Paradigms for Clinical Ethics Consultation Practice

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Clinical bioethics is big business. There are now hundreds of people who "do" bioethics in community and university hospitals, nursing homes, rehabilitation and home care settings, and some (though quite a few less) who play the role of clinical ethics consultant to transplant teams, managed care companies, and genetic testing firms. Still, there is as much speculation about what clinically active bioethicists actually do as there was ten years ago. Various commentators have pondered the need for training standards, credentials, "certification" exams, and malpractice insurance for ethicists engaged in clinical consultation. Much of the discussion seems to accept an implicit presumption that all clinical ethics consultation practices look pretty much alike. But is this accurate? What do clinical ethicists do, how and where do they do it, and what kind of clinical ethics is useful in the hospital and in other settings?

While various authors have identified roles for clinical ethicists[1–6] as well as methods for training them,[7–11] the literature has paid little attention to the wide variance in bioethical practice engendered by differences in settings. A detailed analysis of actual clinical ethics practice, however, must surely be performed before any decision can be reached about how clinical ethics should be integrated into clinical practice in hospitals. To contribute to such an analysis by providing paradigms for further study, we have examined the practice of ethics consultation in our own medical centers, Vanderbilt University and the University of Pennsylvania. We conclude that it is not the training or ethical orientation of the clinical ethics provider, but the practice setting in which he or she works, that determines the role and usefulness of the clinical ethicist.

We have identified three different *kinds* of clinical ethics practice. While each has its attendant problems, we argue that clinical ethics providers need to be situated in ways that make them accountable for patients and for clinical practice, and may even need to be identified as members of clinical teams.

The Generalist: The Ethicist At-Large

The first kind of practice setting we identified is also, we suspect, the most common. The clinical ethicist at-large provides services to an entire hospital. A generalist of sorts, he may be called to consult on virtually any hospital unit, from pediatrics to neurosurgery. As a result, he must be prepared to encounter a broad array of ethical issues. The clinical bioethicist at-large thus resembles

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the generalist physician in that he must be acquainted with various fields of clinical endeavor; unlike the at-large physician, however, the at-large ethicist is expected to be equally adept in all units of the hospital.

The role of the at-large ethicist corresponds to the early images of the clinical ethics consultant presented by both Purtilo[12] and Glover, Ozar, and Thomasma.[13] Two fundamental assumptions underlie these characterizations: 1) that the at-large ethicist has no special affiliation or allegiance to a particular clinical unit, and 2) that the presence of the at-large ethicist in a particular unit has been prompted by a specific request.

Our observation suggests that the at-large clinical ethics consultant resembles the Lone Ranger. He arrives on the scene to solve a particular case, unfamiliar with the relationships or clinical practice of the unit. After the problem is solved, the ethicist leaves, but is always ready to reappear in the unit in response to a new crisis.

The Unit Ethicist: Ethics on Retainer

A second role for clinical ethics corresponds to Agich's model of the "watcher,"[14] derived originally from social scientists studying aspects of hospital culture for documentation. Watching an entire hospital proved a nearly impossible proposition since the hospital is comprised of numerous unique clinical communities with different protocols, policies, and medical parameters. In their wake, clinicians and ethicists began to surmise that differences among these communities and their practices might engender different ethical implications.

Since different hospital units have different needs, some hospital units requested the participation of ethicists in teaching and consulting capacities more often than others; these concentrations began to prompt a closer affiliation between bioethicists and particular units. For example, the Baby Doe trials and tribulations led our neonatal units to think carefully about their procedures for discontinuation of life support; many brought ethicists into regular conversations about cases. These ethicists stopped by regularly to visit, even attended daily rounds. As the ethicist became more familiar with the unit (and vice versa), his contributions became more proactive. Rather than waiting for the surgeon or neonatologist to identify an issue or punt a case to the ethics committee, the ethicist began to identify cases *before* they became controversial. Thus, his contributions went subtly beyond "watching" as he ventured to offer opinions about generalized approaches to particular treatments or to general problems in the unit, e.g., communication among staff or with families.

When such an arrangement becomes formalized, the practice of *unit-based ethics* begins. We use this term to denote a predominant, if not exclusive, commitment from an ethicist to be available to a particular unit and competent regarding issues that might characteristically be faced in that setting.

