Teaching Nonauthoritarian Clinical Ethics:
Using an Inventory of Values and Positions

One area of bioethics education with direct impact on the lives of patients, families and providers is the training of clinical ethics consultants (CECs) who practice in hospital-based settings. In the on-going national dialogue about the professionalization and credentialing of CECs, there is a universal call for increased skills and knowledge among practicing consultants[1] and broad recognition that many are woefully under-trained.[2] In articulating the standards for competence in clinical ethics consultation, there is a clear consensus that CECs must avoid an "authoritarian approach"[3] to consultation in which the consultant imposes his or her values, ethical priorities and/or religious convictions on the stakeholders in an ethics conflict. Despite widespread agreement that such an authoritarian approach is ethically unsupportable in the context of a diverse, pluralistic society, little work has been done on how to teach CECs to prevent values-imposition in an ethics consultation.

In this essay, I propose a potential tool for bioethical instruction that targets this specific question: how can CECs be taught a non-authoritarian mode of ethical analysis and consultation that can avert the problem of values-imposition? I argue that the essential first step in non-authoritarian consultation is learning to identify one's own personal convictions and normative commitments against the backdrop of justifiable, but contrasting, positions commonly found in

[1] A. Tarzian and 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* 13, no. 2 (2013):3-13; N. Dubler, et al, "Charting the Future," *Hastings Center Report* 39(6) (2009): 29-33; American Society for Bioethics and Humanities. 2011. *Core Competencies for Healthcare Ethics Consultation*, 2nd edition. Glenview, IL.
[2] E. Fox, S. Myers, and R. A. Pearlman, "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics* 7, no. 2 (2007): 13-25.
[3] ASBH, *Core Competencies*.

American values pluralism. Locating one's own positions among a set of possible other legitimate beliefs works to dethrone the moral commitments that one might subliminally take to be objective, absolute, or universal. Proposing a vehicle I term the "Bioethical Positions Inventory," CEC trainees first perform a self-diagnostic that highlights their normative commitments on a host of contemporary bioethical issues and debates. The second critical step in preventing authoritarian CEC is the subsequent exercise of producing a values-based defense for each of the positions that conflict with the trainee's own. I believe this two-step exercise of (1) identifying one's own positions and reflecting on the ethical rationale that undergirds them and then (2) defending the antithetical positions held by others protects CECs from values-hegemony and what I elsewhere call the "weaponizing" of moral principles.[4]

Although primarily intended as a teaching exercise for students training to be CECs and for ethics committee members already part of an active ethics consult service, a Bioethical Positions Inventory could adapted to other bioethics educational settings (such as training programs for IRB's, IACUC's, in-house pharmaceutical review boards, etc.).

Values-Imposition: Universal Concern, Paucity of Prevention

Despite the prevalent concern that CECs could be susceptible to imposing their moral commitments on the stakeholders in a clinical ethics conflict, the field of clinical ethics education has not offered concrete strategies for the prevention, or even assessment,[5] of this problem.

The recognition of the risk of values-imposition by CECs is woven throughout both the American Society for Bioethics and Humanities' *Core Competencies for Healthcare Ethics*

[4] A. Fiester, "Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable," *Bioethics*, in press.
[5] A. Fiester, "'Quality Attestation' and the Problem of the False Positive," *Hastings Center Report*, 44, no. 3 (2014).

Consultation[6], as well as the report from the newly created Quality Attestation Presidential Task Force (QAPTF)[7]. In fact, the concern about values-imposition undergirds the *Core Competencies*' central distinction between the "authoritarian approach" they deride and the "ethics facilitation approach" they embrace. In the authoritarian model, CECs implicitly or explicitly "suggest to participants in the consultation that the moral values or perspectives of the consultant are more correct or important than the moral perspectives of other participants in the consultation."[8] This, they rightly argue, "amounts to moral 'hegemony'" in which the CEC "usurps the authority of the primary decision makers."[9] The *Core Competencies* authors caution that "[e]thics consultants need to be sensitive to their personal moral values and should take care not to impose their own values on other parties."[10] In a recent defense of the *Core Competencies'* ethics facilitation approach, Mark Aulisio (the lead author of the first national report on CEC competencies and standards[11]) reiterates the mandate that "consultants not usurp the decision-making authority of others or impose their values on them."[12] Aulisio adds that CECs have an obligation to identify any value-laden positions they take in the consult as "the consultant's views rather than a settled view in the field."[13] The QAPTF report echoes these warnings that CECs "must be trained to avoid the risk of imposing their values and judgments."[14]

