying their own values” (p. 7). The likely meaning of this is that bioethics consultants should act as moral counselors, helping patients to determine their values. However, even if it were eventually determined that clarification is an appropriate goal of consultation, more would need to be said about the side-constraints on such an activity. For many, values lie at the core of their self-identity. Clarification of those values may come in practice to look very much like psychoanalysis or psychotherapy. In addition, it is not clear at what end clarification might aim. One interpretation of it might be coherence among beliefs. However, moral philosophers can focus on a handful of issues over the course of a career and still not reach coherence among their own beliefs. Pushing a patient or family member towards such a coherence might be extremely damaging, or at least wildly unrealistic. Even if it were accepted that clarification is an appropriate goal of consultation, more would need to be said about the side-constraints on such an activity. We should therefore have some account of why clarification is important and what it entails if it is to be part of bioethics consultation. (Problems with goal (g), facilitating the building of consensus, will be discussed below in section IV.)

IV. THE ROLE OF THE ETHICS CONSULTANT

The report considers the appropriate role of the ethics consultant in two separate sections. The initial descriptions of the role of bioethics consultants are vague: they “help...address uncertainty or conflict regarding value-laden issues that emerge in health care” and “help
sort through the ethical dimensions of complex cases" (p. 3, emphasis added). And “[d]ue to the complexity of these ethical issues, health care providers, patients, families, or surrogates may request assistance to help think through questions or resolve conflicts that may be present” (p. 4, emphasis added). Consultants are also charged with “helping to identify the implications of these rights and who has decision-making authority in particular cases” (p. 4, emphasis added) and “[h]elping to identify the implications of law and institutional policy for particular cases.” It may seem that vagueness is necessary in descriptions of this field. But this purports to be a document that explains what bioethicists ought to do. If this amounts to the claim that bioethicists “help”, it is so vague as almost completely to fail to identify a profession or its activities. This judgment regarding the Core Competencies recommendations does not involve a selection bias on my part. In the pages concerning the concrete roles for the consultant, the reader can find multiple sections where the word “help” appears. The central question is in what manner and toward what end the consultant is to help.\footnote{Ross makes a similar criticism: “If we look at the examples of case consultation actually provided by the Task Force ..., we find none presented with an eye to helping the reader understand the nature of what the ethics consultant pursuing the ‘ethics facilitation approach’ is actually doing” (1999, p. 29).}

One of the most important aspects to consider for the role of bioethics consultation, according to the report, is the societal context in which autonomy is a pervasive value, both in society in general and in its laws. The difficulties in establishing what this constitutes have already been discussed (see section III.B). Therefore even if we understood what “help” entailed in terms of action, the context in which help must be undertaken is not clear.

One side-constraint on bioethicists’ actions is offered: the Task Force recognizes that if there are a number of acceptable options in a case, the bioethicist may be in a
position to guide discussion. This can translate, as discussed in section III.B, to a position of power for the bioethicist. For some patients and their families, the knowledge that the consultant is an “ethicist” may incline them to accept whatever the consultant says (since, the thinking might go, “she must know what is ethical”). The report allows that it is “impossible for ethics consultants to be value neutral”, and suggests that in recognition of this, “it is important that consultants make it clear to other involved parties both when they are offering moral judgments based on their own values and the reasons underlying their position” (p. 7). This side-constraint seems especially important in the absence of an agreement on the possibility of moral expertise or on particular moral issues.

It also, however, controverts what the Task Force suggests elsewhere (see section III.B) regarding the existence of ‘morally acceptable options’. If bioethics consultants themselves can legitimately be divided on an issue, why may the bioethics literature and society in general not be legitimately conflicted? That is, previously the report seemed to imply that it was wrong of a consultant to base her opinion on a controversial topic in the literature. However, if it is possible for a bioethics consultant to make a recommendation provided she disclose her position, why can the same not apply to positions in the bioethics literature?

The suggestions contained in the report for the roles of the bioethics consultant do not add much to the definition of bioethics consultation. The report repeatedly describes bioethics consultants as “helping” in various ways, but fails to specify what this help entails. The one relatively concrete guideline offered, that a consultant be forthcoming
about his own values and beliefs, is in conflict with other recommendations made. The proposed evaluation standards for bioethics consultation also fail to delineate the activity.

V. EVALUATION STANDARDS

The Task Force holds that the evaluation of bioethics consultants, processes and outcomes is of “great importance.” However, given the ambiguity outlined so far, it is not clear what there is to evaluate, or how it would be conducted. Nevertheless, though the Task Force notes that a full discussion of this area is beyond the scope of the project, they offer some brief indications of what they have in mind. For example, they note that the outcomes of ethics consultations must be evaluated because this is “an important way to justify and correct recommended competencies for consultant and process procedures” (p. 27). However, this is a circular argument. In what manner are the appropriate outcomes to be determined apart from a conception of the aims of the profession? If such a conception is established, it would also determine professional competency requirements. One might instead argue that outcome evaluation is important because the profession of bioethics consultation, like other professions that claim to provide a service, ought also to be able to tell clients what constitutes a better or worse professional. To attempt to establish professional competency requirements before establishing the concrete goals of the profession makes little sense. A discussion of the Task Force’s standards of success will highlight more ambiguities and suggested roles for bioethicists.

The Task Force suggests that consultations be evaluated by asking four questions:

(1) Was a consensus reached?
(2) Was the consensus within the boundaries set by societal values, law, and institutional policy?

(3) Was the consensus implemented?

(4) What was the level of satisfaction among participants? (CC, p. 28).

Again, we meet with ambiguity: what constitutes success given these standards? Question (1) asks, "Was a consensus reached?" First, we might ask why consensus is the mark of success. While any treatment decision agreed upon by both doctor and patient may count as consensus, if there are cases where more parties are involved, an argument needs to be offered for why their views ought (or ought not) to be considered. Potentially the reasons given for such participation render reaching consensus unnecessary. For example, if a patient is incompetent and has appointed a surrogate decision maker, he or she may be the only relevant party. If other family members disagreed with the surrogate, one must take a stand on which party must be overruled if their deep disagreement prevents consensus. Thus the first problem with this standard of success is that it asserts without argument that consensus is the desired goal.

The second problem is that even if we agree that we ought to reach consensus, the reasons for reaching consensus may not only be multiple, but incompatible. These different reasons may also carry with them disparate criteria for success. For example, one might want to reach consensus in a case simply to fend off legal liability. In this case, if a party to the consultation was unempowered to take any legal action, his agreement would be unnecessary. If one construed consensus in this fashion, the bioethicist would be playing the role of risk manager.
If instead one takes consensus to be an indication that one has arrived at the moral
truth, what is to be made of disagreement? Does the majority by definition always point
to the moral truth? How are we in a principled fashion to resolve the dispute (assuming
that the disagreement is based not on conceptual or logical mistakes, but on fundamental
differences in values or moral views)? Alternatively, if we take consensus to be a means
of respecting the dignity of the parties involved, how can this dignity be recognized in
cases of disagreement? And to what lengths should one go to respect this dignity? How
might other values at stake (such as consequences of various actions or the integrity of
the health care worker, for example) be recognized if they conflict with the recognition of
dignity?

Question (2), regarding whether a consensus falls within acceptable boundaries,
has already been discussed at length. Regarding question (3), it is not clear that it is the
consultant’s role actually to implement a decision. It is entirely conceivable that the
bioethicist has nothing to do with the more administrative aspects of the position, so to
make implementation of the decision a standard of success seems unnecessary. What the
Task Force might mean is that actual implementation is a mark of success in the sense
that a decision would not be just a hypothetical agreement. This standard might be used
as the basis of a quantitative measurement of the effectiveness of bioethics consultations.
There are two possible reasons to assess implementation.

First, one might hold the assessment to be a measurement of the ‘goodness’ or
accuracy of decisions reached with the help of bioethics consultation, on the premise that
the better the decisions are, the more often they will be implemented. However, no
matter how sound the decision reached, many factors can prevent its implementation,
including the death or improvement of the patient or other changes of circumstance. Such a quantitative measurement would be very difficult to interpret in terms of 'success'.

Second, this assessment might help to pinpoint the extent of a consultant’s influence. This has obvious benefits for a profession: if the numbers of a particular consultant are low, one can research why such consultants’ recommendations are not implemented with more frequency. If the numbers are high, one can point to one’s effectiveness as a basis for claiming authority, a higher salary, more respect, etc. All of this would be based, however, on an undefended claim regarding the connection between implementation and the ability of the bioethics consultant, made more glaring due to the very vague definitions of the activity given in the report.

Finally, it is interesting that in question 4, the Task Force suggests that participant satisfaction is a standard of success. Setting such a standard runs the risk of encouraging bioethics consultants to undertake public relations work, increasing the chance of participant satisfaction. Thus, whatever else consultants ought to do, it may be secondary to the goal of “customer satisfaction,” and even at times conflict with it.

We have found that there is too much ambiguity in the Task Force’s understanding of the goals and success standards of bioethics consultation for us to make much headway on our initial questions regarding the goals of consultation. Much more must be said about the goals before success standards can be suggested.
V. CONCLUSION

The point of examining this document has been to ascertain whether there is an existing standard that would answer the questions raised in the Introduction, such as what the end goal of consultation ought to be, what actions are permissible in the pursuit of that goal, and whether there is yet any way to identify consultants as better or worse. While the Task Force has begun to sketch out their favored model for bioethics consultation, it is far from being able to ground a profession either philosophically or practically. The problem is not just that their terminology is ambiguous and their examples vague (and scarce). The problem is that once these terms are analyzed in more depth, it becomes clear that they can be interpreted in many plausible but conflicting ways, with very different implications for bioethics consultation. A bioethicist who facilitates by using force of personality to convince the parties involved, and who takes consensus to mean that no one has a strong opposition to or “good” argument against the position he sees as favorable, will be very different from one who facilitates by asking questions designed to lead to further conversation and who takes consensus to be real agreement among all parties. Establishing which of these or other possible models constitutes a justified basis for bioethics consultation is the point of this project. The Core Competencies document does not resolve this problem. As a result, it would be unwise to attempt to standardize the profession on the basis of this document. Even if some chose voluntarily to subscribe to its recommendations, they would fail in the end to derive practical guidance from the document.
CHAPTER FIVE: A SEARCH FOR PHILOSOPHICAL FOUNDATIONS

Up to this point we have encountered no identifiable conceptual integrity underlying the field of bioethics consultation. (Or as Judith Wilson Ross once put it, we have not yet established a “unified field theory” of bioethics (Ross, 1996, p. 24).) Given the multiplicity of historical influences and the incompatible set of understandings among representatives of the field, further analysis is clearly needed. However, from what perspective should the analysis proceed? Each of the authors discussed in chapter three begins from different premises regarding the features of bioethics consultation. It is therefore not surprising that their conclusions also differ. Nor has the ASBH Task Force’s report resolved the difficulty. The next step must be to a meta-level analysis. What are the appropriate philosophical foundations for the field of bioethics consultation? Is it a purely contractual relationship between an employer and a bioethics consultant, or are there philosophically justifiable requirements and boundaries to such a practice? The goal of this chapter is to assess philosophical approaches to establishing a positive account of the basis of bioethics consultation.

The first section of this chapter examines George Sher’s study of the possible moral grounds for obligations of university faculty members. In the end, as he admits, his search is fruitless. The same will be true when the argument is applied to bioethics consultation. However, he does conclude that there are other avenues worth exploring, and section two takes up those suggestions in search of the moral foundations of bioethics consultation. Despite some signs of promise, however, neither option is successful in the
Section three resurrects an option Sher discards: a profession might derive obligations from multiple sources. This possibility is also problematic. A discussion of social work, a historical parallel to bioethics consultation, shows how a social practice can come to look like a single profession, but in fact is a heterogeneous set of useful roles. As a result, it becomes clear that it would be an error to search for conceptual unity underlying the field of bioethics consultation.

I. SHER’S ARGUMENT

George Sher’s paper (1996) on the role of a university faculty member provides an excellent template for considering arguments regarding the obligations of bioethics consultation. According to Sher, investigating the obligations of a faculty member requires asking both what specific goals he has and why he has them. On the one hand, if we have no reason to care whether faculty members comply with their obligations, we are unlikely to be concerned with what those obligations are (indeed, it would be a stretch to understand them as obligations at all). On the other hand, it is difficult to answer why a faculty member must fulfill certain obligations without specifying those obligations. The argument can be pursued by beginning with either question, but since the two are connected, the answer to one must also lead to the answer to the other. He concludes that while some headway may be made with each question separately, in the end, there is no solution that answers both.
A. The Obligations of a Faculty Member

In asking what special requirements the role of faculty member at a university requires, Sher points out that since there are no “prior normative considerations” (i.e., prior assumptions; p. 473), the content of these requirements will need to be derived in some other way. He offers three alternatives: first, there is some metaphysical or essential truth about what it is to be a good faculty member; second, there is some fundamental meaning in terms like ‘professor’ that might guide us; or third, we share some “(mutable) understanding of the teacher’s role, or certain (alterable) expectations of those who occupy the role” (p. 473). He rejects the first alternative as “metaphysically extravagant,” and acknowledges that appeals to analyticity are “widely suspect,” therefore rejecting the second and settling on the third as the only viable option.

‘Shared understanding’, as he interprets it, is consensus regarding particular obligations faculty members have, such as grading according to merit, showing up to class prepared, etc. It is plausible to argue that people with some familiarity with the university system would arrive at consensus regarding a recognizable list of obligations. The more difficult task, Sher points out, is to show why any faculty member is obligated to fulfill this shared understanding.

Recall that we need an account that delivers both the content and the source of obligations. Sher considers three possibilities. First, it might be that the obligations of faculty members derive from general moral obligations. For example, the duty not to lie might imply that a professor should give grades according to merit, since only in this way is he telling the truth about a student’s performance. He discards this option because there are many other obligations it seems professors have that are not covered by general
moral obligations. For example, he suggests, it is difficult to see how one might derive the obligation that teachers not lecture beyond their competence from some combination of general moral obligations.

Second, perhaps the obligation to honor explicit agreements is what governs the requirements of faculty professor. The problem with this option is that few if any professors have contractually agreed with universities to fulfill the kind of requirements that we generally understand professors to have (for example, grading by merit or preparing for class). This leads to a third possibility: there may be a tacit agreement to perform certain roles or tasks. However, Sher notes various problems with invoking a tacit agreement as the basis for the obligations of a university professor. It would provide no basis for criticizing particular tacit agreements; it is belied by the fact that even in the absence of tacit agreements there seem to be obligations on the professor; there seems to be no basis for claiming the existence of such a tacit agreement; and finally, with whom can one be said to share a tacit agreement?¹

Though the idea of a shared understanding seemed the best option for deriving obligations for a faculty member, Sher argues that no source of such obligations can be found. That is, though we might be able to enumerate various obligations for the faculty member rooted in our common preconceptions about the role, we have as yet no way of arguing why he should fulfill those obligations. Before proceeding further with Sher’s argument, consider the implications for bioethics consultation of the foregoing arguments.

¹ Sher suggests that perhaps one is obligated to one’s students or to the wider society, but responds that neither the students nor society seem to “own” the role of professor in the sense necessary to be able to invoke tacit agreement. He does suggest in conclusion that the possibility of a tacit understanding should be reinvestigated to see if more headway can be made. I argue below that at least as far as bioethics consultation is concerned, this possibility is unsuccessful.
B. The Obligations of a Bioethics Consultant

Sher suggests three possible sources of obligations: essentialism, analyticity, and shared understanding. His rejection of the first two options also applies to bioethics consultation. The challenge then is to determine whether bioethics has the kind of shared understanding he mentions.² If it does, perhaps this will give us, or at least lead us towards, some conceptual integrity underlying bioethics consultation.

