7-5-2014

Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable

Autumn Fiester

University of Pennsylvania, fiester@mail.med.upenn.edu

Follow this and additional works at: https://repository.upenn.edu/bioethics_papers

Part of the [Bioethics and Medical Ethics Commons](#)

Recommended Citation

Fiester, A. (2014). Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable. *Bioethics*, 29 (5), 309-315. <http://dx.doi.org/10.1111/bioe.12115>

This is the peer reviewed version of the following article: Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable, *Bioethics*, 29, 5, 309-315, June 2015, which has been published in final form at dx.doi.org/10.1111/bioe.12115. This article may be used for non-commercial purposes in accordance With Wiley Terms and Conditions for self-archiving.

This paper is posted at ScholarlyCommons. https://repository.upenn.edu/bioethics_papers/85
For more information, please contact repository@pobox.upenn.edu.

Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable

Abstract

Internationally, there is an on-going dialogue about how to professionalize ethics consultation services (ECSs). Despite these efforts, one aspect of ECS-competence that has received scant attention is the liability of failing to adequately capture all of the relevant moral considerations in an ethics conflict. This failure carries a high price for the least powerful stakeholders in the dispute. When an ECS does not possess a sophisticated dexterity at translating what stakeholders say in a conflict into ethical concepts or principles, it runs the risk of naming one side's claims as morally legitimate and decrying the other's as merely self-serving. The result of this failure is that one side in a dispute is granted significantly more moral weight and authority than the other. The remedy to this problem is that ECSs learn how to expand the diagnostic moral lens they employ in clinical ethics conflicts.

Keywords

clinical ethics; consultation; mediation; professional standards

Disciplines

Bioethics and Medical Ethics | Medicine and Health Sciences

Comments

This is the peer reviewed version of the following article: Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable, *Bioethics*, 29, 5, 309-315, June 2015, which has been published in final form at [dx.doi.org/10.1111/bioe.12115](https://doi.org/10.1111/bioe.12115). This article may be used for non-commercial purposes in accordance With Wiley Terms and Conditions for self-archiving.

Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable

Abstract

Internationally, there is an on-going dialogue about how to professionalize ethics consultation services (ECSs). Despite these efforts, one aspect of ECS-competence that has received scant attention is the liability of failing to adequately capture all of the relevant moral considerations in an ethics conflict. This failure carries a high price for the least powerful stakeholders in the dispute. When an ECS does not possess a sophisticated dexterity at translating what stakeholders say in a conflict into ethical concepts or principles, it runs the risk of naming one side's claims as morally legitimate and decrying the other's as merely self-serving. The result of this failure is that one side in a dispute is granted significantly more moral weight and authority than the other. The remedy to this problem is that ECSs learn how to expand the diagnostic moral lens they employ in clinical ethics conflicts.

Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable

In the new movement to professionalize ethics consultation services (ECSs), there is universal call for increased skills and knowledge among those who conduct clinical ethics consults¹. One central skill set considered requisite for competence in consultation is what the American professional bioethics organization terms “Ethical Assessment and Analysis Skills”², under which falls the ability to “clarify relevant ethical concepts”³ and then “apply relevant ethical considerations”⁴. Although this criterion of ECS-competence is well and good in theory, implementing it effectively in practice is easier said than done.

¹N. N. Dubler, M. P. Webber, D. M. Swiderski, the Faculty & the National Working Group for the Clinical Ethics Credentialing Project. Charting the Future. *Hastings Center Report* 2009; 39(6): 29-33; American Society for Bioethics and Humanities’ Core Competencies Update Task Force. 2011. *Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics And Humanities* (2nd ed.). Glenview, IL: American Society for Bioethics and Humanities; A. J. Tarzian & ASBH Core Competencies Update Task Force. Health Care Ethics Consultation: An Update on Core Competencies and Emerging Standards from the American Society for Bioethics and Humanities’ Core Competencies Update Task Force. *American Journal of Bioethics* 2013; 13(2): 3-13.

² ASBH, *op cit.* note 1, p. 22.

³ Ibid: 22.

⁴ Ibid: 23.