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[6] ASBH, *Core Competencies*.
[7] E. Kodish and J. Fins, et al., "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics and Humanities," *Hastings Center* Report 43, no. 5 (2013): 26-36.
[8] ASBH, *Core Competencie,s* at 6.
[9] Ibid., at 7.
[10] Ibid. at 9.
[11] M.P. Aulisio, R. M. Arnold, S. J. Youngner, Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation, "Health Care Ethics Consultation: Nature, Goals, and Competencies: A Position Paper from the Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation," *Annals of Internal Medicine* 133, no. 1, (2000):59-69.
[12] M. Aulisio, "'Facilitated Consensus,' 'Ethics Facilitation,' and Unsettled Cases," *Journal of Clinical Ethics* 22, no. 4 (2011): 345-353, at 348.
[13] Ibid., note 12, at 353.
[14] Kodish and Fins, at 27.

There is consensus among these authors that the key to the prevention of values-imposition is the accurate identification of the CECs' normative convictions and commitments. The authors of the *Core Competencies* conclude that avoiding values-imposition "requires that consultants be able to identify and articulate their own views and develop self-awareness regarding how their views affect consultation."[15] Aulisio argues that "ethics consultants need to be clear when they are offering moral judgments based on their own values, a clarity that requires including the reasons for their position in the discussion."[16] In their instructions for the Quality Assessment submissions, the QAPTF advises applicants to answer the question: "How do you recognize and handle your personal beliefs and biases when conducting CEC with others who may or may not share those beliefs?"[17] Although there is widespread agreement that the cornerstone for preventing values-imposition is a CEC's awareness of his or her positions and beliefs, there have been no proposals that lay out how CECs are to accomplish this self-awareness.

Teaching Non-Authoritarian Clinical Ethics

The main pitfall of those directives to prevent values-imposition is the way they underestimate the unwitting, involuntary role that our deeply held beliefs play in performing ethical analysis. To merely direct CECs to "identify and articulate" their own positions, "be clear" about their normative biases, or "recognize personal beliefs" is to treat as straightforward and readily apparent what is actually deep-seated, assumed or covert. Few of us could easily or thoroughly lay bare what John Rawls famously called our personal "conception of the good,"[18]

[15] ASBH, *Core Competencies*, at 9; again at 22.
[16] Aulisio, "'Facilitated Consensus,'" at 348.
[17] Kodish and Fins, at 31.
[18] J. Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press), 11.

i.e., what we hold to be our core values, religious and moral beliefs, and life-priorities that give our lives normative structure and meaning. Exacerbating the difficulty of articulating a conception of the good is the very human tendency to believe that the normative positions one takes are not merely a feature of a particular conception of the good but represent the objectively right position among other inferior and morally incorrect views.[19] In clinical ethics consultation, we can be quite unaware of how our own unarticulated conception of the good is driving the agenda, steering the conversation, and being inserted into the recommendations we make.

To see this, take a classic ethical dilemma that would be brought to a CEC: the physician and nurse in the case want to withdraw life-sustaining treatment and the family, acting as the patient's surrogate, wants all life-sustaining therapies to continue and even escalate, if needed. In this scenario, the nurse in charge believes it is morally wrong to continue the suffering of someone who ought to be allowed to die. The nurse feels that the family seems oblivious to the patient's wasting, skin breakdown, or grimacing whenever turned. Every day the nursing staff complain "this isn't care – it's torture" and they feel complicit in the continuation of this patient's obvious anguish in a blatant violation of the ethic of "do no harm." The physician in charge is equally appalled at being forced to pummel the patient with procedure after procedure that offers no prospect for even minimally conscious existence. The physician also views the ICU bed as a scarce resource that is being kept from someone who could truly benefit from it. The family, on the other hand, finds it morally abhorrent to take air, food or water away from a loved one and they see it as tantamount to murder. They believe that the decision to end someone else's life lies only with God. And they believe that the patient's commitment to the inherent dignity and value of life demands aggressive measures to prolong it. All of these conflicting moral stances are grounded in deep-rooted moral principles that are indisputably defensible as

[19] Fiester, "Quality Attestation."

part of American values pluralism. For the CEC who has strong convictions that align with one of the stakeholder's in this conflict, it is not so easy to consider that moral judgment as merely one particular normative view of a situation that legitimately admits of other morally supportable views.[20] We are inclined to perceive ourselves as articulating what is objectively morally correct, not expressing a stance anchored by a specific conception of the good.