Assuming one thinks that such a shared understanding exists (and the foregoing chapters give reasons for thinking it does not), what would be the best way of determining what it is?³ There are two possibilities. First, we could actually poll people to discover a shared understanding. However, the moral significance of the results of such a survey is difficult to discern. How do particular opinions empower particular moral obligations? Additionally, whom ought we to survey? Surveying some subset of the public, such as hospital staff and employees, will not have an uncontroversially normative force. Moreover, there are reasons to question whether such a survey would yield any concrete results. The experiences of the Center for Ethics and Health Policy

² There might seem to be some headway to be made by considering the meaning of terms such as “bioethics consultant,” since analytically, “consultation” seems to imply that one is called on to give advice on a particular question. However, this temptation should be resisted for two reasons. First, there is no unique term to analyze, since the official title of bioethics consultant is still in flux. Often the term “bioethics consultant” is used interchangeably with “ethicist,” “clinical ethicist,” “clinical bioethicist,” or simply “bioethicist.” Moreover, the term “bioethics” was coined almost simultaneously by two different people and held by them to mean two different things (Reich, 1994). Which should be privileged as the analytical meaning? Second, one of the central issues in bioethics consultation is whether it should be understood as a consulting service for the physician or, perhaps, as patient advocacy or moral activism. Assuming some analytical meaning of “bioethics consultant” at the outset would sidestep some of the important questions.

³ A further and much deeper question is the normativity that any shared understanding would have. Why, for example, would the results of a survey be a candidate for determining professional standards? Though here the point should not be pressed (see Sher, 1996 for an extended discussion of the normativity possible from shared understanding), it seems that in the absence of an analytic or essentialist argument, a shared understanding is at least a good candidate for establishing the basis of a profession. This is not least the case because professions exist in part to serve some subset of the public. If that public does not understand or want those services, the profession will simply not exist. Most crucially, it is argued that there is no shared understanding of bioethics, so any defense of its normativity is moot.
Baylor College of Medicine) in a local hospital (Methodist), for example, found that a majority of the hospital’s own staff did not know a bioethics committee existed, let alone what it did. No explicit or implicit agreement appears to exist regarding the governing moral obligations. Surveying the bioethicists themselves brings into question the existence of external, relatively objective standards for the practice. Moreover, such a survey is unlikely to result in consensus, as demonstrated by chapter three’s discussion of the diversity of opinion regarding the field’s goals. Is there some other way of determining a shared understanding of what bioethicists ought to do that is not up to the practicing bioethicists themselves?

A shared understanding of what constitutes a certain role or function might derive from precedent. Though there may not be a shared understanding concerning the obligations of bioethics consultation, it is possible that certain precedents are held in common by practitioners in the field. Perhaps there are touchstones by which we can discover some common understandings of the field. In bioethics, there is precedent in two different areas. First, there is actual legal precedent regarding the duties of various bioethics committees. There is in addition a historical precedent grounded in the actual functions such committees have played. Such committee functions might help to specify the role or aim of the ethics consultant. This is not to suggest that such precedents ought to determine the function of bioethics committees (see footnote 3 above), but insofar as there might be a possibility of a yet-unrealized shared understanding of what bioethics committees ought to be and do, one good candidate for the origin of this understanding lies in the events and commitments that give rise to the practice. As chapter two made clear, there is no such foundational precedent to guide bioethics consultation.

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4 Personal communication with Maureen Kelley, November 15, 2000.
First, there simply is no core concern or set of concerns to be found in history; no consensus or single consistent focus of attention over time is evident from examining bioethics' beginnings. Second, the concerns that are found are ambiguous. It is often unclear what actions particular goals would warrant. For example, though the history of research scandals may have conveyed the sense that bioethics consultation is partly concerned with patient protection, it is not clear what would follow even if that were taken to be the basis of a shared understanding of the field. Numerous questions arise. Should a bioethicist roam a hospital looking for the violation of patient rights? Does the very circumstance that bioethicists are hired by institutions compromise their ability to protect patients in meaningful ways? How paternalistic should a bioethicist be in protecting patients—does it extend to prohibiting certain clinical trials because patients might be endangered, or should patients have a choice? In addition, this basis for a shared understanding offers no guidelines regarding what to do if roles conflict. Using precedent as a basis for a shared understanding of the field fails to yield a concrete conception of bioethics consultation.

Thus, the third possible source of an account of obligations (i.e., shared understanding) is unsuccessful for bioethics consultation (as it is in Sher's example of university teaching). Note, however, that it fails for bioethics consultation at an even earlier stage: whereas one might be able to outline generally accepted faculty obligations, it is very difficult to do so for bioethics consultation. As chapter three indicated, even practitioners themselves have radically different understandings of their obligations.

Even if we could find a list of commonly-held bioethics consultation responsibilities and role requirements, the argument fails when we attempt to discover
why they would have such obligations or what force they would have. Sher’s first suggestion, that one might derive certain obligations for the bioethics consultant from general moral requirements (for example, that one should be honest with patients regarding prognoses, etc.), answers very few of the important questions at issue in bioethics consultation, such as whether the bioethics consultant ought to give positive advice, or whose interest the bioethics consultant serves.

The second possible source of obligation, explicit agreement, fails because bioethics consultants do not currently sign explicit contracts regarding such issues as whether they should advocate for patients, represent a particular “moral order” by being a moral activist, or facilitate discussion in some particular way. Third, it should by now be obvious that there is even less chance of discovering a tacit agreement regarding the obligations at stake in bioethics consultation than there is regarding university teaching. Additionally, the problem of with whom one has a tacit agreement is even more complicated in bioethics consultation that it was in university teaching. The obvious candidates for tacit agreement in Sher’s argument regarding the academy are the university, the students, and perhaps society at large. In bioethics consultation, on the other hand, the candidates are the patient and his family, health care team, health care institution, and society in general. Whereas it does not appear that universities, students and society at large have radically competing views of the importance of learning, it does not appear in bioethics that the candidates to a tacit agreement have enough in common to choose among competing views. A patient might want a treatment that the health care team and institution do not want to provide, and both might be opposed to a certain conception of what morality dictates. (Who authoritatively represents which of the
competing viewpoints is another wrinkle in the argument.) Just as Sher concludes in his pursuit of the obligations of university teaching, the conclusion here is that beginning from a set of obligations for bioethics consultants and trying to work towards the source of those obligations will not be successful. Contentions regarding the role of bioethicists have less promise than arguments regarding the obligations of faculty members, because establishing even prima facie obligations for bioethics consultants requires what is not available, mainly some shared understanding of even the basic obligations of bioethics consultation. There appears so far to be no hope for a shared understanding of the field of bioethics consultation.\footnote{This is not an in-principle claim, merely an assertion of fact. Campaigning by a bioethics organization (ASBH, for example) may in time achieve some sort of shared understanding of the field (among whom is not exactly clear; candidates include the members of the Society, bioethicists at large, or society at large). Indeed, this seems to be an implicit goal of the Core Competencies document. Were such a shared understanding to be achieved, however, one would still face the problem of its normativity.}

Sher’s next tactic is to begin from the other direction, attempting to delineate sources of obligation for the faculty member, and to work from that to specific obligations. After all, if we could determine why professors are obligated at all, that overall justification might convey specific role requirements. Again, this will prove to be an unsuccessful tactic both for the university professor and the bioethics consultant.

C. The Sources of Obligation for the Faculty Member

If we can determine the aim, function or purpose of the role of university professor, Sher suggests, we might then discover the obligations such a role entails. That is, if we can establish that a particular role exists in order to further a particular worthwhile aim, then we might conclude that the university professor is under an obligation (at least prima facie) to do whatever activities are required to further that aim effectively. If such

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activities can be identified, then we have at last established both the obligations of a university professor and the sources of those obligations.

However, Sher points out, problem with this approach is that it is not clear that there is a single worthwhile aim of university teaching. In addition to passing along knowledge, the university professor can also participate in the worthwhile aims of making new discoveries, promoting a variety of social agendas (such as equality), or instilling desirable attitudes and values in students (such as toleration). Given these competing aims, how can we establish which aim takes precedence? Sher cites four possibilities, concluding in the end that none can establish the case.

First, we could appeal to the actual aim of a majority of the profession. The problem with this option, he points out, is that it is too contingent and heterogeneous to deliver any normative force. As a second option, we might appeal to facts about “the nature, concept, or essence of the role itself.” This has already been shown to be problematic, and is likely to be even more so when applied to the social roles of bioethicists than it was when applied to specific bioethical obligations. The third option is to examine “the functional organization of the system within which the role is embedded.” Insofar as the system itself has moral value, the source of one's obligations derives from that larger valuable aim. So, for example, the duties of a prosecutor are derived from the place of prosecution within the legal system. When one becomes a prosecutor, one is pursuing a particular aim within that larger system. Again, this fails to establish a normative model for university teaching. It fails primarily, as Sher points out, because whereas the overall goal in the legal system is clear, there is no equivalently clear goal in the education system. The fourth option, that we examine the “overall
consequences of alternative activities,” remains. The suggestion is that we examine the implications of various ways of playing a role and try to maximize them with regard to bioethics consultation. The problem with this option is that both ways of interpreting it fail: either it reduces to act-consequentialism (in which the overall consequences of each individual activity must be evaluated) or, must be interpreted instead as a rule (viz., “choose that activity which, if generally practiced, tends to maximize consequences”). In either case, it suffers from the fact that it will be difficult or impossible to evaluate such consequences. For example, Sher notes, it is unclear what consequences should or could be evaluated that would enable us to make definite claims regarding whether teaching one list of authors would be better than teaching another. Any success this tactic (of choosing obligations on the basis of which brought about the best overall consequences) offered in discerning sources of obligations is unfortunately rendered moot by its failure to give practical guidance in terms of generally justified obligations.

D. The Sources of Obligations for Bioethics Consultants

Unsurprisingly, Sher’s argument has the same implications for bioethics consultation. If we could determine the aim, function or purpose of the role of bioethics consultant, then we might be able to derive specific obligations from that aim. However, arguments so far have made it abundantly clear that there are many different potential worthwhile aims of bioethics consultation. So far there is no basis for claiming that patient advocacy, moral activism, mediation, emotional assuagement or spiritual guidance (to name only a few potential aims) has more of a claim to be “the” worthwhile aim of bioethics consultation in comparison to any other aim.
Given the reality of multiple worthwhile aims, we face the question of which aim takes precedence in yielding our sources of obligation. The means Sher suggests for resolving this problem fail to provide normative guidance for bioethics consultation just as they do for university teaching. First, there does not seem to be a majority conception of the practice. Second, the problems of essentialism and analyticity, which have already been discussed, suggest that these avenues are not promising. The third option, that somehow the priority of aims might be derived from the functional organization of the institution within which bioethics is embedded, is even more problematic for bioethics consultation than it was for university teaching. Though the larger organization within which bioethics consultants function is the health care delivery system, I have already argued that it is not obvious that bioethics consultants contribute in any intrinsic sense to health care delivery nor that we know the moral aim of health care delivery. In addition, one of the possible aims of bioethics consultation is to function as a critic of health care institutions. It is not clear exactly how this aim might be derived from the overall functional organization of the health care system, nor what its focus would be. Such an aim may be pointedly opposed, by its very nature, to appropriately serving the functional organization of health care institutions. The presence of bioethics consultants within the hospital exists in what many argue is an important and necessary tension with the surrounding values and framework of the health care institution. Finally, the fourth option of discovering the most valuable aims of bioethics consultation by making consequentialist calculations fails just as it did with university teaching because of the difficulty in establishing which obligations bring about optimum consequences.
E. Conclusion

We were led to Sher’s arguments by a search for the conceptual integrity behind bioethics consultation. The result of his argument is that there is as yet no account that can offer both the obligations a professor may have and the reasons he has them. The application of the argument to bioethics consultation has a similar result. However, as we saw, in bioethics consultation matters are even more problematic. We lack still an account which unifies and gives prescriptions for the field of bioethics consultation.

II. STILL SEARCHING FOR THE FOUNDATIONS OF BIOETHICS CONSULTATION

There are further avenues of exploration. Sher suggests two in his parting remarks: first, we could return to the idea that there is some undiscovered tacit agreement, and second, we can try to find another principled way of establishing the faculty role’s aim. This section pursues these possibilities for bioethics consultation. In the end, however, neither is successful. Section four returns to a discarded option: perhaps we derive obligations from multiple sources.

A. Tacit Agreement

Consider again the possibilities for tacit agreement as the source of obligations for bioethics consultation. The context of the university suggests that there may be a tacit understanding between a university and its students. What is the parallel in bioethics consultation? It might be argued that there is a tacit understanding between the institution and its patients which would then guide the bioethics consultant in his
activities. As was discussed earlier, it is not clear whom we should take to be in the morally relevant tacit agreement. After all, bioethics consultants currently provide services to patients and their families, and also to staff and hospital administration. Whose interest controls the content of tacit agreement? If we had some basis for asserting particular obligations for bioethics consultants, we might be able to work from that to the choice of which tacit agreements are most important. This would manifestly involve arguing in a circle, since the very reason for reexamining the possibility of tacit agreement is as a ground for these obligations in the first place.

Even if we could determine which parties can be said to be in tacit agreement regarding bioethics consultation, crucial problems would remain. What would be the content of that agreement? First, one might posit a tacit agreement (between the institution and the patient, for example) that health care will be delivered ethically, and that the bioethics consultant is charged with ensuring that this is the case. Multiple problems leap to mind. First, this would seem to dictate that there be numerous consultants in hospitals (particularly in large ones) in order to oversee the delivery of health care, and interestingly, this might also require that physicians who have outpatient examination offices retain bioethics consultants. This would be quite invasive and costly, as well as relative overkill if we presume, as seems reasonable, that most physicians succeed in delivering morally acceptable health care. At a minimum, such an agreement would require that rigorous training in “ethicality” ought to be offered at every health care institution. This leads us to the more central problem: what is *ethical* health care?

There are multiple, radically divergent understandings. One might have a ‘thin’ theory of ethical health care, by which is meant, for example, simply telling the truth. In
this case, it is not clear why bioethics consultants would be required at all, unless it was as part of an ethics police force, present at all discussions to ensure that honesty was respected. On the other hand, if one had a ‘thick’ theory of ethics in an institution, what would have to be done with those whose moral positions differed from that of the institution? This points out the only situation in which tacit agreement might be said to work. An institution which declared itself publicly to subscribe to a particular moral position, and which made that position clear to patients, could legitimately hold that its patients tacitly agree to that same position when they receive health care there. The institution would then be justified in hiring bioethics consultants to practice according to specified standards. This begins to look much more like explicit agreement than tacit agreement. The point of examining tacit agreement as a source of obligations is to determine whether there is a widely-held conception of such obligations. The fact that there is a particular circumscribed area in which an understanding can be reached does not convey any conceptual integrity to the field at large because it is based on particular moral premises that need not be shared.

Second, one might argue that ethical consultation is an important element of health care. That is, there is something about what bioethics consultants do that is integral to health care itself and is not merely a manner in which health care can be delivered. For example, one might hold that health care applies to a whole person, and insofar as a patient is troubled or confused about the moral implications of a decision, a bioethics consultant can treat those moral ‘symptoms’ just as a cardiologist might treat arrhythmia. In this case, the bioethics consultant’s activities might count toward healing the patient. Recall that this is exactly what the Core Competencies report seemed to
propose: “The general goal of health care ethics consultation is to ... improve the provision of health care and its outcome through the identification, analysis and resolution of ethical issues as they emerge in clinical cases in health care institutions” (ASBH, 1998, p. 8; italics added). Recall also that there are two problems with this goal: first, it seems to understand value uncertainty or conflict as a failure to provide or improve the outcome of health care, and second, that it is entirely possible to be the recipient of the best care possible while still suffering from ethical dilemmas, uncertainties or concerns.