One thorny difficulty with this criterion of ECS-competence that has received scant attention from reformers is the liability of failing to adequately capture all of the ethical considerations or moral reasons that undergird an ethics conflict – a failure that carries a high price for the least powerful stakeholders in a dispute. When an ECS does not possess a sophisticated dexterity at translating what stakeholders say in an ethics dispute into ethical concepts or principles, it runs the risk of naming one side’s claims as morally legitimate and decrying the other’s as merely self-serving – or even immoral. Deeming one side as having principles and the other side as merely having preferences, inclinations, self-interest, etc. creates an imbalance in the moral weight of each respective side, with one side benefiting by having significantly more “moral” power and authority than the other. While earnestly seeking to “clarity [the] relevant ethics concepts” and then “apply” them, the novice ECS can inadvertently weaponize the ethical principles they *do* recognize to detriment of the cause and claims anchored by the principles they *don’t*.

One obvious proposal to address this liability is to simply demand that ECSs possess “advanced knowledge about ethical duties”⁵. But the solution of schooling ECSs to recognize a higher percentage of existing duties and principles is only a viable one if there is truly an exhaustive, definitive list, which I will argue here – and have elsewhere⁶ – is not the case. In this essay, I will argue that clinical ethics conflicts that appear wildly imbalanced morally are often an artifact of unrecognized principles. If I can make good on the claim that both sides in a

⁵ Tarzian et al, *op cit.* note 1.

⁶ A. Fiester. Why the Clinical Ethics We Teach Fails Patients. *Academic Medicine* 2007; 82(7): 684-689; A. Fiester. Ill-Placed Democracy: Ethics Consultations And the Moral Status of Voting. *Journal of Clinical Ethics* 2011; 22(4): 23-32.

dispute are secured by legitimate ethical principles – one side with long-established principles and the other with possibly only nascent, half-articulated ones – then, in lopsided cases, the ECS that recognizes the principles of only one stakeholder has not illuminated the side of the righteous, but stacked the deck against the morally vulnerable.

The remedy is for ECSs to learn how to expand the moral lens they bring to clinical ethics conflicts – not to learn better utilization or application of an existing, narrow set.

I. The Principlist Paradigm vs. Moral Archaeology

The problem of weaponizing principles begins with the false assumption that all of the pertinent bioethical principles and legitimate moral considerations relevant to clinical ethics disputes have already been articulated and are bound in number. With a belief in a limited arsenal of moral tools at one's disposal, it is understandable that ECSs peer into their repository and apply the ethical principles they find waiting there. The common repository used by American ECSs is "principlist" in composition⁷, based loosely on the theory of principlism set out by Tom Beauchamp and James Childress⁸. But unlike the original theory, the "principlist paradigm" – as I have called it⁹ – operates like a short diagnostic check-list that scans for a

⁷R. De Vries, L. Low & E. Bogdan-Lovis. 2008. Choosing Surgical Birth: Desire And The Nature of Bioethical Advice. In *Naturalized Bioethics: Towards Responsible Knowing And Practice*, H. Lindemann, M.U. Walker, & M. Verkerk, eds. New York, NY: Cambridge University Press.

⁸T. Beauchamp & J. Childress. 2001. *The Principles of Biomedical Ethics*. Oxford, UK: Oxford University Press.

⁹ Fiester 2007, *op. cit.* note 6.

handful of ethical considerations in clinical encounters and then makes its normative assessment based entirely on that reductive set of ethical concerns. Of course, if the check-list were exhaustive of all of the moral considerations that arise in a clinical situation, then this mode of moral diagnosis would not be cause for alarm. But this ham-fisted use of principlism inadvertently leads us to detect only a limited range of existing moral considerations. The effect is a narrowing of the moral lens through which clinical ethics cases are viewed at the cost of missing other salient features and the moral obligations attached to them. The cost of failing to recognize the salient moral considerations of one side of a dispute is that the principles that are recognized on the other side amass a disproportionate ethical heft in the debate to the point of being fortified as proof of ethical supremacy.

The problem is not the employment of “principles” as the unit of moral analysis, as critics who have raised parallel concerns have maintained¹⁰. It’s our abuse of them. It is the severe curtailment of the set of pertinent ethical concepts utilized in bioethics. ECSs, trained to spot only a handful of principles, are blinded to obligations that fall outside the limited range of principles or concepts articulated by the dominant theoretical and conceptual models of the field¹¹. This view of a finite set of moral considerations isn’t even consistent with the

¹⁰ S. Toulmin. The Tyranny of Principles. *Hastings Center Report* 1981; 11(6): 31-39.