To overcome the propensity to mistake one's particular moral perspective for the universal good, CECs require training in identifying their core bioethical commitments and appreciating the diverse, defensible moral perspectives of others. To facilitate this process, I propose a method of moral reflection that employs what I will term a Bioethical Positions Inventory (BPI).

Moral Reflection and the Bioethical Positions Inventory

The proposed BPI (See Appendix) is a set of common bioethical positions that are at root of a large percentage of bedside ethical conflicts, such as the one discussed above. The positions are arranged in loosely dichotomous pairs that represent opposing, adversarial, or antithetical views. My suggested BPI should be understood as a method for uncovering one's bioethical commitments and reflecting on the commitments of others. It is an exercise intended to facilitate moral analysis, rather than an empirically validated instrument. The BPI should not be taken as a final tool that contains an immutable set of positions, since there may be additions, modifications, or deletions that are determined to be more useful, accurate or revealing. Because it is an exercise, it can easily be amended to encompass new empirical data, additional bioethical issues or more precise formulations. It can also be adapted to different settings.

[20] A. Fiester, "Mediation and Advocacy," *American Journal of Bioethics*, Volume 12, No. 8, August 2012, 10-11; A. Fiester, "A Dubious Export: The Moral Perils of American-Style Ethics Consultation," *Bioethics*, 2013, Volume 27, No. 1, ii-iii.

In using the BPI, trainees are first asked to assess their stance on each bioethical position listed using a Likert scale. An example from the BPI, related to above case, is the pair: "It is a waste of resources to continue life support on a patient who will not recover minimal cognitive function" and its opposite stance: "It is a not a waste of resources to continue life support on a patient who will not recover minimal cognitive function." A second set related to the above ICU case is the pair: "Life-sustaining therapy should be given whenever patients or families demand it" and "Life-sustaining therapy should only be given when the clinical team deems it appropriate."

The BPI is a method for revealing *positions* on bioethical controversies, not *values*. It does not – and cannot – directly reveal the values, principles or moral concepts that underlie those positions because concrete positions can be anchored by a multitude of disparate values. Take the earlier example of the conflict over withdrawal of life-sustaining therapy. Both the nurse and physician in my example take the position of withdrawing therapy, but the values that undergird their respective stances need not be entirely overlapping. The values that anchor the position of withdrawing therapy might include: "conserve scarce resources," "prevent physical suffering," "avoid death-prolonging measures," "defer to clinical judgment and expertise," among others. And this speaks to the worth of the BPI exercise: it enables trainees to reflect on the positions they take and uncover for themselves the moral justifications (the values, principles, moral concepts) that lie behind those positions.

Identifying one's values in context or application also pays bigger dividends in learning how to do non-authoritarian CEC. When trainees start the other way around – identifying their values rather than their positions – they think about values in purely theoretical form. But there is much less disagreement and rancor, even in the pluralistic US, over abstract values or

principles. For example, few Americans would reject the values "respect informed consent" or "honor patient choice," but the devil lies in the details: e.g., what are the ethical boundaries of legitimate patient choice? When should professional clinical judgment trump, limit or structure patient choice? When do macro-level allocation concerns override the individual provider's or patient's choice? Should all competent patients' decisions be respected regardless of how deleterious they might be? Is there ever a role for paternalism in the competent adult patient population?, etc. Answers to the preceding questions put those values into the context that begins to demarcate the points of friction and disagreement between different individuals. It is those points of moral disagreement, and their rationale, that are essential for CECs to appreciate.

After completing the BPI, trainees identify the positions on which they took the strongest stance. Each of us will have strong beliefs on at least some subset of these dichotomies, which is what makes us committed moral agents. But the choices of "strongly agree" or "strongly disagree" (and to a lesser extent "agree" or "disagree") also flag the positions most likely to influence and affect the CEC in an ethics consult. It is in regard to these bioethical dilemmas that the CEC must make the most effort to guard against values-imposition on the stakeholders in a conflict. On others of the pairs, trainees with discover that their positions are "neutral," indicating equipoise on the issue and very low risk of values-imposition in a clinical ethics dilemma.