Patients almost certainly do not include an “ethical workup” or “intervention” as part of their conception of health care. It is difficult to imagine how one would argue that such a tacit agreement regarding ethics is fundamental and normative to the provision of health care (and is not instead a way of providing health care). It is a further question as to whether tacit agreement would necessarily be between patients and institutions rather than between patients and individual physicians or even between patients and society at large (if we understand the provision of health care to be a societal aim that health care institutions are simply fulfilling by proxy). Reexamining tacit agreement for sources and descriptions of the obligations of ethics consultants seems to be fruitless.

B. “Frankly Normative Considerations”

Sher’s second parting suggestion is that perhaps the moral aims of a faculty member (and by extension in our argument, a bioethics consultant) might be derived from normative societal goals. For example, he suggests, perhaps the professor might ascertain his obligations if he determines how his job contributes to large-scale considerations such as
“what we owe to future generations, the intrinsic value of knowledge and culture, and the place of an educated population within the democratic ideal” (1996, p. 485). In other words, the role of faculty member results from a contingent application of fundamental moral values (where by ‘contingent’ I mean that there are other ways in which these values might be realized besides the current system of tertiary education). The source of his obligations is the value inherent in these societal goals, and the application of these values in the context of university teaching will give the specific obligations.6

It is not clear exactly where we should search for the overarching normative considerations guiding bioethics consultation. Some professions may have a clear moral basis. For example, medicine’s basis is usually taken to be healing (and concomitantly not harming). While this is a much-oversimplified claim, the fact of the matter is that it serves as a touchstone in many arguments regarding the profession.7 Where should we look for this overarching normative direction in bioethics consultation? Three possibilities recommend themselves. First, we could examine the fundamental aim guiding moral philosophers and theologians prior to their incorporation, as bioethics consultants, into the hospital. Perhaps whatever aim guided their studies prior to entering the hospital can still guide bioethics consultants. A second possibility is the social goal of protecting the weak, vulnerable or unempowered. Several aspects of the history of

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6 As Sher points out, there will still be empirical questions about which methods/tactics/roles are most effective in advancing these goals.

7 In JFK Memorial Hospital v. Heston, for example, the New Jersey Supreme Court found it acceptable for the hospital forcibly to transfuse a Jehovah’s Witness patient. The basis of the decision was that “Hospitals exist to aid the sick and the injured. The medical and nursing professions are consecrated to preserving life. That is their professional creed. To them, a failure to use a simple, established procedure in the circumstances of this case would be malpractice...” (JFK Memorial Hospital vs. Heston; reprinted in Arthur, 2002, p. 379). In other words, according to this court, healing is so fundamental to the health care professions that doctors and nurses should not be forced to stand by and do nothing when a healing measure could easily be pursued.
bioethics suggest that this holds promise for giving bioethics consultants a directing set of obligations. Third, there is the more diffuse social goal of “helping”. That is, there is arguably a social goal of making better rather than worse decisions. In complex, unfamiliar cases, individuals often want or need help in coming to such a decision, and in order to do so, they consult experts. If we can attain some clarity on this goal, perhaps it will yield obligations for bioethics consultants.

1. The aim of moral philosophers and theologians

Interpreting this aim seems to place us in a dichotomy: either moral philosophers and theologians aimed simply at the advancement of knowledge, or they aimed to guide others towards the ethical life. The first option is clearly insufficient to give a bioethics consultant any substantive obligations. To the extent that it does give obligations in the context of actual health care decision making, it might suggest only that consultants should conduct empirical studies. It certainly would not address whether consultants should give positive recommendations or advocate for their patients. The second possibility, however, begs most of the important matters at the outset. Since it is important to ask whether bioethics consultants should give positive advice, influence others to conform to their own views, or even exercise the right to ‘police’ the ethical decisions made within a hospital, assuming prima facie that all of this is legitimate would be unjustified. In addition, of course, there is the looming question about which account of “the ethical life” one would need to follow.

Philosophers and theologians (and others who entered bioethics consultation later) have multiple aims. What motivated those who considered moral questions and their
expression in medical situations may have been intellectual interest or a desire to
discover the right, do the right, and/or help others to discover and do the right. In this
light, “the aim” or “the goal” is an inappropriate term, because certainly some were
motivated by an interest in the questions independently of whether or not they could be
answered. The goal of some was simply discovery, while the goal of others was to
ensure that the right was done. Broadly speaking, the general tenor of these early
activities was to investigate moral questions; the goals which directed the use of the
results (e.g., pure acquisition of knowledge, personal moral motivation, moral activism,
etc.) varied from the outset. The difficulty in pinning down a particular aim or family of
aims reflects the circumstances in which we find ourselves as well as makes it difficult to
establish the guiding moral obligations for bioethics consultants. It is necessary to cast a
wider net in order to find a relevant societal goal capable of directing bioethics
consultants’ aims.

2. Patient Protection

Arguably there is another social value driving the field of bioethics consultation. Patient
protection has been a part of the field from the early days of bioethics, in reaction to
perceived physician paternalism. This was especially apparent in the area of research
ethics, where revelations concerning particular research protocols (see in particular
Beecher, 1966) indicated widespread mistreatment of unwitting research subjects. These
revelations, combined with the civil rights movements of the 1960s, suggested that
patients in the hospital require protection. Perhaps this is the social aim that will yield
obligations for the bioethics consultant.
It seems feasible at first glance. Some of the historical events discussed in chapter two, such as the Beecher article (1966), Tuskegee study (Jones, 1981), etc., certainly indicated that patients needed protection. Additionally, it is quite plausible to argue that society has a moral obligation to protect its weak, vulnerable and unempowered members. The combination of these two considerations suggests that bioethics consultants can fulfill this aim on behalf of society in an area proven to need such services. Indeed, it seems to be assumed in some accounts of bioethics consultation, such as Freedman’s (1994, p. 123). On this account, bioethics consultants might be obligated to advocate for patients on a variety of issues, search out instances where patients require protection (since, after all, the best defense is a good offense), and overall keep a wary eye. It would certainly suggest that at least patients, and perhaps anyone, may call for a bioethics consult even against the wishes of the attending physician. It would also suggest that bioethics consultants may not represent the interests of their own institutions whenever doing so would conflict with the primary aim of patient protection. Thus this aim seems to provide relatively concrete obligations as well as some idea of priority ordering among other possible obligations.

However, this will not work as the defining source of obligations for bioethics consultation, for several reasons. First, there is a question of efficacy: there is a need for patient protection and advocacy across a wide range of situations. Many hospitals already have patient advocates, and non-profit patient advocacy groups currently lobby for patient protection legislation (e.g., the Patient’s Bill of Rights) and often intercede

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8 It may, however, contribute some of the obligations of bioethics consultants. This possibility will be examined further in section four, which investigates whether bioethics consultants have obligations from multiple sources.
between patients and their doctors or insurance agencies. If patient protection (and by extension, advocacy) is an important social goal, patients would seem to be best served by those who dedicate their time and training to advocacy on a large scale. One might take all current bioethics consultants and deem them Patient Advocates, but doing so would be pointless, since (a) better-trained advocates already exist and (b) this removes a majority of current tasks bioethics consultants currently perform. While the latter is no argument for keeping the status quo, it does suggest that we have not yet captured some of the fundamental factors that led to bioethics consultation.

Second, more often than not, bioethics consultations seem to arise because people are uncertain what to do, not because the patient’s autonomy (or some other interest or right) is at risk of being overridden (though certainly there are cases of this). This fact has two implications. Making patient protection a fundamental value, guiding principle, or goal of bioethics consultation may bring confrontation to a situation where none had existed. Many bioethicists have observed anecdotally (no actual evidence to this effect exists to my knowledge) that very few of their consultations actually involve an issue of patient protection. If bioethics consultants entered the medical context ready to fight for a patient’s rights (or were even perceived as having this attitude or responsibility), it would create an adversarial atmosphere that might impede a calm and collegial exploration and discussion about other issues and questions. This partisan position will not only make it difficult for other concerned parties to feel that their interests are being

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9 Think here of Michael Moore’s recent work (on his television program “The Awful Truth”) in lobbying (read: publicly harrassing) a health insurance corporation on behalf of a patient needing a non-covered organ transplant.
10 It is worth remembering that Institutional Review Boards are now responsible for protecting patients in the principal areas in which they were historically abused, clinical research. With that responsibility shifted to a different group, it is not so surprising that bioethics consultants encounter fewer instances of patients needing protection than the historical record might otherwise suggest.
taken seriously, but it may also prevent a resolution based on compromise between competing interests. In an area where different values are at stake, the parties concerned are likely to be more willing to consider the positions of others if the spirit of the inquiry is that of open, honest pursuit of a good solution.

A further problem with taking patient protection to be the guiding goal of bioethics consultation is that it neither argues against the possibility of other equally important goals nor provides a priority ordering among goals. However, though patient protection has proven not to be the monistic source of obligations for bioethics consultation, it does seem to have captured something important to the field. Therefore we will need to consider such obligations again when we investigate the possibility that bioethics consultants have obligations from multiple sources.

3. “Helping”
Another normative consideration that might be able to give obligations to bioethics consultants is the aim of making good decisions. It seems to be the case, often for consequentialist reasons of wanting outcomes to be as good as possible, that we think we (and others) should seek help when making difficult decisions. Broadly construed, such a goal accounts for many professions dedicated to specializing in a particular area and, in a sense, selling the benefit of that expertise. Accountants and estate planners are consulted on financial issues, physicians on medical matters, spiritual leaders on spiritual issues, etc. If we apply this aim to medical-moral decision making, perhaps we will derive some obligations for bioethics consultants.
Physicians and patients began to confront difficult decisions as medicine changed in the 1960s and 1970s. Increasing technological capacities, the growing demand for autonomy and the general questioning of authority meant that physicians were no longer in sole charge of medical decision making. The questions themselves had also become more difficult, and physicians and their patients sometimes wanted help in answering them. It was natural that they would turn to those who had spent time addressing moral issues: philosophers and theologians. Obviously, desire for help of this kind is not unique to the medical context.\(^{11}\) Such a desire arguably reflects a pervasive (though not ubiquitous) goal of making good decisions, which includes avoiding obviously wrong or

\(^{11}\) One might ask why this kind of help is only available in hospitals. For example, Judith Wilson Ross argues that if one suggests that the function of bioethics consultants is to improve patient outcome or patient care, one should also consider why they are only found in hospitals. There are many places money could be better spent in ‘improving patient care’ – for instance, bioethics consultants could make house calls, or work at nursing homes. Moreover, she asks,

Why, if ethics consultants are so vital to modern life, do they exist in no other comparable social institution? Significant decisions involving value conflicts, miscommunications, power inequities, gendered realities, cultural differences, [and] narrative potential ...are made in other places in our society: in education, in the law, in the church. Why do those institutions not see a need for ethics consultants? And if they don’t, is there some problem in our conceptualization of ethics consultants? (1996, pp. 25-26).

This is a reasonable question, the complete answer to which would take us far afield from the present discussion.

However, there are several responses that can be made. First, there are ethics boards and school boards who arguably serve the same purpose (though why philosophers and theologians are not de rigueur part of these boards is possibly still worth inquiry). Second, it is not entirely true that such consultants only work in hospitals. The new field of philosophical counseling is arguably an extension of the basic point of assisting people with difficult decisions, capitalizing on the training philosophers have in thinking through these matters. Third, the fact that they are at present only found in hospitals may be a contingent fact; we might see more and more people finding this kind of consultation to be a good idea and expanding services at the school or church, for example. Fourth, there are good reasons why consultants might only (or for the most part) work in hospitals: the decisions involved in this setting are quite serious, often concerning life and death. Though as she mentions, moral issues are always involved in schools and churches (they are a part of life, after all), for the most part decisions there do not have the immediacy that hospital decisions involve, nor do they generally engage the concomitant issues of competence, high technology and cost considerations. Bioethics consultation may be either a fluke profession destined to disappear, a sign of things to come, or simply an area where the gravity of choices faced favor this sort of help more than in other areas.
bad answers, ensuring that one has thought through all possibilities and obtained relevant
information, and that one is not making a mistake in reasoning.

Although vague, the aim outlined above is a good start to understanding the
origins of bioethics consultation and has significant explanatory power. First, it explains
how “strangers at the bedside” (Rothman, 1991) initially entered the hospital. As Albert
Jonsen describes his own introduction to bioethics at the bedside, a faculty member at the
local medical school invited him to come and see “what an ethical problem really looks
like”, which involved, for example, helping to assess the requests of chronic
hemodialysis patients who wanted treatment stopped, knowing they would die without it

Second, understanding bioethics consultation to be a helping profession explains
why it is so multi-faceted. There is virtually no limit to the kind of help people might
require when facing moral decisions. Such decisions involve much more than merely
moral considerations and at more levels than simple individual decision-making. A
decision about a treatment might involve moral dimensions, medical considerations and
practical limitations. In addition, the fact that some moral problems arise simply because
of the way in which an institution is organized has given rise to a new sub-specialization:
organizational ethics. As a result, bioethics consultants might find their days spent
researching a particular treatment, liasoning with medical administrators, presenting
moral arguments on one side of a decision or the other, helping to formulate hospital
policy, etc. If the impetus to assist in complex moral decision making lies behind the
field of bioethics consultation, and individuals have come forward to satisfy that impetus,
it is unsurprising that helping others to make complex decisions involves mastering many different skills and fields of knowledge.

Third, conceiving of bioethics consultation as a helping profession explains the vast array of ‘home’ professions from which consultants hail. Moral philosophers and theologians have had perhaps the most formal training in moral considerations, but many other people consider themselves, rightly or wrongly, as possessing insight into such matters. More importantly, perhaps, they have the desire to help others make complex decisions, which may stem from having seen bad decisions made, from their own desire to share their moral views, or simply from an altruistic desire to be ‘of help’ in this particular way. If no more specification of the field is garnered than that its purpose is to help others make complex decisions in the hospital, there is yet no reason to preclude anyone from playing such a role. In fact, this is where bioethics consultation finds itself at present: both Albert Jonsen, who entered the field over 30 years ago, and John Doe, who has just taken a one-week intensive course in bioethics, may call themselves bioethics consultants. While many would no doubt prefer Jonsen’s advice to Doe’s, others might prefer Doe’s on the grounds that Jonsen is too steeped in theory (whether or not this accusation is true). There is no shortage of people who want to help, and this is salutary. But it makes it very difficult to distinguish the wheat from the chaff.

Fourth, understanding bioethics consultation’s purpose to be “helping” explains the secularization of this area of human endeavor. With the availability of non-denominational (and even non-religious) bioethics consultants for moral advice, it is no longer necessary to seek help regarding deep moral questions exclusively from religious officials. Engelhardt (1991; 2000) has repeatedly discussed this turn away from religious
leaders and towards secular authorities of one sort or another for help in moral matters. Despite such changes, humans must still make decisions – more to the point, they must still make decisions involving moral considerations. Who else might be better able to give guidance in this area than those who have spent some time thinking about and studying the issues? Bioethics consultants fill the need, and since even ministers, priests, theologians, etc. can be bioethics consultants, there is still room to include spirituality for those who value it.

Fifth, understanding bioethics consultation as a helping profession accounts for the language used in discussions or publications regarding bioethics consultation. For example:

* The *Core Competencies* document describes the purpose of the field as follows: “Health care ethics consultation is a service provided...to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict regarding value-laden issues that emerge in health care” (ASBH, 1998, p. 3; italics added).