¹¹ Beauchamp & Childress *op cit.* note 8; R. Gillon. Ethics Needs Principles: Four Can Encompass the Rest – and Respect for Autonomy Should Be “First among Equals.” *Journal of Medical Ethics* 2003; 29: 307-312; R. Veatch. Resolving Conflict among Principles: Ranking, Balancing, and Specifying. *Kennedy Institute of Ethics Journal* 1995; 5: 199-218; B. Gert, C. Culver & K.D. Clouser. 1997. *Bioethics: A Return to Fundamentals*. New York, NY: Oxford

philosopher notorious for having only *one* formal principle: Immanuel Kant. On Kant's view, nicely explained for the context of bioethics by Bert Heinrichs, the "Categorical Imperative" spins off a "multitude of material principles"¹² that flesh out the myriad, complex obligations we have to each other. As Heinrichs puts it, the "multitude" honors "the diversity of moral life"¹³, and, as Barbara Herman argues, it must expand as moral perception and moral insight evolve¹⁴. The moral arsenal created by bioethics treats as static and fixed what should be understood as an ever-enlarging set. The role for an ECS is to engage in "moral archaeology" – a systematic uncovering of the moral values, interests, principles, and laws at play in an ethics dispute¹⁵ – not the rote application of a small set of ethical concepts that many have railed against¹⁶.

In fact, the method of moral archaeology has strong echoes of the central strategy and insight of the casuists¹⁷. Casuistry recognizes this same need to expand the moral lens by

University Press; Gordon, Rauprich, Vollman 2011 JS. Gordon, O. Rauprich & J. Vollmann.

Applying the Four-Principle Approach. *Bioethics* 2011; 25 (6): 293-300

¹² B. Heinrichs. Single-Principle Versus Multi-Principle Approaches in Bioethics. *Journal of Applied Philosophy* 2010; 27 (1): 72-83, p. 73.

¹³ Ibid: 81.

¹⁴ B. Herman. 1996. *The Practice of Moral Judgment*. Cambridge, MA: Harvard University Press.

¹⁵ A. Fiester. Mediation and Recommendation. *American Journal of Bioethics* 2013; 13 (2): 23-24, p. 24.

¹⁶ Toulmin, *op cit.* note 10; J. Arras. Getting Down to Cases: The Revival of Casuistry in Bioethics. *Journal of Medicine and Philosophy* 1991; 16(1): 29-51

¹⁷ Arras, *op cit.* note 16, p. 37.

focusing on what Arras calls “moral diagnosis”¹⁸. Two decades ago, Arras articulated the casuistical approach as a “derivation of...principles” “develop[ed] incrementally through the analysis of concrete cases”¹⁹, enabling “principles...to emerge gradually from reflection upon our responses to particular cases”²⁰. This strategy is mirrored in the work of the hermeneutical school of clinical ethics consultation, in which the theoretical apparatus that one brings to case analysis is best viewed as “dynamic frameworks” that are “responsive to practice.”²¹ And bioethics – at its best – does exactly that. In fact, the whole history of bioethics’ development as a field can be viewed as the articulation of novel principles that bring into relief newly recognized obligations or moral considerations.²² Moral orthodoxy should be the anathema of a field in the business of changing the way people think about the ethical dilemmas of medicine and science. And yet, we repeatedly find that yesterday’s radical moral change not only becomes today’s bioethical dogma, but one viewed as a moral truth tracing back to time immemorial. Take but one example: it was not that long ago that the state’s interest in

¹⁸ Ibid.

¹⁹ Ibid: 31.

²⁰ Ibid: 33.

²¹ R. Proz, E. Landeweer, & G. Widdershoven. Theory and Practice of Clinical Ethics Support Services: Narrative and Hermeneutical Perspectives. *Bioethics* 25: 354-360, at 357.

²² It is important to note that bioethics is not the only field that is generative of such novel moral principles. Another good example is the construct of “sexual harassment” forged by Catherine MacKinnon in the late 70’s. I thank the anonymous reviewer for this helpful point. See, C. MacKinnon. 1979. *Sexual harassment of working women: A case of sex discrimination*. New Haven: Yale University Press.

preserving life was understood to trump a competent patient's refusal of treatment – whatever their moral or religious reasons. From the landmark US Quinlan decision: “Simply stated, the right to religious beliefs is absolute but conduct in pursuance thereof is not wholly immune from governmental restraint. So it is that, for the sake of life, courts sometimes (but not always) order blood transfusions for Jehovah's Witnesses (whose religious beliefs abhor such procedure)”²³. Today, the right of a Jehovah's Witness to refuse blood products is an unquestionable doctrine taught to all American nursing and medical trainees. Bioethics generates new moral principles (or is at least responsible for their newfound recognition) and then treats them as if they were acknowledged all along: it is a short distance from casuistical discovery to timeworn canon. But the lesson of patients' rights for religious minorities – or the actual Quinlan case itself – is that there is an ever-expanding set of salient moral principles. Bioethics' history belies a determinate set of “material,” or what in bioethics are often referred to as “middle level”²⁴, bioethical principles.