The unit-based ethicist may fulfill a variety of functions through his participation in the working or teaching rounds of the unit. One corresponds to Agich's "watcher," though the term "learner/watcher" may be more appropriate. While for Agich the "features of disinterestedness and objectivity are crucial"[15] to the watching enterprise, the unit-based ethicist as learner/watcher has additional concerns. Participation in rounds provides the occasion not simply to study the practice of medicine as Agich's watcher would, but also to develop skills of clinical discernment and a familiarity with clinical medicine

that also allows the ethicist to learn more about the clinical care of a specific patient population.

The unit-based ethicist may also be what Agich calls a "witness," serving to "establish or ratify the moral community that defines the practice in question"[16] *without* actually becoming a part of the community. The witness's presence is never quite accepted: he participates in the unit's routine without being socialized into its purposes. The ambiguity of this role can be quite taxing for the ethicist; he is not entitled to the enthusiasm of the unit as it perfects its techniques, yet he is a *de facto* comrade, learning and developing relationships.[17–18]

The relationship between unit and ethicist resembles a retainer. When lawyers are put on retainer, they are paid to take a long-term interest in their client's legal defense. This arrangement allows them to be proactive, inoculating their client against future problems. By analogy, the unit ethicist begins to represent the interests of the unit in several ways. He begins to "matter," gathering responsibilities toward the unit itself that exceed those common in business consulting or ethics at-large. However, like the lawyer on retainer, the unit ethicist accrues only limited responsibility. Unlike accountants, lawyers and unit-based ethicists cannot be held legally responsible for their clients' *actions*; the execution of representation *itself* must be deficient or malpractical.

Ethicist for a Clinical Team: The Team Player

The multidisciplinary team represents the emerging paradigm in patient care. Transplantation has led the way by bringing together surgeons, nurses, social workers, ethicists, chaplains, psychologists, and internists to care for patients needing transplantation. The transplant team directs the care of its patients regardless of the unit to which they are admitted. For instance, the heart transplant team manages the care of patients from end-stage heart disease through the peri-operative period and into life after transplantation. The team may operate on a consensus model, in which everyone has a stake in patient care and the success of the practice. As ethicists become involved in evaluation of patients for transplantation, or genetic testing, to offer another example, they have become members of these clinical teams.

It is our contention that these ethicists are forging a new conception of clinical ethics: the team player. In contrast to the other models discussed, the team player enters into a kind of essential affiliation with the purposes and protocols of the team. This affiliation is controversial. Some may deny emphatically that they are part of the team, or are ethicists for the team, opting instead to describe their role in a way that seems to denote the "unit" or "at-large" practice setting. Indeed, the team ethicist may necessarily face basic conflicts of interest: to study the team while occasionally offering advice seems to violate the nondirectiveness so central in social science research, and criticism of the team's activities may interfere with integrated membership in the team. Possibly, this fear has prevented early assimilation of the team model for ethics.[19]

In team meetings, the ethicist may serve to clarify the values that shape the processes of policy development or patient selection. However, the team ethicist's involvement is not limited to the conference table. The transplant team ethicist, for example, moves from the conference room to the wards with the team through its various activities and physical settings; the team represents his primary affiliation.

Evaluating Clinical Ethics Practice

The description of each of these models is based on observation and analysis of clinical ethics practice in our own institutions. Each model offers its own advantages, though some may be conceptually or practically more limiting than others. For example, the model of bioethicist at-large allows ethicists to be available to the whole of the hospital for a relatively insignificant cost; access to ethics consultation is allowed to follow demand. There are significant problems, however.

First, in a large hospital setting, the ethicist is a stranger not only to the patient, but also to most healthcare providers. The last thing the patient wants in a large hospital setting is another strange consultant with dubious accountability and little demonstrable long-term interest in the patient. The ethics consultant appears as an outside expert rather than as that member of the team who is actively working on ethics issues. Moreover, even the most thoughtful clinical ethicist will have to cope not only with the fact that different clinical settings produce different ethical problems, but also that general ethical concepts are often inadequate when it comes to assessing subtle ethical issues arising in specific clinical contexts. Futility in the rehabilitation unit differs from futility in trauma settings. Informed consent and the determination of competency take on unique dimensions in pediatrics. Radiology plays host to a range of questions about conflict of interest that do not beset oncologists. Unfamiliar with the particularities of each setting, the generalist must rely on all-purpose theoretical ethics. The "application" of theoretical ethics, however, is a complex process of identifying values and clarifying assumptions within a specific context that cannot be reduced to a set of simple principles like autonomy, beneficence, justice, nonmaleficence, fidelity, or confidentiality. Conversely, a bioethicist who finds none of her general principles applicable to a particular case may miss moral implications merely because she has too little knowledge of the history of moral issues in the unit.