In the second phase of the BPI exercise, trainees are asked to defend and justify positions that are in direct contrast to the ones they marked "strongly agree" or "strongly disagree." The frame for this exercise is the following question: How would a decent, rational, respectable person with good moral character offer a reasonable, values-based defense for the viewpoints diametrically opposed to the ones you hold most strongly? Consider, again, the case above. If a

trainee "strongly agreed" that "Life-sustaining therapy should be withdrawn in futile cases," the task would be to offer a values-based justification for the position that "It is morally wrong to withdraw life-sustaining therapy, even in futile cases." The trainee might cite the values of "prolonging life by all means" or "recognizing the inherent dignity of life in all forms and stages" or a prohibition against denying someone food or hydration, or being complicit in the timing and manner of someone's death.

The rationale for this exercise is to twofold. First, repeated practice at trying to see the world from the normative vantage point of individuals with radically different perspectives from one's own builds competencies necessary for effective consultation. This training strengthens the skills the *Core Competencies* deem "critical to nearly every aspect of HCEC," namely "the ability to listen well and to communicate interest, respect, support, and empathy to the involved parties…; elicit the moral views of involved parties; represent the views of involved parties to others; [and] enable involved parties to communicate effectively and be heard by other parties."[21] The second rationale for this phase of the BPI exercise is to demonstrate to trainees in a very tangible way that the conflicting moral views of the stakeholders in an ethics conflict can be credibly defended by myriad legitimate values in our pluralistic society. This phase of the exercise drives home the point that the CEC's fervent convictions do not represent an objective moral truth.

While the most prevalent setting for use of the BPI would be clinical ethics training programs, a potential secondary application could be in clinical ethics credentialing efforts, such as the newly proposed Quality Attestation (QA) process. While the QAPTF is clear that CECs "must be trained to avoid the risk of imposing their values and judgments,"[22] the QA process

[21] ASBH, *Core Competencies* at 24.
[22] Kodish and Fins, at 27.

offers no guidance or structure for candidates to answer the related diagnostic question[23], "How do you recognize and handle your personal beliefs and biases when conducting CEC with others who may or may not share those beliefs?"[24] If the BPI were a standard self-diagnostic tool included in the QA process, candidates could complete the first two steps of the exercise and then respond to a set of analytical prompts about past consultations that make use of the insights gleaned in those preliminary steps. For example:

- Describe a consult in which a deeply held position of yours was in direct opposition with the patient's, family's, and/or providers' in a CEC. How did you conduct the consult? How did you ensure that your position on the issue did not result in the imposition of your values on the stakeholders? Or, alternatively, did you believe it was necessary to insert your normative assessment into the process? Explain.
- Describe a case in which you were concerned that you were steering the outcome of the consult to align with your positions and underlying values or principles. What steps did you take to avoid this? How did the consult get resolved?
- Describe a case in which one (or more) stakeholder(s) struggled to have a moral voice in the case. What strategies did you use to "amplify"[25] and articulate those positions and values? How did you maintain value-neutrality in the face of this task?

This type of post-BPI analysis would not only provide QA reviewers with more accurate data about the quality of the candidate's past consults, but would offer the candidates themselves a valuable opportunity for self-reflection and self-criticism.[26]

There are two objections that one might raise against the BPI exercise. (1) First, one might argue that CECs sometimes really *are* articulating objective moral truth, at least understood as "consensus views expressed in the bioethics literature, relevant legal cases and statues, and prevailing standards of practice."[27] How does the BPI differentiate between tenable

[23] Fiester, "Quality Attestation."
[24] Kodish and Fins, at 31.
[25] Dubler et al, uoted in Kodish and Fins, 29.
[26] I owe this point to Paul Ford who persuaded me of this potential benefit of the QA process.
[27] A. Adams, "The Role of the Clinical Ethics Consultant in 'Unsettled' Cases," *Journal of Clinical Ethics* 22, no. 4 (2011):328-334, at 328.

pluralism and untenable violations of settled societal norms? There are several responses to this objection. First, the test of whether the BPI includes indefensible normative positions is simply whether the positions in the BPI can be effectively anchored by values or principles. If not, they should be jettisoned. Thus, there is a built-in safety net against the "untenable violations" worry. Second, the BPI is intended to be a tool that is flexible enough to accommodate accumulating moral knowledge as our societal views evolve. The dichotomies can be altered, or even eliminated, to reflect these broad societal changes. But my third response is to urge caution before offering an imprimatur to any normative claim. Too often we have seen yesterday's "settled" bioethical norms become today's untenable positions. As just one example, consider the New Jersey Supreme Court's position in the Quinlan decision on transfusions for Jehovah's Witnesses: "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 procedures)."[28] Today, forcing a Jehovah's Witness to accept blood products is one of those untenable positions, and we sneer at the "settled" norms of 1976.