If the supposition of a delimited set of moral considerations is wrong (and the casuists have it right), then we must have a stance of looking for principles archaeologically, especially if the stakes of failing to see them are as high as I will claim.

II. Excavating Unrecognized Principles

One possible counter to evidence of past ethical discoveries, such as obligations to the Jehovah Witness faithful, is that there simply are no more principles to be found. Bioethics has come of age, one might argue, and the work of the past forty years has exhausted the moral

²³ *In Re Quinlan*, 70 N.J. 10, 355 A.2d 647 (N.J. 1976), p.19.

²⁴ Beauchamp & Childress, *op. cit.* note 8.

terrain. To demonstrate that this objection is false and that the need to mine cases for new principles is as pressing as ever, let's look at a sample case, the conventional bioethical interpretation of it, and what additional moral principles might be found there. As we try to unearth ethical features of the case not standardly recognized in bioethical analysis, we should be wary of limiting our lens to "principles" as the sole moral entities. Much handwringing in the field has hinged on concerns about "principles"²⁵, and the bioethical obsession with principles has likely blinded us to more nuanced readings of bioethical cases and situations. To avoid this baggage, I will refer interchangeably to a generic class of moral entities that speak to "what we owe each other"²⁶: e.g., "principles," "obligations," "virtues,"²⁷ "moral considerations" and "moral reasons" – even what casuist Toulmin, in his tirade against "the tyranny of principles," labels our "different rights and claims...and responsibilities"²⁸. For my argument, these metaethical distinctions do not matter. The issue is whether one's concerns, interests, claims, or

²⁵ Toulmin, *op cit.* note 10; K.D. Clouser & B. Gert. A Critique of Principlism. *Journal of Medicine and Philosophy* 1990; 15: 219-236; Arras *op cit.* note 10; E. Emanuel. The Beginning of the End of Principlism. *Hastings Center Report* 1995; 25 (4): 37-38.

²⁶ T. Scanlon. 2000. *What We Owe to Each Other*. Cambridge, MA: Harvard University Press.

²⁷ I include the "virtues" in the set of moral entities that describes what we owe to each other. Although a Kantian in stripe, I believe that the contrast between Kantian and Aristotelian ethics has been too sharply drawn. Following Barbara Herman, I believe that the best reading of Kant is to recognize the virtues as duty-bound. See, for example, B. Herman. 1996. Making Room for Character. In *Aristotle, Kant, and the Stoics*. S. Engstrom and J. Whiting, eds. New York: Cambridge University Press, 36-60.

²⁸ Toulmin, *op cit.* note 10.

views can be legitimately framed in moral terms, or whether they are instances of non-moral self-interest²⁹. It is worth noting that I am employing a classical Kantian dichotomy here of “moral” versus “non-moral” motives. For Kant, the central question is whether the underpinnings of our actions are “from duty or from some purpose of self-interest”³⁰. In this Kantian framework, “self-interest” does not mean “selfish,” but rather “not sourced in a moral duty to either oneself or others.”³¹ My concern is that some stakeholders involved in clinical ethics consults will have their moral motives mistaken for non-moral ones.

The case I want to examine is taken from the second edition of Nancy Dubler and Carol Liebman’s book, *Bioethics Mediation*³². The case, “She Didn’t Mean It,” is one of the role plays

²⁹ Herman, *op cit.* note 14; Fiester 2011, *op cit.* note 6.

³⁰ I. Kant. 1964. *Groundwork of the Metaphysics of Morals*. H.J. Paton, trans. New York, NY: Harper and Row, p. 9.

³¹ Although Kantian exegesis is beyond the scope of this paper, it is worth mentioning that the distinction between moral and non-moral motives is not intended to exclude the virtues from the set of morally worthy motives. There is a great deal of hand-wringing over what Kant meant by his exclusion of “virtuous motives,” but I follow Barbara Herman’s interpretation that “virtuous motives” are not co-equal to motives anchored in Aristotelian conceptions of virtues. On that view, Kant’s intention in this passage in the *Groundwork* (Kant, *op cit.* note 28) is to exclude motives based solely on emotion because feelings are not stable; it is not evidence of a stance on virtues as moral entities. For a robust discussion of these issues, see J. Wuerth, ed. 2010.