A practice of bioethics based on a stance of acontextual application of values is deeply flawed. Agich,[20] Zaner,[21] McGee,[22] and Kane and Caplan[23] and others have shown that specific cases may require something akin to the casuist's flexibility of orientation, or the phenomenologist's questioning of context. If practitioners receive the same mantra in response to any clinical quandary, no matter how unique or unusual, they may become suspicious of the need for ethical deliberation altogether.

The second set of problems facing the generalist arises from the fact that her service is largely crisis oriented. Ethics consultation happens during or after a breakdown of conversation; it is accompanied by a sense of "dilemma." The consultant thus conducts "trauma" ethics—working in a tense and perhaps alien territory while under pressure to resolve a crisis. Since the duration of the ethicist's consultation is limited to the crisis, her ability to pursue additional educational efforts to proactively avert such crises in the future may be limited.

Third, the structure of this consultative arrangement suggests that the physicians, nurses, and other staff invite the ethicist as an "expert" consultant. But is that an accurate and appropriate way of captioning ethical expertise and deliberation in the hospital? The posture of applying theoretical principles from the outside, as it were, sends the message that clinical practice and ethics are two different, independent enterprises. We argue below that the turn to outside

experts is inappropriate. Unlike a nephrology consult, successful ethical practice does not easily fit in the consultative paradigm: it requires more than a 15-minute discussion.

By contrast, both team and unit-based ethicists operate within stable networks of relationships with healthcare providers. The ongoing nature of these relations gives credence to the understanding of clinical ethics consultation (and education) as a process. Rather than particular patient care issues being viewed as obstacles to be hurdled or problems to be solved, difficult cases can be understood in the context of the continuous moral development of the various professionals involved. Furthermore, the continuous involvement of unit and team ethicists may convince healthcare providers that ethics are not specialists' concerns. Instead, the ethicist in the unit or on a team may foster a sense of shared responsibility among all the healthcare providers.

Their preventive, proactive potential is perhaps the most important advantage of both unit- and team-based ethics. Forrow, Arnold, and Parker[24] note several features of the preventive medicine model that may also benefit the practice of ethics. First, preventive ethics seeks to anticipate ethical issues, "recognizing predictable patterns through which common ethical dilemmas develop."[25] It furthermore stresses the need to articulate personal and institutional values that affect patient care: "the earlier the parties identify and (where possible) resolve [value] differences, the less likely these differences are to develop into conflicts that adversely affect clinical care."[26] The regular presence of the ethicist may serve to foster an attention to ethical issues that, in turn, may lead to earlier and better communication among staff or team members as well as with patients and families regarding potential sources of value conflict, possibly averting the eruption of moral conflicts.

A subtler advantage of the unit- and team-based practices over the at-large model is their inherent commitment to the particularity of each case, each unit, or each clinical specialty.[27] The unit-based ethicist recognizes that the specific histories, cultures, lives, and professional practices of clinicians, patients, and families produce subtle moral configurations rather than dilemmas to be solved by general principles. Thus, unit ethicists recognize the practical and moral significance of the unit's distinct medical and personal context.

The unit-based model, however, comes with its own disadvantages. While its retainer structure can be advantageous from the perspective of the ethicist as disinterested "watcher," it is also potentially dangerous when the ethicist loses sight of important discrepancies between his role and that of a lawyer on retainer: the lawyer is able to provide a fiduciary, confidential relationship of advocacy because it is *clear whom she represents*. By contrast, the ethicist is not, in the final analysis, clearly wed to any particular part or person of the unit—unlike doctors, nurses, and even social workers who have clear lines of representation accompanied by professional pledges of beneficence or care or advocacy.