* The web site of the National Institutes of Health Clinical Center Bioethics Consultation Service states that “The CCBCS provides a team of consultants to help research subjects, families or surrogates, physicians, nurses, social workers, pastoral care providers and anyone else who requests assistance with the resolution of ethical issues” (NIH, accessed October 2002, italics added).12

* The Centre for Bioethics at the Clinical Research Institute at Montreal states that “[t]hose working at the Centre are expected to serve as consultants to hospitals, professional associations, specialty units, ethics committees, and

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12 Available online: www.bioethics.nih.gov/whatisconsult.html
physicians and health care professionals requiring assistance in the clarification of ethical issues.\textsuperscript{13}

* The Stanford University Center for Biomedical Ethics states, in their section on consultation, that “The clinical bioethics program provides services within Stanford Hospitals and Clinics, including leadership of the hospital's clinical ethics committee, ongoing ethics rounds in the intensive care units and consultation to individual patients, families and health care providers confronting moral conflicts and uncertainties”.\textsuperscript{14}

These are randomly chosen but illustrative examples of how the profession sees itself: as helping others to make complicated decisions.

Sixth, if bioethics consultation’s aim is to help, it explains why bioethics consultants often find themselves in a dilemma about whom they serve. If their main purpose is to help people confront difficult moral decisions, this potentially extends to all those in the hospital who face such decisions: doctors, nurses, social workers, administrators and others, in addition to patients themselves, whose interests and goals may be in tension. It extends as well into many different realms of “confronting”, including psychological, emotional and intellectual confrontation and all of their subsidiary tasks.

Yet despite the explanatory power of taking “helping” to be the principle aim of bioethics consultants, what does it really deliver in terms of concrete obligations? The way in which we understand the social aim of making good decisions will determine what we can mine in terms of bioethics consultants’ obligations. We could, for example,

\textsuperscript{13} Available online: \url{www.ircm.qc.ca/bioethique/english/consultation.html}.

\textsuperscript{14} Available online: \url{http://scbe.stanford.edu/main.html}.
understand it in a strong sense: we have an aim of making the right decision in particular situations, and when we face a decision in an unfamiliar context (medical decisions would qualify as such for many of us), we need help in making it. An obvious problem with this understanding is how we will interpret “right decision”. It hardly bears repeating that we live in a pluralistic society with competing conceptions of the good. Philosophy has failed to deliver a proven interpretation of what constitutes the good or the right, so there is no conception that justifies conferring authority on bioethics consultants in this matter.

In addition, this understanding gives no guidance regarding the bioethics consultant’s authority. If a particular family does not want the bioethicist’s help, to what extent may it be forced upon them? If even the strong understanding of society’s aim of making right decisions does not convey any force to a bioethics consultant’s recommendations, the result seems to be that bioethics consultants ought to be used as each person sees fit. The aim of giving moral advice regarding the right decision might also suggest that bioethics consultants are in fact capable of making positive recommendations, but it would not address many of the other questions that arise for the practice, such as the priority rankings of various roles or the appropriateness of performing the role of mediator or facilitator in family discussions. It also fails to deliver side-constraints to the practice.

Understanding this general social aim weakly, on the other hand, would mean that each of us and/or society at large aims at making better rather than worse decisions. Since others often surpass our abilities to discern better and worse decisions (especially in areas where we have little familiarity), one implication of this goal is that we should
search out help when making decisions in unfamiliar areas. But this option too gets us nowhere. It is a “good idea” rather than a normative guide, and has no binding force. It is true in a trivial sense, and therefore unhelpful. Moreover, establishing in any depth what would count as better and worse decisions would carry us back to a strong understanding of the aim, since the more specific we are about what counts as better and worse, the more we imbue the aim with moral content.

This weak understanding may, despite its paucity in delivering specific obligations, reflect truly the social aim that has brought bioethics consultants into the hospital. When people confront uncertainty, they often want help resolving it. In bioethics, the sources of uncertainty are myriad. One might be uncertain about the law, institutional policy, possible ethical positions, the reasons for those positions, one’s unexamined motives or values, etc. If it is the case that bioethics consultants are called on to help in a great variety of situations (and there is copious anecdotal evidence from virtually any bioethics consultant to suggest that it is), they are catch-all professionals who could benefit from a great number of areas of expertise. And, *mirabile factu*, this is exactly what we see suggested in the *Core Competencies* document.

It appears that we have accurately captured an underlying societal aim that helps to direct bioethics consultation’s obligations: when making decisions, we often need help in doing so optimally or correctly (which adverb one chooses depends on how one interprets the aim). It helps to explain the genesis of bioethics consultation and the disarray the field experiences now, and it accounts for the areas of expertise often cited as important for bioethics consultants to have (e.g., in the ASBH’s report). The achievement brings no assistance in delineating specific obligations and goals for the
bioethics consultant, though, because however we try to interpret this societal goal, it has no non-arbitrary implications for bioethics consultation. It may be that there are other normative considerations that would be suitable candidates from which to derive obligations for the field, but they are not immediately obvious. Moreover, the arguments above suggest that we have in fact captured the right aim; it is simply unhelpful.

4. Conclusion

We began by considering again the possibility of tacit consent as a foundation of bioethics consultants' obligations. This suggestion suffers both from the problem of whom we should consider to have made the relevant tacit agreement and the problem of the way in which we might interpret a tacit agreement regarding the bioethics consultant's role in the hospital. More progress was made by considering three social aims in which bioethics consultants might be participating when they perform their roles in the hospital. The first possibility, adopting the aim of moral philosophers and theologians before their entry into the hospital context, failed because there is no plausible way of claiming that they had any one particular goal. The second possibility, that patient protection is the relevant goal, was promising. It both accorded with historical precedent and delivered some obligations that look familiar in bioethics consultation. However, in the end patient protection cannot be held as the cardinal value of bioethics consultation because (a) others (patient advocates) already pursue related aims; (b) it fails to capture the fact that a majority of bioethics consults do not involve any form of patient protection but rather, address confusions about what to do; and (c) there is yet no argument for taking this rather than other plausible aims to be paramount.
in bioethics consultation. Our third possibility, that bioethics consultants take part in the larger social aim of helping others to make good decisions, captured much more about bioethics consultation than the claim that it focuses on patient protection. Again, however, this third option is insufficient, because it gives no real concrete obligations.

So far we have failed to discover the source of obligations of bioethics consultation. There is a final option to consider: does bioethics consultation have multiple sources of obligation? Sher concedes that there is ‘much truth’ in the proposal that we can derive professional obligations from different sources, but argues that attempts to do so in the area of university teaching fail to give an answer to the question of whether a lazy professor is violating his moral obligations. However, it may have more promise for bioethics consultation.

III. MULTIPLE SOURCES OF OBLIGATION

The only conclusion we may reach is that bioethics consultants have multiple goals deriving from multiple sources. In retrospect, it seems we should have predicted this. Professional roles are social. They are embedded among other normative, overarching and competing considerations, which temper the manner in which the fundamental moral consideration (if there is one) is exercised, since they must compete for resources of time and energy as well as importance. Bioethics lies at the intersection of many fields, such as law, medicine and philosophy, each of which has its own standards. Often the decision a patient faces has aspects of many fields. Insofar as bioethics consultation
involves patient decision making, we should expect there to be both many different obligations and many different sources of obligation.

Recall that physicians began to invite philosophers and theologians into the hospital to assist in making difficult decisions, or at least to shed light on the questions. Note the potential difference in goals at the very inception of bioethics consultation. Physicians’ goals were to obtain help in difficult, concrete cases – perhaps even help that would decide a course of treatment. On the other hand, the theologian’s goal, for example, might have been to lead the case toward God or salvation, or at least towards decisions that accorded with what he perceived as God’s will. The philosopher’s goal might have been to help the physician achieve conceptual clarity in the case; alternatively, those philosophers who hold that philosophical arguments yield clear moral answers might have had the goal of instructing the doctor and/or patient. Bioethics consultation had multiple goals from the outset.

If this is the case, we confront a number of problems. First, this lack of conceptual integrity or integrated understanding of the purpose of bioethics consultants leaves us unable to answer many (if not all) of the questions raised in the Introduction, such as whether consultants ought to advocate for patients, give positive recommendations, support the attending physician, etc. Second, the multiple goals are themselves ambiguous. Even if everyone were to agree that patient protection is an important part of bioethics consultation, without some argument for why it matters, it is difficult to know how to pursue this goal. Third, we have a priority problem among the ambiguous goals we do have. Even if we can reach some relatively concrete understanding of the goals, and even if they do not conflict, there is not always time to
pursue all of them. Towards which goals should we work first? In the institutional setting, time is a commodity, and bioethics consultants will not have the luxury of pursuing each worthy goal at leisure.

Finally, if bioethics consultants lack a clear idea of their purpose in the hospital, then the expertise they at first glance seem to have will be used towards the ends of others. This cooptation need not happen with malicious intent, but it means that bioethics consultants find themselves pulled in several (competing) directions, with no principled way in which to tell employers or users of their service what they do or why. The field of social work has experienced just this sort of problem of self-definition in the very same context as bioethics consultation. A brief examination of the history of social work will illustrate this.

The superficial similarities between the two fields are obvious: first, neither field is indigenous to the medical context, but rather came to it later, for a variety of reasons. Practitioners of either type are separate from the traditional medical hierarchy, yet work within it. Moreover, the goals of each activity are different from (but related to) the goals of medicine – they are extra-medical goals which are nevertheless organically connected to medical goals.

A consideration of the emergence of the profession of social work can shed light on the emergence of the profession of bioethics consultation in showing how a disparate set of undertakings can come to constitute a single problem. Social work, like bioethics, is a profession that came about as the final common pathway of a number of social forces that allowed social workers to serve a complex set of constituencies and then establish themselves as a profession within a particular social niche. Like the profession of
bioethics consultation, social work has no conceptual unity or single, unambiguous moral justification; instead, social work provides "professionals" able to supply a range of services useful for society in general and health care in particular. This state of affairs, the phenomenon that a number of social forces produce a social creature able to survive in a particular social environment, may explain the character of many professions. In this case in particular, the similarities between social work and bioethics consultation offer an insight into the integration of a heterogeneous set of interventions within the rubric of a particular profession.

IV. A BRIEF HISTORY OF SOCIAL WORK

Social work began as social reform within charity organizations at the end of the twentieth century. Initially, philanthropic women's organizations focused on helping the needy (in particular the widowed and orphaned) by 'friendly visiting', in which members were each assigned a particular neighborhood and set of families on whom to pay regular 'friendly visits'. The purpose was explicitly normative: to help re-form communities in inner cities and to encourage the proper normative development in the poor. It may also have had a more prudential purpose:

Organized charity was the urban community's surest safeguard against revolution, for it had "preternatural powers for fusing and moulding and tearing down and building up. Surely here, if anywhere, society will find that better thing than instantaneous revolution -- gradual regeneration." Charity organization represented, in large measure, an instrument of urban social control for the conservative middle class. Charity organization, and volunteer visiting in

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15 The bulk of my discussion of social work stems from Lubove (1973).
16 Friendly visiting actually took the place of simple handouts; philanthropic organizations at the time argued that simply handing out material relief did not induce the proper moral outlook in the poor and that other oversight to prevent indolence was necessary (Lubove, pp. 2-3; 7-9). Friendly visiting was their way of becoming personally involved in the lives of the poor in order to adduce whether or not requests for relief were legitimate (Lubove, pp. 9-17).
particular, were the “only hope of civilization against the gathering curse of pauperism in great cities” (Lubove, 1973, p. 5; quotes are from his sources).\textsuperscript{17}

However, it quickly became clear that friendly visiting did not have the desired effect; the obvious differences in economic circumstances between the visitors and visitees precluded any real friendship. Social workers themselves became frustrated with their lack of success, and began to examine the field and other ways in which the ideal of helping people might be realized.

The call for professionalization came shortly thereafter, fueled by a number of considerations in addition to the workers’ frustration. The legitimacy of moralizing about the poor that had been previously assumed was challenged, and there was a realization that in order to be effective, social workers (although they were not yet called that) should have special training in the work. Combined with this was the emergence of scientific perspectives on social work, most notably Mary Richmond’s book \textit{Social Diagnosis} (1917), which established the bases for that training.\textsuperscript{18} Charity organizations realized that they needed concrete facts about their subjects in order to practice effectively, and the search for these facts formed the basis of their special training. At the same time, charity workers were being invited into various organizations, and the “knotty problems of adjustment which social workers confronted in these institutions sparked a

\textsuperscript{17} It is stunning to note the eerie similarity between this claim that charity work might forfend “instantaneous revolution” and M.L. Tina Stevens’ claim that bioethics “proved far less threatening to existing social arrangements than the changes demanded by more radical, and more popular, social critics of the sixties” (Stevens, 2000, p. x). In other words, Stevens suggests, bioethicists served the purpose of defusing tension in the medical context. The difference of course seems to be that charity workers (or some, at least) set out on their path with a specific goal in mind, whereas it would be hard to claim that bioethicists intended to ease social tension. However, it remains true that there is a very good chance that bioethicists, and bioethics in general, have been embraced by various institutions precisely because they provide what Stevens calls an “inoculation”: “Bioethics won ... legitimacy, however, as a reward for functioning as a kind of cultural inoculation, an immunization that forestalled the more virulent attacks of radical critics, who were mistrustful of biomedicine’s undergirding role in a technological society” (Stevens, 2000, p. 2).

\textsuperscript{18} As she reports in this work, however, she had been lecturing and circulating her thoughts on the scientific approach for many years before publishing the book.
search for the expertise which differentiated them from other members of the staff and justified claims to professional status” (Lubove, 1973, pp. 22-23).

The invitation by doctors for social workers to enter the hospital setting proved especially important for the emergence of the profession.

The work of the friendly visitor in the nineteenth century was sanctioned by an organization established to eliminate pauperism and dependency; her motives coincided with those of the agency. Social work in more specialized settings created unique complications for it had to be related to the primary institutional service and structure. Medical social service, one of the first casework specialties, faced a particularly acute problem of integration. It was an innovation toward which many administrators and physicians were hostile, lukewarm, or indifferent. The hospital was among the most authoritarian and conservative of social institutions, impatient with frills or luxuries having no direct relation to medical diagnosis and treatment. The medical social worker, hard-pressed to justify her existence, could not remain indifferent to questions of professional function or skill. If, as she claimed, the physician and patient often required her services for accurate diagnosis and effective treatment, she had to explain just what her contribution was and how it differed from nursing. Concerned with her status in the hospital hierarchy, she self-consciously scrutinized her function, skill and technique, knowledge base, and relation to patient, medical profession, and hospital administration. In the process she allied herself with the other social workers struggling to establish a profession (Lubove, 1973, p. 24).19

The struggle to defend its value against skeptics helped to give the profession a foundation. In large part it was based on Mary Richmond’s work, which established “social evidence” as the basis of social work. Social evidence included any fact relevant to the client’s situation, such as living arrangements, employment, family status and history, medical conditions, etc., and in Social Diagnosis, Richmond dedicates several chapters to the painstaking discussion of sources and possible interpretations of this evidence. The social worker, after accumulating this information, could then make an expert interpretation regarding the source and type of social difficulty. This expertise was

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19 This quote could apply equally to the current state of bioethicists in the hospital.
noticeably different than that of the physician’s or, more to the point, the nurse’s, and helped to make the case for social work.

Part of the reason for the invitation of charity workers into hospitals in the first place was a growing awareness of the need to investigate the social aspects of sickness and disease. Dr. Richard Cabot began social service at the Massachusetts General Hospital in 1905 "to overcome the hospital’s depersonalization and isolation from the social roots of disease. The physician needed the social worker to insure full and accurate diagnosis ‘through more careful study of the patient’s malady and economic situation’" (Lubove, 1973, p. 28). The social worker functioned as an extension of the doctor, acting as his eyes and ears outside the hospital.