Perfecting virtue: Kantian ethics and virtue ethics. New York: Cambridge University Press.

³² N. Dubler & C. Liebman. 2011. *Bioethics Mediation: A Guide to Shaping Shared Solutions*. Nashville, TN: Vanderbilt University Press.

included in the volume, and it comes with both a transcript of a sample mediation of the case, as well as an accompanying commentary from the authors. I have chosen it because it lends itself to a stock bioethical analysis – one that Dubler and Liebman explicitly call into question. Here is the summary they provide of the case:

Mrs. Dee is an elderly woman, critically ill with multiple medical problems, currently in the ICU. She's on a ventilator and her blood pressure is falling, even though she is on medication to support her pressure. She has had one episode in which the staff felt they might need to attempt resuscitation, but the patient stabilized and remains in the same tenuous condition. Mrs. Dee's kidneys have failed, and the renal consultant raised the possibility of dialysis. Mrs. Dee made a living will years ago that she later affirmed, stating that if critically ill and unlikely to recover she should not get dialysis, a ventilator, or artificial hydration or nutrition and that she should have a DNR order. She also stated that she never wanted to be a burden to her family. Her named health care proxy is her husband, who has since become severely demented. Mrs. Dee has been his primary caretaker at home. The Dees have two grown children, Pat and Tanner. Tanner, who wants to honor her mother's intentions, just heard that the nephrologist got Pat to sign consent for dialysis and is very upset³³.

If we imagine a conventional ethics consult on this case, the ECS would likely cite the principle of autonomy, arguing that the mother's clearly stated treatment preferences in her advance directive and her right to refuse death-prolonging care are being violated by her son on grounds of pure self-interest, namely, his selfish desire to keep her alive despite her wishes. Although the ECS might feel sympathy for Pat and the sad circumstances he finds himself in, they would find little moral weight in his contention that his mother "didn't mean it" and no moral legitimacy in his decision to consent to starting dialysis. The stance of the usual ECS is nicely summarized in the role play transcript by the patient advocate, who states definitively, "[I]t's not really what [the patient's children] want; it's what the patient wants. If she has made up her mind about how she wants to take care of herself towards the end of life, we have to respect that, because her intentions were made clear when she signed [the living will]. [W]e are duty bound to respect that and to just follow it"³⁴. Invoking a duty to respect the patient's wishes

³³ Ibid: 197.

³⁴ Ibid: 258.

on the one side of the moral equation while flagging the mere “wants” of the children on the other makes the situation ethically quite cut and dry. The sole position in the conflict that is tethered by moral principle must necessarily be allowed to dictate the medical course of action. Not only should dialysis *not* be started, but there should be a DNR order in the chart and perhaps even steps taken to withdraw Mrs. Dee’s ventilator, as per her living will. Grief counseling and/or pastoral care can be procured to comfort Pat, but he cannot be allowed to continue to wrong his mother.

This account should sound familiar, since it is the conventional bioethical analysis of a very commonplace conflict, and the subsequent recommendations are the standard fare of a typical ECS. On this account, all of the moral weight clearly falls disproportionately to one side, in a lopsided conflict that can conjure up absolutely no ethical justification for the other. Pat has no good *moral* reasons for his position, so he must yield.

The impetus for questioning this striking moral lopsidedness is that Pat does not believe he is wronging his mother. In fact, his claim is that “she didn’t mean it”: i.e., despite whatever is literally written in the advance directive she signed, it does not tell the whole story about her values and wishes in the current situation as it unfolded. But Pat cannot get any further than that in making his ethical case. He can’t translate his gut feelings or intuitions into anything like the powerful ethical principle the ECS has produced to defend their position. He has no moral weapons to combat their powerful claims and defend his own: Pat is morally vulnerable.

Are there unrecognized moral principles in Pat’s position that he can’t articulate and the ECS fails to see? Dubler, Liebman, and I believe there are. I will defend two such principles: the first is anchored by a commitment to family-centered care articulated by Dubler and Liebman

in the commentary included with the case; and the second is my own, born out of a critique of an overly narrow understanding of autonomy.