(2) A second, important objection one might raise about the BPI relates to its status as a diagnostic tool. As it stands, it is a classroom exercise designed to stimulate conversation and reflection among CEC trainees, and it does not purport to be an empirically or statistically validated instrument that will definitively identify variations in beliefs and values positions, or discriminate between different respondents. It also does not claim to capture all of the important bioethical positions or dichotomies relevant in American bedside ethical conflicts. To achieve that standing, the BPI would require significant statistical and empirical development and testing, including measures of reliability, and such a project would be worthwhile, in my view. That said,

[28] *In Re Quinlan*, 70 N.J. 10, 355 A.2d 647 (N.J. 1976), at 19.

I believe that even in its current, nascent form, the BPI provides a useful pedagogical vehicle for teaching non-authoritarian clinical ethics.

Conclusion

While there is universal agreement that values-imposition by CECs is serious violation of national consultation standards, there have been no concrete suggestions for either diagnosis or prevention of the problem. The national bioethics organization and various task forces have all issued warnings and cautions, but the problem is too insidious to be ameliorated by mere directives. Students training to be CECs need a concrete method for identifying their personal positions, locating them within the set of defensible American values, and defending those opposing positions by bioethical principles. The two-step BPI is an instrument that can assist with these elements of CEC training. While critical for CECs, the recognition of one's moral commitments in the context of other legitimate views is a useful exercise for all bioethics students, especially those who will use their bioethics training in other practice settings or contexts such as QA, IRB's, IACUC's, or other review boards.

Appendix 1:

Bioethical Positions Inventory (BPI)	
For each statement below, please circle the response that best matches perspective:	
Strongly Agree Agree Neutral Disagree Strongly Disagree **A woman needs to start chemotherapy but it would be toxic to the fetus. Terminating the pregnancy would be the best course of action.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **It is morally wrong to terminate a pregnancy in a case like this one.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Life-sustaining therapy should be withdrawn in futile cases.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **It is morally wrong to withdraw life-sustaining therapy, even in futile cases.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **It is a waste of resources to continue life support on a patient who will not recover minimal cognitive function.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **It is a not a waste of resources to continue life support on a patient who will not recover minimal cognitive function.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Miracles do not happen and waiting for one is naive.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Miracles can happen and it is reasonable to hold out for one.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Withdrawing life support is morally equivalent to withholding it in the first place.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Withdrawing life support is much more serious morally than withholding it in the first place.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Anyone with a very low probability of a successful resuscitation should have a DNR order.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **CPR should be done in any and all cases when the patient or family wants it performed.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Faith-healing should never be an alternative to Western medicine (only allowed if a harmless supplement)**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Faith can heal and should be considered as a viable alternative to Western medicine.**

Strongly Agree Agree Neutral Disagree Strongly Disagree **Advance directives are an important piece of data in treatment decisions for incompetent patients, but surrogates' wishes and preferences are another important piece.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Advance directives should always be treated as the patient's final word and any surrogate preference that challenges it should be overridden.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **No one would want to be kept alive in a PVS state.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Life is life, pvs or not, and it needs to be respected and protected.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Life-sustaining therapy should be given whenever patients or families demand it.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Life-sustaining therapy should only be given when the clinical team deems it appropriate.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Life without dignity isn't worth living.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Life cannot *not* have dignity. Being a person is all the dignity there is and it cannot be lost.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Patient requests to be treated (or not treated) by particular demographic groups (race, gender, religion, sexual orientation, etc.) should never be honored.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Patient requests to be treated (or not treated) by particular demographic groups (race, gender, religion, sexual orientation, etc.) should be honored as much as is feasible.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **It is selfish and backward not to terminate a pregnancy with a fetus that has Trisomy 13** (Only five percent to 10 percent of children with this condition live past their first year.)	Strongly Agree Agree Neutral Disagree Strongly Disagree **It is a reasonable choice to continue a pregnancy with a fetus with Trisomy 13.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Physicians are justified in refusing to treat difficult, angry patients.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Physicians are not justified in refusing to treat difficult, angry patients.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Brain-Death is real death. It means the person is dead.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Brain-Death is not actual death. The person is still alive as long as the heart is beating.**
Strongly Agree Agree Neutral Disagree Strongly Disagree **Patients from other cultures need to conform to our values and bioethical standards.**	Strongly Agree Agree Neutral Disagree Strongly Disagree **Patients from other cultures require as much accommodation of their values as we can possibly provide.**