Not all physicians agreed about the value of the field; Lubove observes that even almost 20 years after social work became part of the medical scene, one physician observed that “the ‘over-worked hospital doctor cares nothing for ‘case work,’ his interest lies in curing disease” (Lubove, 1973, p. 29). This experience will sound familiar to the hospital bioethicist, as will the following:

In the critical first two decades, when medical social work labored to define its place in the hospital hierarchy, its survival depended upon the prestige and power of sympathetic physicians and administrators [...] Looking back to the first decade of medical social work, Ida Canon pinpointed the insecurities and challenges confronting her colleagues: “A few physicians and laymen saw the possibilities of our usefulness in improving the care of patients but most doctors and administrators were either indifferent or considered us intruders in an already complicated organization. We had to find our place in the institutional organization and demonstrate a special and useful function different from and sustaining to the service of doctor and nurse” (Lubove, 1973, pp. 30-31).

With the increased scrutiny came extra pressure to professionalize the practice. This professionalization would consist, according to Lubove, of moving both to a uniformity in training standards (grounded in the scientific approach to fact-gathering) and the
formation of a professional subculture, comprised of a) a differentiating skill; b) the establishment of a professional community with shared values, and c) institutions which controlled access to the field. Social work came eventually to have such a professional subculture (including the development of a group consciousness about their skills and role) and institutional control over the access to the field. Formal association began to cement such shared professional norms, and lacking state licensure requirements, these associations gained the ability to control standards of technical competence and inculcate professional norms [albeit] only indirectly through its own membership requirements. Even this was significant because it established, for the first time, minimum, uniform criteria of practice. The mere existence of the requirements stigmatized noncomplying hospitals as institutions willing to entrust important responsibilities to unqualified personnel. ... Given the absence of state licensing, the chronic shortage of social workers, and the wide variation in hiring practices, the professional association could not impose the ultimate sanction of excluding an individual from social work, but it could exclude her from the benefits and satisfactions of membership in an organization acknowledged as the legitimate spokesman for the group interest (Lubove, 1973, pp. 125-126).

The social work organizations may not have created the need for their services, but by providing a mechanism of quality control, they likely increased the prestige, competence and remuneration of the field.

In preparation for the move to professionalization, social work organizations conducted surveys of education, salaries, etc. Knowledge of the contemporary status of the field allowed associations to set entry-level membership requirements that were not

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20 Lubove argues that the shared values of social work fit Talcott Parson’s framework for professional action, comprising four main areas: rationality (the desire to formulate a scientific basis for the practice); universalism (by which social workers demonstrated their professional dedication to help individuals even in cases where they did not approve of them); disinterestedness (or service for service’s sake, which “implied a desire to serve at all times irrespective of monetary or other personal considerations” (Lubove, 1973, p. 121)); and specificity of function, which translated into technical competence in case work for the social worker.

21 More will be said about the development and implications of a group consciousness in section D, below.

22 Surveys of just this sort have been recently conducted in bioethics consultation, the results of which have been presented at the last two professional meetings of the ASBH.
too high to include most current practitioners, and to raise the bar from that introductory level in the future. At the same time, schools of social work were starting, and engaged in an ongoing process to set standards and admission criteria, adding to the prestige (and reliability) of the practitioners. Institutionalization of the practice bestowed benefits on the practitioners, and arguably also on the organizations in which social workers served.

At the same time, the increasing influence of psychiatry and its usefulness in the analysis of social work cases helped the profession to define itself as well as to secure the scientific basis upon which it made many of its claims. As Lubove notes, “In 1913 the state legislature [of New York] broadened the scope of social service when it authorized each state hospital to establish an out-patient department with a physician and social worker. Psychiatric social work forged ahead in Massachusetts in 1913 when the Danvers and the Boston state hospitals added social workers to their staffs...” (Lubove, p. 63). Psychiatry’s claims at the time that many “degenerates” were “feeble-minded” increased the tendency to treat all such social deviants as requiring help and oversight, precisely the domain of the social case worker.

Social psychiatry represented a form of casework rooted in an understanding of the patient’s social environment in addition to his mental and physical condition. ... Social work and psychiatry shared the common goal of understanding and control based upon a differential diagnosis, upon an accurate and comprehensive insight into the individual patient’s needs, and treatment adapted to this insight (Lubove, pp. 76-77).

The emergence of psychiatric social work not only reinforced the quest for skills and technique in casework, but foreshadowed major changes in the entire structure of theory and practice (Lubove, p. 79)

All of these trends had profound implications for a task that began as charity work. The increase in specialization, the quest for and acceptance of (and subsequently training in) scientific bases for the profession contributed to the respect it garnered at the price of
virtually eliminating the volunteer with whom the whole field began. In addition, the relationship that could be maintained with the needy when one served as a friendly visitor was no longer appropriate to the case worker/client relationship. “The social worker had begun to view herself as the professional representative of an agency or institution rather than of a class” (Lubove, p. 84).

In the face of all this success, Lubove suggests that social workers belied their true niche:

Yet if social work could claim any distinctive function in an atomized urban society with serious problems of group communication and mass deprivation, it was not individual therapy but liaison between groups and the stimulation of social legislation and institutional change. Since no other occupational group presumes as does social work a generalized mandate to perform these indispensable functions, the preeminence of the therapeutic role created a vacuum which remains unfilled. Professionalization – the machinery of altruism – was adapted far more successfully to a limited individual and group service process than to the distinctive social work functions of liaison and resource mobilization (1973, p. 220-221).

It is possible, in other words, that in its drive to professionalize by adopting a concrete, scientifically supported methodology, the practice of social work lost sight of the unique contribution it could make.

A. The Professionalization of Social Work

There are two general factors which drove social work towards professionalization. First, there was an initial impetus to the field, by which its early practitioners were motivated and which prompted others to take advantage of their services. In social work, the motivation or impetus was the instinct to help the unfortunate, generally understood as those with meager economic resources, but often (especially today) also understood as those who suffer from some form of abuse or other chronic difficulty (physical, mental,
or emotional). The way in which that help is given has changed over time, but social work is still counted among the helping professions.

The second main characteristic was a reconceptualization of the field in reaction to many changing circumstances:

(1) Social workers’ own initial observations regarding ‘friendly visiting’ and its failure to achieve the desired successes prompted them to reexamine their methods and effectiveness;

(2) The initial paternal (or ‘maternal’ in light of the fact that early practitioners were nearly exclusively women) attitude towards the needy came to be seen as often inappropriate and unjustified;

(3) The expansion of these practitioners into novel institutions meant having to explain and justify their presence and expertise to those who were not convinced of the usefulness of the field. This prompted the investigation of scientific bases for the practice, both as a way of functioning effectively and of gaining respect within an institution in which empirically substantiated claims (or at least scientifically substantiated claims; viz. the claims regarding psychiatry in pre-evidence-based medicine days) were the gold standard. The combination of these factors prompted the pursuit of a standardized profession, which included describing the special expertise of the field (via scientific claims), generating a professional subculture, establishing uniform training standards, and founding institutional gatekeepers of the profession.

The pattern in social work’s evolution began with a fundamental moral value: the desire to help others overcome obstacles to reaching their full potential. Over time, various institutions in society saw a need for the service provided by the philanthropic
organizations, which began the drive for specialization and professionalization.

However, this meant that the sometimes competing values of the institutions within which social work was practiced served to alter the fundamental impetus behind social work. Lubove's final warning is that the pursuit of professionalization actually thwarted the most promising aspect of social work: its ability to act as a liaison between people and resources.

B. The Professionalization of Bioethics Consultation

What of bioethics? Large-scale parallels between its development and the development of social work are no doubt obvious even to those with only a passing familiarity with bioethics consultation. Both professions show a history of being shaped not by a guiding, single moral vision, but by a constellation of needs to which the professions then respond, in the process redefining themselves. There are in addition many other similarities which require exposition and which point to some of the difficulties that bioethics consultation has in self-definition.

One difference between bioethics consultation and social work is that social workers developed out of a group of philanthropists whose goal was to provide relief to the indigent. Unlike social work, bioethics consultation had no distinct, organized group of practitioners, at least in terms of dedicated organizations, that predate consultants' arrival in the hospital. There were, however, individuals pursing in various ways what came to be germane in bioethics consultation: making decisions about one's life on the basis of particular moral values. At the outset in bioethics this included both religious
leaders (priests, ministers, rabbis, etc.) and philosophers. Additionally, the initial process of clinical social work and clinical bioethics is similar: hospitals (at the beginning, doctors) perceived a need and found those who were either more available or more informed and who could provide the service. The project of philosophers and theologians was brought into the hospital. That project was, like the project of social work, altered by the inclusion of bioethics consultants in the hospital.

Recall that social work developed in four main areas on its road to professionalization: description of its expertise, development of a professional subculture, establishment of uniform training standards, and the founding of training institutions which could act as gatekeepers to the profession. Again, one discovers a similarity between bioethics consultation and social work. Like social work, bioethics consultation is attempting to create a professional identity and professional standards. The burgeoning bioethics consultation literature is evidence that practitioners are searching for accurate descriptions of their expertise. The publication of the Core Competencies document is a significant attempt both to develop a professional subculture and to standardize the practice. Numerous programs granting a Master’s degree in bioethics and one (St. Louis

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23 For example, according to Jonsen’s history of bioethics, “Three theologians presided over the creation of bioethics: Joseph Fletcher, an Episcopal minister; Paul Ramsey, a Methodist professor; and Richard McCormick, a Jesuit moral theologian” (1998, p. 41). Regarding philosophers, he names Hans Jonas, Samuel Gorovitz, K. Danner Clouser, Dan Callahan and Stephen Toulmin as some of the philosophers who “joined the theologians as shapers of the field of bioethics ... [but] they differed profoundly in their purposes: theologians studied ethics in order to educate their congregations in the moral life; philosophers pondered ethics in order to unravel conceptual puzzles and probe theoretical foundations” (p. 83). It is important to note that the birth of bioethics consultation is not the same as the birth of bioethics, though it may be difficult in any easy way to differentiate them. However, we know that people were being invited into hospitals to discuss difficult cases even at the outset of the field; Jonsen himself relates in his preface that immediately after defending his dissertation in religious studies in 1967, he was invited by a physician to become an ‘ethical intern’ at the hospital and to reflect on the moral issues involved in particular cases. This demonstrates that at the very beginning, bioethicists were invited into the hospital on their own terms and using their own concepts (i.e., “ethical intern”).
University) granting a Ph.D. in bioethics have arisen, establishing a basis for gatekeeping of the profession.

In the process, however, bioethics consultation confronts the ambiguity that results from its complex social constitution. If this analysis is correct, it would be an error to look for a conceptual unity, where instead at best a causal history can be provided. If this is the state of affairs within which the profession of bioethics consultation finds itself today, the philosopher will not be able to provide a grounding justification, but at best a conceptual geography of different practices with different goals that have been brought together by the accident of social history and historical happenstance.

V. CONCLUSION

The focus of this chapter has been the possible philosophical bases for the obligations of bioethics consultants and the sources of that obligation. Despite numerous attempts, such a basis was not established. Attempts that began with particular obligations failed to deliver the sources of that obligation, and those that began with possible sources of obligation failed to yield specific obligations. A reexamination of the possibility of tacit agreement as a source of obligations did not reveal who should be party to such agreements or what such an agreement might consist of. Despite some success in accounting for the field’s current state, a consideration of three overarching values from which obligations might be derived in bioethics consultation also failed to deliver concrete, canonical obligations. The most promising of the three, that the value of bioethics consultation might be in its ability to help others make difficult decisions, had
great explanatory but little to no normative power. Attempting to establish the scope and aims of the profession from multiple sources was also unhelpful, especially in its failure to deliver a priority ranking of possible goals that resulted from such sources.

A consideration of the professionalization of social work gave an historical parallel to bioethics consultation. Both fields came to be understood and used in a variety of ways based on numerous, sometimes competing social forces. The fact that both professions appear to be successful and well-utilized does not imply that either possesses an underlying conceptual integrity. The arguments in previous chapters have amply demonstrated that bioethics lacks such integrity.

The following chapter begins from the premise there is no conceptual integrity in bioethics consultation. Therefore, it provides a conceptual geography of various possible roles of bioethics consultation. Some roles seem prima facie permissible, while others should be approached with great caution. All require an overarching account in order to be interpreted with clarity. For example, it is difficult to conclude whether or how the role of facilitation ought to be pursued unless one knows why it is undertaken. This conceptual geography will, however, highlight main areas of tension and articulate important questions that must be addressed by any account of the profession.
CHAPTER SIX: A ROLE GEOGRAPHY

I. INTRODUCTION

The previous chapters left us unable to identify any conceptual integrity underlying the field of bioethics consultation. It is, of course, always open to individuals to make contractual arrangements regarding services such as bioethics consultation. But because there is no principled way in which to exclude possible aims of the bioethics consultant, such contracts could be based on several different foundations. The result is that bioethics consultation as we find it is an amorphous field that has all of the characteristics of a creation of complex social forces and historical accident, as the last chapter has argued.

A theoretical account of bioethics consultation must then turn to an attempt to display a geography of the different roles prominently embraced by bioethics consultants towards the goal of judging which if any of these roles could be ruled out of court, or whether one must simply recognize that bioethics consultation is a complex social creature likely to take on different functions in different social environments. This chapter therefore begins by focusing on twelve different roles bioethics consultants assume in order to assess their appropriateness under the rubric “bioethics consultant”. This exploration of these dozen roles will attempt en passant to ascertain whether there are arguments for or against particular roles which will at least delimit the scope of the field. In addition, there may be restrictions on which roles may be played together or on the extent to which a role may be pursued.
The conclusion is that there is no clear argument against a bioethics consultant playing any of the roles discussed. Nevertheless it is possible to give some indication of where ambiguity, danger, or conflict exists. Some roles, such as the counselor, spiritual advisor, or risk manager, may simply be imprudent for a consultant to play. These roles are already played by others, and thus convey no unique value to a bioethics consultant’s presence in the hospital. These same roles should be approached with caution for a variety of reasons.

Since many of these roles can be interpreted in a wide variety of ways, even if one in particular were taken to be the main aim or an appropriate subsidiary aim of bioethics consultation, much more would need to be said in order to have a clear idea of how to pursue that goal. In the absence of an overarching account of the goal of bioethics consultation, the appropriate scope of these roles is impossible to articulate, as each account may identify some side-constraints rather than others. The needs of the hiring institution will also help to shape the performance of that role.

In what follows, the terms I use to describe roles could be controversial. It is therefore important to note that I do not place much weight on any particular term. I do not hold that there are analytical meanings behind these words through which a particular role must be understood. The terms are chosen because they accurately capture, in lay language, something about the role. They are pointers to a particular social reality so that there would be little cost in exchanging one term for another. What is significant is the role to which they point. Here, role is defined in terms of the pursuit of a particular goal or cluster of goals. In the analysis, what is at stake is laying out different complexes of goals pursued.
I. TWELVE POSSIBLE ROLES OF BIOETHICS CONSULTATION

A. Counselor/Therapist

A counselor or therapist attends to psychological and emotional needs, helping patients and their families to come to terms with a situation, address interpersonal conflict, etc. The goal of this role varies from trying to help someone feel better, overcome a perceived or real obstacle (e.g., a particular phobia or a difficult history with a relative), or improve relationships. The relevant question for present purposes is whether this is a goal a bioethics consultant may pursue.