The first principle is embedded in the rationale Dubler and Liebman offer for circumventing the mother's advance directive. In a radical departure from patient-autonomy orthodoxy, they write, "The dynamics of the family are such that if the patient is not suffering, his or her wishes must sometimes be subordinated, at least temporarily, to the emotional needs of the family members, for they must live with the solution and the consequences after the patient dies"³⁵. In the case of Mrs. Dee, we have an unconscious patient whose sedation levels suggest that she is not aware of any pain or discomfort. In such a case, we might think of the pertinent principle as an *obligation to (sometimes) prioritize the needs of family members over patients*. This obligation follows directly from the insight of the US family-centered care movement that there is more than one person in the room who matters morally, more than one who can be harmed³⁶. It is also consistent with the "dialogical" clinical ethics model that is part of the

³⁵ Ibid: 145.

³⁶ J. Davidson, et al. Clinical Practice Guidelines for Support of the Family in the Patient-Centered Intensive Care Unit: American College of Critical Care Medicine Task Force 2004-2005. *Critical Care Medicine* 2007; 35 (2): 605-622; J.R. Curtis & D.B. White. Practical Guidelines for Evidence-Based ICU Family Conference. *Chest* 2008; 134 (4): 835-843; L. Leape, D. Berwick, C. Clancy et al. Transforming Healthcare: A Safety Imperative. *Qual Saf Health Care* 2009; 18: 424-428; W. Boulding, et al. Relationship between Satisfaction with Inpatient Care And Hospital Readmission within 30 Days. *The American Journal of Managed Care* 2011; 17(1): 41-48; Fiester. What Does 'Patient-Centered Care' Demand in Serious Cultural Conflict? *Academic Medicine* 2012; 87(1): 20-24.

European conversation about ECS.³⁷ Again, invoking Scanlon's famous description of the set of our moral obligations as being "what we owe each other"³⁸, the family-centered care proponents recognize that "mattering" in this context means that we "owe" family members a sincere effort in safeguarding their well-being and helping them avoid harm and injury.

This sincere effort to find a resolution to the conflict that "meets the emotional needs of the family"³⁹ undergirds Dubler and Liebman's unorthodox approach to living wills. Both trained as lawyers, Dubler and Liebman block the rejoinder that advance directives are legally sacrosanct. They continue: "Living wills are important, but in the clench of hard decisions they amount to just one more piece of information that must be factored into a solution"⁴⁰.

Anticipating the sharp rebuke from the clinical ethics stalwarts, they retort, "Why is [the advance

³⁷ G. Widdershoven, T. Abma, & B. Molewijk. Empirical Ethics as Dialogical Practice. *Bioethics* 2009; 23: 236-248; J. Ives and M. Dunn. Who's Arguing? A Call for Reflexivity in Bioethics. *Bioethics* 2010; 24: 256-265; T. Abma, V. Baur, B. Molewijk, & G. Widdershoven. Inter-ethics: Towards an Interactive and Interdependent Bioethics. *Bioethics* 2010; 24: 242-255; A. Frolic. Who Are We When We Are Doing What We Are Doing? The Case for Mindful Embodiment in Ethics Case Consultation. *Bioethics* 2011; 25: 370-382; and, K. Ohnsorge and G. Widdershoven. Monological and Dialogical Consciousness: Two Epistemological Views on the use of Theory in Clinical Ethics Practice. *Bioethics* 2011; 25: 361-369.

³⁸ Scanlon, *op. cit.*, note 24.

³⁹ Dubler & Liebman, *op. cit.* notes 28-31, p 271.

⁴⁰ *Ibid*: 271.

directive] not the end of the matter? Their answer is that in medical care there are ethical obligations to all the parties in the decision structure”⁴¹.

A second moral principle that bolsters Pat’s position comes from Pat himself, albeit in nascent, inchoate form. In the mock role play included in the Dubler and Liebman text, Pat says, “She would want to be available for Dad and to be there for us”⁴². This claim can appear to be merely self-serving – in fact, it can appear to lend support to the interpretation that Pat has no moral reasons for his stance. He seems to be suggesting that a dying woman should sacrifice her own healthcare needs and preferences for the benefit of others’ needs. Doesn’t this suggestion shine a poor light on Pat? Isn’t asking for self-sacrifice from the dying morally suspect? Commenting on a very similar case, Jecker (2001) takes this concern one step further, leveling what she calls a “feminist critique” in response to the ECS recommendation that treatment continue⁴³. Her claim is that a sexist bias denies “women’s moral agency,” allowing us to ignore a woman’s clearly stated wishes in deference to the wishes or needs of others⁴⁴. But Jecker might be too hasty here. Nested in Pat’s claim is an attempt to articulate his mother’s *own* moral code and thus to enhance, rather than deny, her moral agency.

