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Mediation and Recommendations

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Comments

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Mediation and Recommendation
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In her systematic review of the work of the ASBH Core Competencies Update Task

Force, Anita Tarzian, et al writes, "The ethics facilitation approach does not preclude offering

recommendations or expert opinions" [2012]. This stance on recommendations is often made to

distinguish the "facilitation" approach to clinical ethics endorsed by the ASBH *Core*

Competencies [ASBH, 2011] from the "mediation" approach that is, at best, wary of offering

recommendations [Fiester 2011; Fiester 2012]. But determining how much difference exists

between the two "camps" is difficult to do, in light of the *Core Competencies'* simultaneous

caveat that HCEC must not "impose their values" on stakeholders involved in an ethics conflict

[ASBH, 2011, 6, 9]. What types of "recommendations" are permissible from the perspective of

the *Core Competencies* that are able to avoid prioritizing the moral commitments of the

consultant over those of the stakeholders? And does the mediation approach really take a

significantly different position on this question?

The concern about the imposition of the consultant's values on stakeholders in a consult

is not limited to the Update Task Force or to the original two *Core Competencies* documents

[ASBH 2009; ASBH 2011], though it is strongly and repeatedly voiced. For example, the 1st

edition of the *Core Competencies* warns HCECs that they "should take care not to impose their

own values on other parties" [ASBH 2011, 9]. Many clinical ethicists in the field fall into step

with this view. For example, Cummins warns, "[I]t is not the role of the healthcare ethics

consultant to make moral decisions" [Cummins 2002], and Zoloth-Dorfman and Rubin chide, "It

is not the ethicist's claim or privilege to impose a particular set of moral beliefs on those who

seek out her counsel" [Zoloth-Dorfman and Rubin 1997].

When this near-universal warning is paired with the *Core Competencies'* directive that HCEC's shouldn't produce "a single 'correct' solution" but a "range of ethically acceptable options" [ASBH 2009, 9], the parameters surrounding acceptable recommendations become even more nebulous. This lack of precision in the *Core Competencies* demarcating legitimate and illegitimate recommendations is especially pressing given that a full half of HCECs recommend a single best course of action at least 50% of the time [Fox et al].

In their essay, Tarzian et al say nothing more to delineate allowable "recommendations" from those that cross the line into "imposing values," nor do the original *Core Competencies*. In turning to the work of the proponents of this "facilitation" approach, we fare no better. For example, in defending the *Core Competencies* from an attack claiming that they "explicitly condemn anything resembling a substantive 'ethics' recommendation" [Adam and Winslade 2011, 313], Aulisio merely quotes at length the *Core Competencies* passage that is the root of the confusion and ambiguity [Aulisio 2011, 347], as if the passage speaks definitively for itself. But beyond a ringing endorsement of mere "process" recommendations that no camp would oppose (e.g., "attempt to contact the patient's daughter", "conduct a clinical assessment of decision-making capacity" [ASBH 2009, 8-9]), the quoted passage merely repeats, with some equivocating, the rhetoric that "consultants should be careful about recommending a single course of action if more than one course of action is ethically acceptable" [ASBH 2009, 8-9].

But what about the "range of morally acceptable options" that proponents of the "facilitation" approach keep talking about [Tarzian 2012; ASBH 2011, 6; Aulisio 2011, 347]? Couldn't one say that those "options" *are* what the *Core Competencies* mean by "recommendations"? One could, indeed, say that, but then one would have both radically altered the standard definition of the term "recommendation" and simultaneously dissolved what is taken to be the central distinction between the "facilitation" and "mediation" approaches. To "recommend" is to "endorse," "advocate," "push towards," or "commend." What would it mean to "advocate" for *every* acceptable option? Laying out the range of ethically justifiable options is not advocacy or endorsement – it's "moral archaeology": a systematic uncovering of the moral values, interests, principles, and laws at play in an ethics dispute. And no process is more

committed to moral archaeology than mediation. So if, in fact, the peculiar species of "recommendation" that the *Core Competencies* have in mind is merely to chart the relevant ethical considerations of the conflict, then the contrast of "facilitation" with "mediation" is a distinction without a difference.

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--, principles of the participants does not constitute a "recommendation."
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--Reviewing the value-based positions,interests and available (justifiable) options of the stakeholders is a critical function of ECS, (and requires a certain type of expertise) but it involves NO advocacy
--it's a kind of *moral archaeology* or *moral excavation,* Arras "discovery" [Arras Casuistry ; too many citations]
--to mine the case for the morally salient features is not the same as hierarchizing them or pontificating on their relevant merit or weight vis à vis each other
--in other words, it is NOT the prioritization or endorsement that "recommendation" requires by definition of what constitutes the act of recommending something
--**and it is in no way antithetical to what clinical ethics mediators see as their role [Fiester 2011; Dubler 2011]**

this archaeological activity is consistent with "not imposing values" but it is hardly falls under the activity of "recommendations But what else?
II. "Range of Acceptable Options"
A lot of talk about ECS laying out "range"
But how is that to be understood as "recommendations"

Take a classic values dispute: ICU, MD's want DNR, family wants full code status, no advance directive
Morally justifiable options are: 1) withhold aggressive care under rationale of non-benefit, scarce resources, moral distress of providers; 2) continue aggressive care under rationale of violating religious beliefs that life is sacred and withholding constitutes killing or usurping God's plan
III.This is in contrast to what I will call "Recommendations as Verdicts" (Fiester 2011)
--heirarchize, give your preference
--single best option, for ex
--maybe even what **Adams means by "Scope Recommendations" (Adams 2011),** though hard to know what he means
want to differentiate from ASBH(is this a distinction without a difference?)
"scope of allowable options" where ethicists express "their own moral conclusions"[332]; "circumscribing the range of allowable alternatives from among which *they* may choose" [331], of the type "here's how I think you should look at this" [332]; "offer their own arguments and conclusions pertaining to the scope of allowable options" [330]; "permitted to offer their own considered

judgment about what we have the strongest moral reasons ro believe the set of allowable options to include (and exclude)" [330]
--even Adams sees that "scope" recom, and certainly what I call "verdict-based" are in conflict with CC's

--So now we have a problem:"
--So is the ASBH disingenuous when it stands behind the legitimacy of ECSs to "recommend" but warns against value-imposition [in other words, the CC's do permit value-imposition and thus recommendations as we colloquially understand them]] or are the CC's against recommendation as we conventionally understand them and so are generating serious confusion for those ECSs that are trying to apply them by value and misleading terminology about what is and is not legitimate activity by ECSs?

address a wide-spread confusion about clinical ethics mediation and its stance on recommendations.
"stop short of making a personal recommendation about the best options" [Winslade 2011]
If not a single best course of action, then What are allowable 'recommendations" that don't impose the values of ECS on the stakeholder?
What types of recommendations can consultants make that do not impose their values on consult participants?
CANDIDATES:

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