First, there is a prudential consideration against a bioethics consultant playing the role of counselor. There are already many people in the hospital whose job it is to counsel. Therefore the first argument against a bioethics consultant playing the role of counselor is that it is redundant. Insofar as a patient is thought to need a counselor (because the physician thinks it necessary, the patient or his family request it, etc.), the obvious response is simply to call a psychiatrist, counselor, or social worker. A bioethics consultant who makes this the main goal of her activity does not thereby make herself uniquely useful to the health care institution.

A more important objection to consultants serving as counselors is the potential danger to the patient. As patients confront mortality, morbidity, and reduced capacities, they often experience mental and emotional anguish and uncertainty. The necessity of making a treatment decision in the midst of such suffering, combined with resulting family disagreement or upheaval, may contribute additional elements of stress. In such a context, one must tread with care. Trained counselors are often better able to know how to discover, address, and resolve psychological or emotional issues. As these issues or
problems become more complex, there is more danger of a novice exacerbating an already tense situation. Insofar as the role of counselor is undertaken by a bioethics consultant, it should be approached with great caution. Most importantly, each individual consultant should be aware of the limits of her ability to recognize and address mental and emotional trauma, and know when to defer to other trained professionals.

Though there is no clear argument against the consultant playing the role of counselor, there are potential conflicts that should be borne in mind. Specific conflicts with other possible roles will be discussed below in section three. There is in addition potential for a more general problem, a consultant with divided attention. If the bioethics consultation member arrives at a consult and begins counseling a patient, it is highly likely that whatever the goals of bioethics consultation, they will be lost or not pursued adequately because the member’s time and attention are occupied with counseling. The patient’s need for a counselor may also not be pursued adequately because of the consultant’s focus on other goals. For example, an important initial task of bioethics consultation is often information-gathering. The consultant who arrives at the scene and discovers the need for a counselor would be wise to inform the health care team of her findings and not perform that function herself, instead focusing on assessing the conflicts and moral issues inherent in the particular situation.

Susan Rubin and Laurie Zoloth-Dorfman (1994) have given another argument against the bioethics consultant playing the role of counselor. They argue that it is inappropriate for bioethics consultants to play the therapeutic role because instead of focusing on the situation at hand, counseling directs one to look at a pathological past in order to address problems. They point out that taking this approach may make a
consultant overlook issues in the present that actually affect the situation and fail to create a forum in which ethical conflict can be discussed. However, the simple objection that counseling is past-directed is not sufficient, and may actually argue against another possible aim of the bioethics consultant that seems prima facie permissible: clarification. Clarification may involve looking to the past (even a pathological past) not in order to improve someone’s psychological well-being, but simply to establish the reasons for familial tension or the roots of a patient’s beliefs or values.

The implication of my arguments is not that a bioethics consultant ought scrupulously to avoid any “counseling effects” of her behavior, only that that ought not to be the principal aim of her efforts. Having advanced these considerations against bioethics consultants playing the role of counselor/therapist, one must recognize that to consult regarding highly emotionally freighted major passages of human life requires a facility in working as a counselor and therapist. One must identify emotional conflicts and often in a genre of group therapy bring individuals ill-disposed to cooperate, in fact to work together. As a result, although bioethicists should not directly hold themselves out to be counselors/therapists, expertise as a counselor/therapist may be essential to the very performance of other roles.

B. Risk Manager

The risk manager protects the institution or its staff from risk. There are again prudential reasons which suggest bioethics consultants should not play this role. First, since most (if not all) hospitals already have a risk management department, the role might be redundant unless bioethics consultants can provide this service in a more effective way.
In addition, it is likely that specialists (usually lawyers) are better able to assess what actions would protect an institution from or make it vulnerable to risk.

However, for two reasons, any bioethicist might (wittingly or unwittingly) play this part as he goes about his regular duties. First, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires that each health care organization have an ethics committee or consultation service. The very presence of an ethics committee, therefore, alleviates some legal risk or at least meets an important regulatory requirement.

There is a more subtle second reason. Studies concerning malpractice suits suggest that patients are more likely to sue when communication with the health care team has been poor (Buller & Buller, 1987; Shapiro, Simpson, Lawrence et al., 1989; Valente, Antlitz, Boyd et al., 1988). Bioethicists who help to establish patient preferences will most likely have conversations with the patient and her family, thus helping to preserve lines of communication.

The relevant question is whether a bioethics consultant may play the role at all. In fact, it may be the case that a bioethics consultant has no choice in the matter, since some of her activities can have risk-managing effects. For example, any meeting that she has with a patient and her family may decrease the likelihood of lawsuit, yet most conceptions of bioethics consultation hold that it is permissible or obligatory to speak with patients and their families. It is also the case that in the pursuit of clarification of moral issues in a case, the consultant may help to disabuse patients of incorrect assumptions or beliefs about the treatment they have received, thus also reducing the likelihood of suit. On this understanding, a bioethics consultant may knowingly be hired
by an institution in order to help manage risk, yet find this arrangement acceptable.

Often virtue is a profit-maximizing activity, so it is reasonable to assume that some roles a bioethics consultant plays will convey such side-benefits to an institution. However, since her usefulness is a contingent circumstance, it would be wise to establish some other function for bioethics consultants if any job security is desired.

There is another facet of risk-management that must be considered: the danger of cooptation. One might take a cynical view and assume that institutions hire bioethics consultants solely in order to manage risk. This does not prevent bioethics consultants from establishing an independent worth to their activities. If this is the case, and if the institution does not interfere with the pursuit of the valuable goal of bioethics consultation, then the institution merely becomes a free rider.\(^1\) That is, it is benefiting from the bioethics consultant’s pursuit of an independent goal (whatever that is). If there are independent justifications for bioethics consultation, the fact that the institution does not intend to hire the bioethics consultant for these purposes may, in and of itself, be irrelevant. This is in fact an important reason for establishing the aims of bioethics consultation: if consultants are convinced they are achieving (or at least working towards) a justified aim, the fact that the institution is also benefiting may be beside the point.

However, one might imagine a case in which it is not beside the point. Imagine a situation in which a family is angry at a physician because a particular treatment did not go as expected. While pursuing the role of clarification, the bioethicist expresses to the family the physician’s interpretation of events (perhaps as a way of eliciting from the

\(^1\) On the other hand, one might argue that the bioethics consultant is the free rider if the institution is paying her for the sole purpose of managing risk, yet she actively pursues other aims that might at times exacerbate risk. For example, if patient protection is deemed the important goal of bioethics consultation, the consultant might encourage a patient to believe that he or she has been treated poorly, thus increasing the likelihood of suit.
family their interpretation). In the process, the family’s anger is defused. Conceivably the bioethics consultant has helped to avert risk. If she was called to the consult by the physician, and knows that what she says to the family on behalf of the physician may appease them, what should she do? Does it matter whether she thinks the physician has behaved wrongly? *Should* it matter?

There seem to be three possible answers. First, if we hold that the bioethics consultant plays the role (among others) of moral policeman or watchdog, we might argue that it is the consultant’s duty to report the physician’s wrongdoing. Second, it might be the consultant’s duty not *qua* consultant but *qua* moral agent to report the physician’s wrongdoing. Third, we might hold that just as confidentiality would prevent a second physician from reporting the primary physician’s wrongdoing, it is would also prevent the consultant from reporting it. The response to the first possibility will depend on the conclusion regarding whether or not bioethics consultants may be moral policemen. The second and third possible answers are interconnected. In order to determine an appropriate response to these possibilities, we would need the results of arguments outside the scope of this project concerning role moralities. That is, we would need an argument that addresses the question of overlapping duties, in this case, one’s duty as a bioethics consultant versus one’s duty as a moral agent. Does one take precedence? Further, should bioethics consultants agree to be held under the obligation of confidentiality? Benjamin Freedman, for example, might argue that they should not. However, from a practical standpoint, it is hard to imagine a bioethics consultant being able to do very much at all if a hospital severely restricted her access to information and
people because patient confidentiality could not be guaranteed. Therefore, it is likely that hospitals would require that bioethics consultants respect the standards of confidentiality.

A bioethics consultant should not aim at risk management. However, if some of her activities have the side-benefit to the institution of averting risk, the consultant does nothing objectionable so long as she follows her aim. Risk-aversion may simply be an effect of bioethics consultation that the institution embraces, encourages, and uses as a justification for hiring consultants.

C. Priest/Spiritual Advisor

Patients often want spiritual advice on what decisions to make, or company when they pray. This role divides into two general categories: “official” and “unofficial.” In the official capacity, a spiritual advisor would need at least to be a member of some particular faith, having entered into the community by whatever means are recognized within that particular faith (for example, through baptism in Roman Catholicism). In order to perform particular duties, he might even need to be an authority of some sort within in the faith—for example, an ordained priest or rabbi.

Efficiency and prudence again suggest that since there are others who could perform the ‘official’ role of spiritual guide, and who are already available, performing official religious duties should not be the aim of the bioethics consultant. There is in addition the possibility that a consultant who attempts to perform this role will divide her attention and thus risk not performing either role well. If there are no other appropriate spiritual advisors available, the bioethics consultant may perform the desired duties, but
he should then invite another member of the committee to play the role of bioethics consultant.

Since priests and ministers are often on bioethics committees, we must address the further issue of such officials attending a consultation where the patient needs spiritual guidance or company. In the first case, if a patient needed spiritual guidance regarding matters of fact or interpretation within a particular faith, it may be acceptable for a bioethics consultant to assist in this matter. A bioethicist’s role in this case falls within the role of clarification, which I argue below is a prima facie acceptable role. The spiritual guide (priest, rabbi, minister, etc.) qua bioethics consultant is simply sharing his knowledge with the patient, in the same way a bioethics consultant might tell people what a law says without giving legal advice.

The second case involves an invitation for the bioethics consultant to pray with a patient or family. This falls under the ‘unofficial’ version of the spiritual guide or counselor. That is, it does not require someone who is an official or authority in the patient’s particular faith. The most recognizable situation in which the conduct of this role arises in bioethics consultation may be when a patient or family asks the consultant to pray with them or discuss personal beliefs about God, spirituality, etc. Since for many people the ability to pray together or engage in such discussions does not depend on any expertise, this situation can arise for any bioethics consultant. Should a consultant pray with a patient and his family? At this point there is no theoretical position from which to argue that it is not within the bioethics consultant’s purview. Because it is a very important facet of some people’s faith that they bear witness, it may be a violation of the consultant’s integrity to prohibit her from praying or engaging in spiritual discussion with
patients. What seems not only reasonable but right is for the bioethics consultant at least to make it clear to a patient when she is stepping outside her role as a bioethics consultant.

However, this may not be enough. It is also important to consider whether a bioethicist who prays with a patient or family oversteps the boundaries of neutrality. In other words, does a bioethicist who engages in this rather personal exercise with a patient lose either the ability to be neutral or the appearance of neutrality to others? If the main role of the bioethics consultant is a neutral role such as facilitation or mediation, spiritual guidance potentially directly conflicts with maintaining such neutrality. Thus the answer to the question of whether a bioethics consultant may pray or engage in personal spiritual discussions with patients will depend on the account accepted regarding the purpose of bioethics consultation. It may also depend on the needs of the institutions. Institutions who place a value on spirituality may desire a bioethics consultant who will perform such roles, while others may discourage such a role. A bioethicist’s function may be heavily influenced by the social context in which she practices.

D. Moral Policeman

Within the hospital context, the policeman can enforce two different “laws”: the hospital “law” (policy) and the moral law. As the hospital policy “policeman”, the bioethicist ensures that hospital policy is followed in particular cases. There are a variety of possible motives for this. One might be that the policy policeman is actually undertaking the role of risk manager, protecting the hospital by ensuring compliance with policy. As such, this would fall within the scope of risk manager as discussed above. Additionally, the
policy policeman might simply feel that the policy is morally right.² This collapses her role as hospital policy policeman into the role of moral policeman.

Some may hold that bioethicists have the duty of defending the moral law when they see others breaking it. Yet it is not clear who is responsible for setting the moral law. Many moral philosophers and bioethics consultants appeal to what they see as obvious or common moral standards. Even if it were empirically the case that such common standards existed, however, there is as yet no answer to the question of what authority anyone has to enforce such standards. The existence of reasonable disagreement and the respect for individual freedoms held as fundamental in this country give both philosophical and legal reasons why no one has the ability to enforce the moral law. There is no justification for the bioethics consultant to play the role of moral policeman, regardless of the aims bioethics consultants might eventually adopt.

There is another important potential facet of this role. Recall that Benjamin Freedman argues that bioethics consultants ought to be moral heroes, standing up to institutions when they go seriously wrong. Possibly this could be construed as a ‘policing’ role, but it would be construed wrongly. Police have authority in some sense; there are consequences to violating some rule they enforce. Even if a bioethicist were held to be in authority as a moral policeman, there would be no consequences of someone’s violating the moral law.

² Another is that the bioethicist might herself have authored some of the policies, and have a proprietary interest in seeing them followed. However, I will not address this possibility, as I think that the proprietary interest in itself either actually represents the desire for “moral policing” (to be discussed below - i.e., where the interest in fashioning the policy in the first place was motivated by a desire to ensure the hospital’s “morality”) or is outside the scope of this project, as it addresses a psychological issue within the bioethicist.
An institution could, of course, empower bioethics consultants as moral policemen, but if they did, it would be as a matter of hospital policy. There is no (secular) moral authority who can enforce the consequences of violating the moral law. Here we encounter the tension between the good and the right, worthiness for happiness, and the happiness of the agent who violates the moral law. Bioethics consultants may be able to point out what morality requires, but they usually, unlike a policeman, will not be able to constrain adherence to the law.

Having advanced these considerations against the role of the bioethics consultant as moral policeman, one must nevertheless recognize that bioethics consultants carry with them the ability to engage social and legal sanctions. Hospitals may take their moral judgments seriously; courts of law may take their judgments as bases for tort actions. As a result, bioethics consultants may be *de facto* moral policemen even when that is not their intention. What follows from this is unclear. What is clear is that there is a danger that a particular consultant may use this fact to help express his personal commitments in a way not always transparent to the institution, physicians or patients.

**E. Facilitator**

To facilitate is to make easier. The bioethics consultant's responsibility in the role of facilitator consists primarily in easing communication between patient, family members and health care teams. This may include the ability to translate, not literally from one language to the other (though that might be necessary), but rather, from one person to another. This ability will be useful in facilitating cooperation between people with different levels or types of education or intelligence—for example, helping to translate
technical explanations into concepts that the non-professional can understand. Other helpful abilities for facilitation include some basic knowledge of psychology, cultural ideals, and clinical terminology. Almost any ability or expertise might qualify, if it somehow makes pursuit of the goal easier. Facilitation is, however, an area where the cooptation of a bioethics consultant is possible. Lacking an independent goal, consultants playing the role of facilitator might find themselves working to make it easier for others to accomplish their goals. Whether or not these other goals are objectionable with respect to bioethics consultation is impossible to say in the absence of an account of the field’s purpose. Yet surely the goals of physicians, nurses or hospitals will affect the manner in which such a role comes to be played in a particular institution.

F. Educator

In this role, the bioethicist is a source of information and education on a variety of issues that arise in the medical setting. A bioethics consultant might present a Grand Rounds lecture to a large number of hospital staff, or simply present to an individual a variety of possible positions on a particular topic. There are some clear boundaries regarding who educates on what topic: the non-M.D. theologian is not understood to be an expert on medicine; the non-J.D. philosopher is not thought to be a legal expert. Which topics a bioethics consultant may lecture on will depend to a certain extent on her education and training.