Reaching beyond the limits of what an advance directive could possibly reveal about a patient’s deepest moral commitments, Pat asserts that his mother would not want to forego or withdraw life-sustaining therapy if her family needed her to continue with it. This might be

⁴¹ Ibid.

⁴² Ibid: 257.

⁴³ . Jecker. Uncovering Cultural Bias in Ethics Consultation. *American Journal of Bioethics* 2001; 1 (4): 49-50, p.49.

⁴⁴ Ibid.

framed as a *principle of staying alive for the sake of others*, and there is a great deal of intuitive plausibility to it. While one applauds Jecker's feminist impulse to safeguard women's autonomous decisions, it would be an overly narrow interpretation of the autonomous agent – male or female – if individuals were construed as autonomous if and only if they made decisions without regard for the welfare of others, especially those nearest and dearest to them. In fact, Jecker's is a fairly idiosyncratic feminist view. The far more predominant feminist ethics of care⁴⁵ would likely take quite seriously Pat's implicit claim about the central importance of his mother's emotional connections and the obligations she would believe follow from them. When she signed the advance directive, she stated that "she never wanted to be a burden to her family." What if she had understood that the hastening of her death, rather than the extension of her life, would actually place the deeper burden on them? Would she then have written the living will in the same way she did? The problem with advance directives is that they are made prospectively, unavoidable without knowing all of the facts of the future circumstance that the patient will be in, some of which might be grounds for negating what was in the advance directive. Mrs. Dee might never have written what she did if she had known what it would have cost her son Pat.

⁴⁵ R. Tong. 1996. *Feminist Approaches to Bioethics*. Boulder, CO: Westview Press; M.U. Walker. 2007. *Moral Understandings: A Feminist Study in Ethics*. New York, NY: Oxford University Press; H.L. Nelson & J. L. Nelson. 1995. *The Patient in the Family*. New York, NY: Routledge; M. Farley. 2002. *Compassionate respect: A feminist approach to medical ethics*. Mahwah, NJ: Paulist Press; J. Scully, L. Baldwin-Ragaven & P. Fitzpatrick, eds. 2010. *Feminist Bioethics: At the Center, on the Margins*. Baltimore, MD: Johns Hopkins University Press; V. Held. 2007. *The Ethics of Care*. New York: Oxford University Press.

This way of looking at the problem sheds new light on Pat's contention that "she didn't mean it," that is, she didn't intend to demand something from her family that would cause them pain or harm. Of course, in the case, there is only Pat's testimony that his mother held this view, but wouldn't most parents, if they were unconscious and could not perceive any pain or suffering, agree to a state of existence with no physical cost to them, if it would significantly help their children? Wouldn't parents willingly to do much more?

It may be that these principles need further justification and argument, but their status as nascent doesn't make them untrue. There is at least a *prima facie* case that Pat does, indeed, have solid moral reasons backing his anti-withdrawal stance.

III. The Duty to Protect the Morally Vulnerable

If the moral claims Pat is struggling to articulate are valid, then the earlier ethical analysis of the conventional ECS is not only flawed, but it maligns Pat in the process. The ECS analysis accuses Pat of, at best, acting selfishly out of grief, and, at worst, violating the personhood of a dying patient. This denigration is particularly egregious because Pat is victim to a kind of susceptibility that I will term "moral vulnerability." Formally, I define *moral vulnerability* as "the condition of having unarticulated or unrecognized moral principles that make one's position difficult to defend with the consequence of being deemed to be acting on pure self-interest." Rather than undermining, or even crippling, the morally vulnerable in an ethics consult, ECSs have a duty to buttress and fortify the claims of the morally vulnerable by mining their positions for moral content.

Why should this be understood as an obligation of an ECS? The answer is simple: because when an ECS fails stakeholders in this way, they cause them harm. To be blinded to the

moral reasons of one side in an ethics dispute is more than a misdemeanor of omission. The consequence of this blindness is that the ECS becomes complicit in turning the ethics dispute into an inherently unfair fight between the “have’s” and “have-not’s, i.e., those who possess the moral might of principles or moral reasons and those who don’t. The ECS inadvertently use the power and authority that comes with moral explanation to diminish the claims of stakeholders that cannot produce their own counter moral arguments. The mandate of ECSs in seemingly lopsided ethics conflicts needs to be a search for the moral claims that underlie the ethically weaker side. The stance I have taken is not unique to the Kantian perspective; it is echoed in the moral deliberation school of clinical ethics consultation.⁴⁶

This invites an obvious objection: what if there really are no moral reasons behind someone’s stance in a clinical ethics dispute? I admit to a deep skepticism about that possibility. Rumors of family members being motivated by the continuing welfare check or a speedy inheritance are legendary, but they may also be caricatures or distortions of those stakeholders’ true views. Until we remedy our scathingly bad track record of uncovering the sincere moral

⁴⁶ See, for example, S. van der Dam, J. Schols, T. Kardol, B. Molewijk, G. Widdershoven, & T. Abma. The Discovery of Deliberation. From Ambiguity to Appreciate through the Learning Process of Doing Moral Case Deliberation in Dutch Elderly Care. *Social Science & Medicine* 2013; 83: 125-132; A. Molewijk, T. Abma, M. Stopler, & G. Widdershoven. Teaching Ethics in the Clinic: The Theory and Practice of Moral Case Deliberation. *Journal of Medical Ethics* 2008;34: 120-124; B. Molewijk, D. Kleinlugtenbelt, & G. Widdershoven. The Role of Emotions in Moral Case Deliberation: Theory, Practice, and Methodology. *Bioethics* 2011; 25: 383-393; and, Y.M. Barilan and M. Brusa. Triangular Reflective Equilibrium: A Conscience-Based Method for Bioethical Deliberation. *Bioethics* 2010; 25: 304-319.

commitments of people like Pat, these uncharitable interpretations should at least be resisted as a last resort. Let's implement an approach to discovering the genuine moral reasons of stakeholders, and then we can see how many cases of pure self-interest persist.

But what about a second, more threatening objection to my argument: how do we know ECSs ever use moral principles as weapons against the morally vulnerable? After all, there have been so few studies of ECSs, and the data that do exist reveal general features of consult services, not details about their inner workings⁴⁷. My first response is that this fact highlights the field's desperate need for more thorough empirical research on ECSs – qualitative, ethnographic, and participant observer, as well as quantitative and statistical. My second response is that while it is true that I cannot provide hard empirical data to prove this phenomenon, I can provide data of another kind: the trope of the self-centered family member. How often in clinical ethics discussions is there a stock character in the conflict who is deemed interested only in receiving the patient's welfare check, or keeping a loved one alive out of guilt, or having a selfish inability to let go? They are certainly the hackneyed staple of the ECSs I witness. Dubler and Liebman's concern in the case "She Didn't Mean It" is important, not because it is so rare, but because it is so commonplace.

IV. Conclusion

⁴⁷ E. Fox, S. Myers, & R. A. Pearlman. Ethics Consultation in United States Hospitals: A National Survey. *American Journal of Bioethics* 2007; 7(2): 13-25.

As important conversations continue about the criterion for ECS-competence, the neglected problem of unrecognized principles and the liability they hold for stakeholders needs to become part of the dialogue. The failure to recognize the moral claims of disputants in a clinical ethics conflict reduces the consultant to a moral bully rather than a fount of moral insight. Rather than merely being armed with a small set of orthodox bioethical principles, ECSs need to be taught how to mine cases for their morally relevant considerations, to think broadly and contextually about what stakeholders are saying, and to unearth the deeply held values and interests that are driving the positions various stakeholders take.

What does this mean concretely for the education and credentialing of ECSs? It means that accompanying instruction in the standard set of bioethical principles and concepts should be training in the process of moral archaeology – the casuists’ skill of mining cases, testimonials, and statements for their moral content. It means teaching consultants how to generate an expansive, inclusive set of moral considerations that accurately represent the most morally generous interpretation of the positions of the stakeholders involved in the conflict. Mediation training is instructive here: ECSs need to be schooled in the perils of framing conflicts from only one perspective, learning costs of reframe the conflict from the perspective of each and every stakeholder just as mediators do. The rubric for assessing ECS mastery of this skill is quite simple: can the ECS provide a moral justification for the stance taken by each individual stakeholder in the conflict?

In the absence of this skill, ECSs will inevitably confer moral legitimacy on only one side of the dispute at the likely peril of the morally vulnerable.