The role played depends both on the degree and type of expertise required. For example, if a fairly high degree of legal expertise is required, one will most likely want a board certified lawyer with experience in health law, perhaps one with experience.
Above all, one will need to avoid practicing law without being admitted to the bar. On the other hand, a bioethics consultant may undertake a simple task, such as presenting the list of appropriate surrogate decision makers. Similarly in cases of spiritual uncertainty, an expert in a particular religion or ritual might be required.

A request for education might instead be motivated by a desire to know the right thing to do. This aspect of the role is better described as ‘moral guide/expert’ and will be discussed in section three below. The role of educator therefore seems acceptable, but just as with facilitation, the side-constraints on this role (if any) must arise from a foundational account of bioethics consultant.

G. Administrator

Even with the movement of bioethicists into the health care setting, it is unlikely that the attending physician’s traditional role as “captain of the ship” will be supplanted by a bioethicist. However, a bioethicist may be called for a consultation (especially when the team does not have much education or experience in bioethics) and find a situation in which issues are not clear. In this role, the bioethicist might analyze the issues involved in a particular case, and then either recommend consultations with other experts (for example, a psychiatrist or religious official) or serve in another bioethical role himself. For example, after sorting out the issues involved, the bioethicist might consider his job as administrator complete, and begin to function as a facilitator.

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3 Deborah Cummins (1998) notes that even as staunch a critic as Giles Scofield “has argued that clinical ethics consultants should limit themselves to the role of ‘educating others’. He has repeatedly emphasized that ‘the role of the clinical ethicist should be to teach and thereby help and allow others to think for themselves’” (Cummins, 1998, pp. 159-160).
An administrator may also have the responsibility to ensure that recommendations are followed – for example, that a psychiatry consultation actually took place. However, until we have an account of the point of bioethics consultation, we cannot say whether this includes ensuring that particular recommendations of bioethics committees are followed. If, for example, one argued that a bioethics consultant’s aim is patient protection, then it might be part of her (or at least the committee’s) responsibility to ensure that a patient’s wishes were followed. On the other hand, if a bioethics consultant is strictly a consultant to the physician, it might be argued that he refrain from administrative activities in order to allow a physician to retain control. In either case, an institution may very well find it helpful (and cost-effective) to have a bioethics consultant oversee certain aspect of patient care. Side-constraints on the administrative role’s authority must result from an overarching conception of the goals of bioethics consultation, but there is no independent reason why the role of administrator may not be included in the duties of a bioethics consultant.

**H. Clarifier**

The clarifying role’s aim is to establish the facts about a consultation. Such facts can include the moral issues involved, the personal values and beliefs of all parties, the implications of law and hospital policy on the case, the patient’s prognosis and family situation (including their ability to care for the patient as needed), etc. The implicit aim of this role is to provide accurate bases on which decision makers can choose. The attitude or guiding thought behind the clarificatory role is one of discovery, elicitiation,
and articulation of a patient’s, health care team’s, institution’s, or family’s values or preferences.

However, the goal of clarification is not as straightforward as it seems. It is Socrates’ classic conception of philosopher as midwife, assisting others to give birth to thought (Theaetetus, 149-151e). In the Theaetetus, Socrates explains to Theaetetus what he perceives himself to be doing when he interrogates the people of Athens: “...the highest point of my art is the power to prove by every test whether the offspring of a young man’s thought is a false phantom or instinct with life and truth. I am so far like the midwife that I cannot myself give birth to wisdom...” (150c). While Socrates considers himself a midwife because he has no wisdom, there are a variety of reasons bioethicists might see themselves in a similar role. The role of the clarifier in bioethics is not automatically a neutral role; bioethicists must at times be proactive, pushing patients to make up their minds (give birth to their decisions) before it is too late, for example in the case of formulating an advance directive. Theoretical clarificatory work in bioethics can be neutral, as academia is a place for sustained discussion of issues, which need not involve endorsing one course of action. Life in the hospital, however, requires constant decision making, so the metaphor of midwifery is particularly appropriate: decisions come with their own contexts, including a time frame which might precipitate decisions before they are fully formed. (This might mean, for example, that patients are forced to make a decision before they have really concluded their reflections on their desires and situation.)

Plato foreshadows some of these problems in the Theaetetus, noting that midwives can bring on labor prematurely or cause miscarriages, and the patients can
leave the midwife prematurely. In addition, labor of thought can be painful and
distressing in itself, and Socrates begs Theaetetus not to be angry when Socrates “take[s]
the abortion from [Theaetetus] and cast[s] it away.”

What are the parallels in bioethics? Certainly the psychological state of the
patient is relevant, but the parallels are even broader: how hard must the bioethicist push
to determine someone’s actual desires? Midwives do not merely catch babies, they guide
labor. But in what ways do they guide? The bioethicist’s understanding of what the
point of the activity of clarification is will determine the lengths to which he will go to
clarify, for example, a patient’s desires. If the point of clarification is to get at the truth,
the bioethicist’s notion of the truth will determine the goal of his actions. If truth is the
same as agreement, then clarification ends with agreement. (The question of degree of
agreement (unanimity, majority, etc.) is still open.) But if truth is defined in the
bioethicist’s mind as something deeper, then he may need to question what seems like
superficial clarity in order to establish a “deeper” clarity as he defines it. It is also
ambiguous whether this role requires taking patients’ expressed preferences at face value,
or instead spending time working towards a deeper clarity. For example, patients when
consulted about end-of-life issues are often heard to say, “I don’t want to be hooked up to
a machine.” The bioethicist’s role in this case will be to prompt the patient with options
which help him more accurately to state his wishes. He might mean that he wants no
machines under any circumstances (and may or may not know that he will die without
them), or he might find it acceptable to be on life-support as long as it is temporary and
he can expect some desired amount of recovery.
It is in addition unclear what clarification would mean if a patient is, for example, contrary by nature, and takes more pleasure in contradicting himself to everyone's consternation than in actually expressing his preferences. The important question in a consideration of the role of clarification is on the type and extent of clarity. In any case, if the point of clarification is to get at truth, we either need to establish the right notion of truth, or, if there are many reasonable understandings, then we need to establish whether the bioethicist has an obligation to disclose his operative notion of truth to the parties involved.

The role of clarification is ambiguous. Unfortunately, even an overarching theory regarding the aim of bioethics consultation is unlikely to give side-constraints to this activity. For example, what would the aim of patient protection suggest are the limits of clarification? On one hand, it might require that a patient’s expressed wishes are sacrosanct; on the other hand, it might mean that for their own good, patients need to be pushed to face questions that are difficult or painful. Clarification of some sort seems obviously acceptable as an aim of bioethics consultation, but the limits of this role are far from clear.

I. Mediator

There are two facets of the mediator’s job: one is to be an intermediary, and the other is to effect a settlement. Sometimes this latter aspect of the role can be achieved by means of facilitation. This, however, is different from understanding mediation to be the same as facilitation. The role of facilitator, as discussed above, need not aim toward resolution in the way that the mediator does. For example, a bioethicist might be called to consult
with a family when the health care team feels that the communication has been difficult or impossible. A 'facilitator' bioethicist would go about opening these lines of communication, ensuring that each party understands the others. A mediator, on the other hand, would be called for a more specific purpose, namely, to resolve or settle differences or to reach a peaceful settlement or compromise.

There are several potential problems with the role of mediator. First, it is not clear at what sort of 'resolution' the role aims. If the resolution is taken to be consensus, then the mediation role actually collapses into the consensus-builder role (discussed below). Resolution need not come about by consensus, however. One might reach a resolution by clarifying the situation to the involved parties, after which conflict dissolves. Or the parties involved may simply agree to disagree without reaching consensus. In this case, however, it is not clear which parties have a stake in the discussion and whose agreement is most important. Need a mediator take the wishes of the health care team into consideration? A grounding account of the field is required in order to establish whose agreement counts towards resolution in this sense.

A second problem with this role, as with others, is that there are no clear side-constraints. How persuasive should the mediator be when trying to resolve conflict? Should she bring in a variety of experts to convince dissenters, or is that inappropriate?

Third, mediation conflicts with several possible models of bioethics consultation. If a bioethics consultant is to protect or advocate for the patient, she cannot mediate. The first role requires one to represent a particular interest, while the latter requires neutrality. Mediation also conflicts with the consultancy model (suggested by Ackerman and LaPuma and Schiedermayer; see chapter 3) because it involves a consultant in the
forefront of discussion rather than keeping her in the background in an advisory capacity. It also conflicts with some of Freedman’s suggestions (see chapter 3) that the bioethics consultant ought to stand up to the institution at times; mediation might require neutral representation of even the institution’s interests.

Finally, there is an argument against mediation on the basis of efficiency and expertise. Even if mediators were not already available in hospitals, if there were sufficient need for this role, it seems preferable actually to hire trained mediators who both understand the dimensions of mediation and, as a separate party, can focus exclusively on the desired goal. Nevertheless, if it is economically advantageous or it helps to improve patient satisfaction, hospitals may find it advantageous to include mediation in a bioethics consultant’s role.

J. Consensus-Builder

Like the mediator, the consensus builder aims at a resolution. But unlike the mediator, the consensus builder wants resolution of a particular type: either by unanimity or at least through a majority agreement on the point under discussion, whether it involves code status, the removal of a patient from the ICU, etc.

Again, there are several reasons why it is not clearly acceptable for a bioethics consultant to attempt to build consensus. First, without the foundational account of the field, it is not clear what would count as consensus. Since it is not clear whose consensus should be sought, it is therefore not clear whether unanimity, majority or perhaps the votes of the ‘right’ people that count. Which dissenting voices count?
It is as well unclear why consensus is sought, and therefore what the side-constraints of the role are. If consensus is taken to be an indication that one has arrived at the moral truth, some account needs to be given of what to make of dissent. If consensus is desired for a more psychological reason (e.g., bringing together a fractured family relationship), it might require unanimity. Consensus-building also potentially conflicts with other possible interpretations of the main goal of bioethics consultant, such as patient protection or consultancy. If a bioethics consultant’s main goal is to protect patients, other parties to a consensus decision might mistrust her. On the other hand, if bioethics consultants are strictly consultants to the physician, it may be inappropriate for them to become involved in the case to the degree required to work toward consensus. Therefore until we have chosen the foundations of bioethics, it will be hard both to establish the goal of mediation and to establish its side-constraints.

K. Patient Advocate

The bioethicist can also play the role of patient advocate, for example in cases where the patient has no family or friends, is unconscious or otherwise unable to advocate for himself, or where the bioethicist holds that the patient may be a subject of discrimination or that the patient’s wishes and preferences are not being attended to. It is not surprising that this goal is often suggested for bioethics consultation; after all, it was accusations of paternalism (inter alia) that brought bioethicists into the clinic in order to protect the rights of patients. In the discussion of patient protection in chapter five, I argued that it was not possible to establish with certainty that it is the fundamental goal of bioethics
consultation from which other duties follow. The present concern is whether it may serve as one of the roles a consultant may play.

If other models of bioethics consultation like those described in chapter three are chosen as fundamental, however, patient protection or advocacy will not be an appropriate role. The consultancy model advocated by Ackerman is clearly opposed to advocacy, and even the LaPuma/Scheidermayer model only includes advocacy as a last resort. Even if patient advocacy were determined to be an acceptable role, however, there are ambiguities in interpreting it apart from a grounding theory. Is advocacy like representation in the criminal system, where the goal is to do virtually anything, within certain limits, to ensure one’s client’s success? Or is it rather ensuring that a patient’s wishes are heard and understood? The aim of the role and its side-constraints cannot be articulated apart from a foundational theory.

L. Moral guide

At times, suggests Freedman, the reason a bioethics consultation is called is because someone wants to know the right thing to do. Frequently, cases do not involve potential or actual rights violations, or dispute over values. Instead, they concern the murky areas of morality. In such cases, people often want guidance about morality and look to “the ethicist” to offer that guidance. Physicians, patients, and family members may expect the bioethics consultant to inform them about the morally correct way to balance claims in favor of liberty and autonomy on the one hand, versus protection against pain, suffering, and anxiety on the other.
Of what would this sort of expertise consist? A Ph.D. in philosophy will ensure that one is to a greater or lesser degree schooled in moral philosophy, but this is not necessarily the same as being a moral expert? There is considerable literature on the question of whether there can be moral experts; opinion seems to be divided. Some consider bioethicists to be authorities on moral arguments (i.e., as knowing something about the subject), while others hold that the bioethicist possesses knowledge about the good and the right.

The former role seems relatively uncontroversial, except for what it might imply about the training and education of bioethics consultants. If this sort of guidance is required for bioethics consultation, then the way in which it is construed will determine what sort of training consultants ought to have. The latter role of expertise concerning the right and the good is more controversial. There are many reasons to think that even rigorous training in moral philosophy conveys no expertise regarding the right and the good. It is clearly possible to imagine a brilliant, immoral moral philosopher. In addition, however, there are reasonable arguments to be made for a wide variety of moral positions. Since these are precisely the kinds of positions among which people need to choose in health care settings, someone acting as a normative moral expert would be arbitrarily advising the choice of one rather than another. “Arbitrary” does not mean that the expert flips a coin; rather, from the patient’s perspective, the choice that the expert

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4 At present, a two-week course in bioethics is sufficient for many people, and in fact, in my limited experience, most members of a bioethics committee only have the training the committee arranges for itself after having been established. If certain areas of expertise in moral arguments is found to be necessary, perhaps testing could establish what sort of training is optimal for instilling that sort of expertise. In the interim, the default position seems generally to be that the more training one has, the more of an expert he is.
recommends is arbitrary because a bioethics consultant with an opposing view might, in the same case, have given a different answer.

On the other hand, it might be a complete abdication of responsibility to tell patients only about the arguments for particular positions and never to give them any idea of where one stands oneself on the issue. Physicians also seem to have little patience with bioethics consultants who have no positive recommendations. It may be prudent for bioethics consultants to give some account of their field that allows them to provide such a service. However, care needs to be taken. It may be that disclosing what one’s own choice would be in a particular situation would influence the patient. In the hospital, where power inequities are an issue, this may be inappropriate. This is similar to the question of whether physicians should, in difficult circumstances, recommend particular treatments to patients. Nevertheless, it seems legitimate to ask people who have experience in a particular area what they would do if they were similarly situated, because even when we have all available empirical information, we cannot always form an accurate idea of the choices we face. What seems important in this case is that if a bioethics consultant offers advice, she should first, make clear where the major differences of opinion lie on the matter; second, make clear that she is giving her own opinion of the matter and is not speaking as a moral authority; and third, remind the patient of the values that inform one’s choice, since they may differ from the patient’s.

What seems inappropriate in this model is moral guidance as a means of personal moral activism. Suggestions like Freedman’s, that bioethics consultation might be a place in which one can express one’s own values, seem gravely misguided if this is
interpreted as the attempt to influence patients and their families to one’s own point of view.

M. Conclusion

Each of the twelve roles discussed above can be interpreted in a number of ways. The choice of a particular interpretation will be arbitrary or will depend on some overarching goal for bioethics consultation. It may also depend on the institution’s needs for the consultant’s services. Arguments regarding potential dangers of the pursuit of particular roles may help limit their scope in minimal ways, but apart from any canonical arguments regarding such a fundamental aim of bioethics consultation, it is impossible definitively to establish whether or not any of these roles should be played and what if any side-constraints exist.

What remains to be seen is whether there are some combinations of roles that conflict. If so, even apart from our justification for the obligations of consultants, we can give some guidance regarding the choices any interpreters of the field face among such roles. These combinations are discussed in the following section.

III. ROLES IN COMBINATION

The primary conflict among roles in combination occurs between those that require representation for a particular party and those that require neutrality. If a consultant takes on the role of patient advocate, it may change the ways in which she is seen by other parties, including the patient’s family, the health care team, the institutional risk manager and hospital administrators. Facilitation will be more difficult in an atmosphere of
distrust. Mediation is directly incompatible with partisanship, since the point of mediation is to function as a neutral party. Even moral or spiritual guidance may be inappropriate, since those desiring guidance may be suspicious that there is an agenda behind the consultant’s advice. Finally, if a bioethics consultant comes primarily to be seen as a risk manager, patients may have good reason to be suspicious of the consultant’s motives in the process of mediation or facilitation.

It may also be unfair to the patient for whom one is advocating. A great deal depends on how we constitute advocacy, but it is likely that even on a weak interpretation, one might fail if one’s attention is divided. If, for example, advocacy is interpreted as simply ensuring that a patient’s wishes are heard and understood, a patient might justifiably be suspicious when a bioethics consultant then turned to mediation. The goal of mediation is to effect a peaceable settlement. If the patient’s wishes are in conflict with the wishes of other parties, why should his advocate be forced to consider those opposing wishes?

A chance of conflict also exists between the role of unofficial spiritual guide and roles that require neutrality such as facilitation, mediation and consensus-building. A bioethics consultant who has prayed with a patient or engaged in deep personal conversations about God, existence, or the meaning of life might become personally involved with the patient in an unacceptable way. The same might be said of the role of counseling. This is not to suggest that joint prayer or spiritual conversation automatically prejudices a consultant, but it remains true that these are fairly intimate experiences. Often we do not conduct these conversations even with those closest to us. It is not hard to imagine that this personal connection has the power to sway one’s feelings or even
opinions in the matter. (Remember, for example, the surgeon’s observation in the kidney
dialysis committee discussed in chapter two: “I am impressed that his doctor took special
pains to mention that this man is active in church work. This is an indication to me of
character and moral strength.”) Other parties to the mediation or facilitation might, if
they were aware of this connection, be justifiably suspicious about their chances of being
fairly heard.

Conflicts between roles that require representation or involve partisanship,
therefore, are incompatible with roles requiring neutrality. Any conception of bioethics
consultation must address this fundamental problem.

IV. CONCLUSION

This analytic geography of twelve different roles that bioethics consultants do in fact play
has been undertaken in order to provide an in-depth presentation of the heterogeneity of
the tasks undertaken by bioethicists. Four of these tasks, counseling, official spiritual
guide, policeman, and risk manager, should be approached with great caution and should
never be the primary goal of bioethics consultation. At best, these roles can be a side
effect of the enterprise of bioethics consultation. There are three main reasons for taking
this position. First, there are already people available in the hospital to play all of them,
so efficiency suggests that when those roles are required, such professionals ought to be
called. Second, for three of these roles (excluding the policeman), particular expertise is
required. Given the differences between particular practicing consultants, it is unlikely
that most will have the requisite knowledge. Moreover, pursuit of these goals at the
novice level can be dangerous. Third, these roles require a particular focus of attention.
Although we have not yet established the purpose of bioethics consultation, there may exist some other worthwhile goal which bioethics consultants ought to pursue instead. If so, *that* goal should be the focus of the consultant's attention.

Another four roles seem possible to play in at least some minimal fashion. Education, facilitation, administration and clarification are all permissible for bioethics consultants to engage in, but the side-constraints and aims of these roles will have to be derived from the larger goal of bioethics consultation yet to be established.

The acceptability of the final four roles, mediation, consensus-building, patient advocacy and moral guidance, cannot be determined. Each potentially conflicts with a possible overarching goal of bioethics consultation. Moreover, the side-constraints on each and the goals for which they aim will have to be determined in light of that overarching goal. Therefore, until that account is offered, we must suspend judgment on the question of whether these roles may be undertaken by bioethics consultation. What can be said, however, is that not all roles can be played. The major obstacle to the inclusion of all roles is the conflict between those that require neutrality and those that require partisanship.

The implication of this conflict means that the fundamental choice facing those who attempt to define the goals of bioethics consultation is whether or not it should include patient advocacy. This is an important choice. Patient advocacy seems to lie at the very heart of bioethics consultation. The history of patient abuse and physician paternalism helped to bring bioethics consultants into the hospital in the first place. Yet the Institutional Review Board is now in place to address many of the areas in which patients might be treated wrongly. Does this obviate the need for patient advocacy or
not? If the choice is made to include advocacy in the description of bioethics consultation, consultants may be unable appropriately to play many of the roles for which they are currently called. If health care teams and administrations see bioethics consultants as patient advocates, it will be more difficult (if not impossible) for consultants to mediate, facilitate, build consensus or act as a moral guide for the health care team. Partisanship will negatively impact the stance of neutrality that such roles require.

This geography of roles offers a further support to the judgment that the profession of bioethics consultation can only be understood in terms of a complex of social forces and historical accidents. The philosopher can nevertheless lay out the geography of these roles, indicating points of conflict and unclarity. The resulting map of bioethics consultation reveals a field with no single purpose or cardinal aim. Bioethics consultants are, like social workers, useful for a variety of reasons, none of which confers a conceptual unity on the field. Instead, the value individuals find in bioethics consultation can be defined in many ways and can conflict. Institutions may find bioethics consultants useful because they mitigate risk. Patients and their families may perceive consultants to be guardians of the patient’s interests. Physicians may value bioethics consultants for their abilities to address conflict over moral issues. Yet a single consultant may not be able to perform all of these roles at once.

An account of bioethics consultation must be causal rather than conceptual. The history of bioethics consultation discloses the conflicting values present at the very inception of the field. It is therefore not surprising that bioethics consultants themselves proffer conflicting models. It is also not surprising that the many possible bioethics
consultation roles are mutually incompatible. This conflict and incompatibility accurately reflect the field and its lack of conceptual integrity. No model may claim to be the one true aim of bioethics consultation. Bioethics consultation is not a unified practice. It is instead comprised of a heterogeneous set of roles which owe their existence to historical circumstance and social utility.
CHAPTER SEVEN: MANY CLOUDS, BUT NO RAIN

I. RESULTS

The search for a conceptual integrity of the field of bioethics consultation has been fruitless. Neither the history of the field nor contemporary accounts of the field nor even professional guidelines regarding permissible, impermissible or obligatory actions in bioethics consultation give evidence of a unified set of goals, but instead of a collage of heterogeneous concerns. Other possible foundations for the field, when subjected to scrutiny, also seem to fail to disclose the basis for a unified field. In addition, when potential subsidiary roles for bioethics consultation are considered, they dissolve into ambiguity in the absence of a foundational account of the field’s aim. It is neither clear which subsidiary roles may be played in the pursuit of principal goals, nor is it obvious at what each role aims and in what manner they may be pursued.

The investigation of the historical antecedents of bioethics consultation demonstrated the multiple, conflicting roles that history has bequeathed to the practice. The legacy of dialysis committees and the Quinlan Court’s opinion involved a conception of bioethics committees as equal but uniquely qualified partners with physicians in moral decision making. The main motivation for this partnership was the protection of doctors from “highly emotional situations”, as one dialysis committee member put it, and from the exclusive assumption of moral and legal responsibility for the decisions they must make.
Federal involvement in bioethics arose, on the other hand, from the need to protect research subjects and patients. Informed consent, research subject protection and the Baby Doe regulations all furnished bioethics with the goal of protecting those who risked being abused by the health care system, and by doctors in particular. This legal concern for persons unable to speak for themselves offered a place for the bioethicist within medical decision making but as what Rothman called a “stranger” to the institution (Rothman, 1991). In addition, in the applications of these protective regulations, bioethicists often had the responsibility of making decisions that required interpretation of moral concepts such as quality of life, the comparative worth of lives, and medical futility. Bioethics came to involve the analysis and application of moral norms. The history of the field demonstrates one of the fundamental tensions in bioethics consultation: it seems at the same time to serve the interests of medical professionals and institutions and the patients who need or want their services, when in fact, these two interests may often conflict.

It is not surprising that this tension between concern for the institution and concern for patients is readily apparent, though often not directly addressed, in four important contemporary models of consultation. These four models are incommensurable with each other. Ackerman and LaPuma and Schiedermayer agree superficially that the bioethics consultant ought to serve at the pleasure of the physician, but they disagree on whether a consultant ought to be a patient advocate. Both accounts conflict with Freedman’s suggestion that bioethics consultants ought to be moral guides in a substantive sense, and with his implication that personal moral activism is a permissible, perhaps even salutary goal. Moreno’s account argues for the moral authority
of bioethicists, which conflicts with Ackerman and LaPuma and Schiedermayer's rejection of such authority.

Each account is also encumbered by flaws that hamper the ability substantively to guide the bioethics consultant in practice. The salient difficulty arises from the impossibility of canonically interpreting either the content of the suggested aim or how that aim may be pursued. That is, these models do not give an account of what actions are acceptable and unacceptable in bioethics consultation. The conflict between these accounts is not superficial. It stems in large part from a fundamental conflict bequeathed to bioethics consultation by its history of serving both the medical institution and the patients who utilize it. There may be accounts that establish a manner in which both interests are served without conflict. However, the models and historical precedents discussed argue that the point of the activity is exclusively service to one party or the other.

The *Core Competencies* document was no more successful in disclosing an account of bioethics consultation. The ambiguity of the terms used means that the role can be interpreted in many plausible but conflicting ways. Each interpretation bears distinct implications for the conduct of bioethics consultants. For example, there are diverse ways of interpreting the goal of consensus. If it is sought so that most or all parties will not leave a consultation angry, the endpoints and side-constraints will be different than if consensus is sought as a means of achieving truth rather than agreement. The document's reliance on concepts such as "morally acceptable options" or "societal values", and who may identify them, is also problematic. The manner in which these concepts are defined may also determine the range of choices presented to a patient.
Without a deeper justification, these recommendations cannot articulate what
distinguishes an excellent from a poor consultant or a virtuous from a vicious consultant.

The philosophical arguments concerning professional obligations shed further
light on the difficulties of providing a unified account of the justification for bioethics
consultation. Not only does the field suffer from a legacy of multivalent goals, it appears
that there is no philosophical argument able to resolve the ambiguity. George Sher’s
work as applied to bioethics consultation demonstrates that there is no account capable of
delivering both particular professional obligations and the sources of those obligations.
A final attempt to articulate the shared understanding behind the field proved explanatory
but not normative. Social work’s history highlights the manner in which a cluster of
social practices can come to constitute what in social space is recognized as a single
profession, though it would be an error to search for a conceptual integrity underlying the
profession. Rather, a heterogeneous set of social needs crystallized around the role of
social worker, creating a profession that came to be taken for granted. The same has
occurred with bioethics. A heterogeneous group of needs came to be met by the role of
“bioethicist” or “ ethicist”. The contemporary character of that cluster-role can be
appreciated as the result of particular historical causal forces. A story can be told even
where no underlying unitary account or justification can be provided.

This state of affairs sheds light on bioethics consultation and raises a series of
issues regarding how one might appreciate other professions or applied practices. At the
very least, with respect to bioethics, one can better appreciate the heterogeneous character
of its contributions. This heterogeneity has been laid out in this work through a
conceptual analysis of the geography of these roles and their constituent elements. This
has been combined with an analytic history of the field embedded in the literature that has come to constitute bioethics as an applied social practice: bioethics consultation. The conclusion is that bioethics consultation has no single, unified foundation for this complex set of normative and other practices.

These results give a superb example of the historical social constitution of a normative social profession and make suggestions about analysis that could be brought to bear on other professions, such as social work, nursing, and even medicine. An analysis of the history and social function of such professions may disclose ambiguities and conflicts that will explain the current face of the field. These reflections also open up interesting points of further research in the philosophy of medicine. A search for a unified account of the aims of medicine, for example, may reveal a similar heterogeneity of aims due to historical forces and social needs.

II. IMPLICATIONS

Bioethics is a heterogeneous practice. The manner in which it arose, the many possible ways in which it may be interpreted, and the diverse social forces which continue to shape it make this an unsurprising result. We are left without an account of the field that could justifiably require certain actions and prohibit others.

This result has several implications. First, it will be impossible to evaluate outcomes in bioethics consultation without specifying which outcomes are important. To the extent that outcomes research is undertaken, the conclusions of that research will be conditional. That is, since the results will be based on an assumption regarding the
appropriate outcomes of bioethics consultation, they will help to direct the activity of the field only among those practitioners who agree on the importance of those outcomes.

Second, it implies next to nothing about what training bioethics consultants ought to have. An emphasis on patient protection or advocacy may dictate that consultants receive training in clarifying and representing a patient’s values. Interpreting bioethics consultation as moral guidance might imply a need for philosophical training, but the content and emphasis of that training would depend on which moral principles, positions, or theories are taken to be correct. For example, a religious institution would be right, under the conception of bioethics consultation as moral guidance, in requiring that their consultants receive training in, and possibly subscribe to, a particular religion. A secular institution may adopt from other sources or formulate on its own a set of distinct moral guidelines. Alternatively, the view of bioethics consultation as dispute resolution suggests either that consultants should receive extensive training in mediation or that already-trained mediators should be hired to perform this service.

Third, and of critical importance as bioethics consultation finds itself on the verge of professionalization, the results of this project imply that any particular choices regarding the form of bioethics consultation will be philosophically arbitrary. Such choices could as easily be a mask for particular ideologies as a genuine intention to pursue the right and the good. The force of a professional self-definition and code of ethics will depend on social forces rather than moral arguments. A bioethics consultant who, as Freedman suggests, views her job as a forum for “fulfill[ing] personal moral commitments and needs” may find herself professional censured if the professional licensing board deems such behavior unacceptable. One of the results of the adoption of
a particular schema of bioethics consultation may be the instigation by others of competing professional organizations in much the same way as chiropractic and osteopathic medicine separated from allopathic medicine. Health care institutions might then choose which approach is most congenial to their needs. Since no particular approach to bioethics consultation would have an exclusive claim to being the appropriate model of the field, such institutions would be justified in making virtually any particular choice. Such potential future developments further demonstrate the heterogeneous, socially contingent nature of the field.

III. CONCLUSION

My purpose has not been to argue against the legitimacy of the very existence of bioethics consultation. In a liberal society, individuals and institutions are in general free to contract with each other as they see fit. Rather, the aim has been to offer a conceptual geography of the field, so as to demonstrate that the problems it faces are not contingent facts. They are instead rooted in deep conceptual ambiguities arising from the history and contemporary practice of the field. I have examined the ways in which the field of bioethics consultation is conceived and defended. The unavoidable conclusion is that its possible goals are conflicting and mutually incompatible. I have also argued that apart from a conceptually integrated and justified foundation, it is impossible to establish what constitutes exceptional and exceptionable practice.

One of the central tensions in bioethics consultation involves the question of whom bioethics consultants serve. Historical precedents and popular accounts of the field diverge over this issue. Therefore even in the absence of a foundational account of
bioethics consultation, I argue that this question must be addressed by any contemplated view of the field. Particular conceptions may preference one model of bioethics consultation over the other, but they must confront this issue of conflicting aims. Even if a particular model holds that neither party should be served to the exclusion of the other, at times the interests of the two parties may conflict. Any conception of the field must therefore determine what the appropriate response to this conflict will be. It may be that in cases of conflict, one party’s interests should prevail. One might also argue that such conflicts could be addressed (or avoided altogether) if bioethics consultation undergoes a particular process (e.g., as Moreno suggests). Either way, the question is inescapable.

Bioethics consultation is not a unified field. Social forces and various moral arguments have shaped and will continue to shape its incarnation. Understanding the dimensions of the debate, its conceptual riddles, and its susceptibility to time and circumstance will at least enable us to understand our disagreements. In the absence of a philosophical justification, however, the strictures placed upon the field and the way in which it is understood will be contingent.
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