In consequence, the unit may see the ethicist as an outsider, brought in to perform nothing but seeking out moral deficiency. At the same time, those on the outside will strongly associate the unit-based ethicist with the practices and problems of the unit, even if he conceives of himself as a consultant to the unit rather than as a member of its staff. Thus, he runs the risk of being perceived as "moral policeman" within the unit, and its "lackey" outside it.

Nonetheless, the unit-based ethicist may be positioned more comfortably here than in either of the other models we observed; her work is not encum-

bered by the problematic distance from the clinical decisionmaking process that plagues the "drop-in" generalist, nor does she run the potential risks of increased accountability facing the team-ethicist who effectively integrates into the purposes of the team itself.

Team ethicists, by contrast, are *conceptually* affiliated to the team. They can more correctly be said to have purchase in their team's decisions, including those not directly related to ethics. This essential affiliation has the effect of enlarging the practice of the team to include the ethicist and his or her practice. The team ethicist's presence is thus riskier than the consultative presence of the unit ethicist, who is still viewed as a visitor on loan from the ethics world, and much riskier than that of the at-large ethicist, who may be viewed as an ethical firefighter from the central office.

The question becomes one of responsibility. The team ethicist has an overt, vested interest in seeing the team succeed in its mission; he or she has in fact signed on to that mission. This part ownership means that the ethicist is correctly culpable when the team acts immorally. This enlarges his role in an interesting, problematic, and completely unstudied way. The ethicist says, "I am responsible for what my team does," which is more than being responsible for having given good advice. While this commitment advances the democratic nature of ethics' role in clinical decisions, it also puts the ethicist in a potentially very difficult position. This degree of involvement effectively abandons the "neutrality" or "applied ethics" paradigms for consultation; it clearly requires that the ethicist have a level of clinical competence (that cannot be determined in advance). The ethicist must be more than "mere" clinician or "mere" philosopher.

Conclusion: Toward the Future of Clinical Ethics

The practice of providing information and assistance by clinicians and others functioning in clinical ethics roles has begun in our hospital to evolve beyond the "consultancy" model into one in which ownership of the care of patients is correctly acknowledged as a part of the practice of clinical ethics. That is good. However, our observations of ethics consultation models pertain mostly to tertiary care settings, which constitute the most-studied chunk of ethics consultation. The community hospitals that treat most patients may find the team approach incompatible with the dominant modes of medical practice. In community hospitals, at-large ethics consultations may also be the only practicable model, insofar as either the financial or the human resources may be lacking for long-term involvement of ethicists or clinician-ethicists. In the smaller hospital without training rotations, where a sense of immediacy among the units prevails, the at-large ethicist borrows the legitimacy of the chaplain or risk manager who has already established the possibility of an omnipresent discussion of patient experiences and problems. The danger, though, is that the at-large ethicist model will be construed by many ethics committees in community settings to be so similar to risk management or chaplaincy as to combine those two functions. This can create the serious conflict of interest problems we have described.

Different roles are and should be appropriate for different settings. In exploring the issues raised by the expansion of clinical ethics into a variety of settings, those in bioethics must remain sensitive not only to context, but also to method and normative outlook in advocating particular models for clinical ethics.

Notes

1. Agich GJ. Clinical ethics: a role theoretic look. *Social Science & Medicine* 1990;30:389–99.
2. Bayliss FE, ed. *The Health Care Ethics Consultant.* Totowa, New Jersey: Humana Press, 1994.
3. Churchill LR, Cross AW. Moralist, technician, sophist, teacher/learner: reflections on the ethicist in the clinical setting. *Theoretical Medicine* 1986;7:3–12.
4. Glover JJ, Ozar DT, Thomasma DC. Teaching ethics on rounds: the ethicist as teacher, consultant, and decision-maker. *Theoretical Medicine* 1986;7:13–32.
5. LaPuma J, Toulmin SE. Ethics consultants and ethics committees. *Archives of Internal Medicine* 1989;149:1109–12.
6. Self DJ, Skeel JD. Potential roles of the medical ethicist in the clinical setting. *Theoretical Medicine* 1986;7:33–9.
7. Thomasma DC. Telling the truth to patients: a clinical ethics exploration. *Cambridge Quarterly of Healthcare Ethics* 1994;3:375–82.
8. Thomasma DC. Models of the doctor-patient relationship and the ethics committee: part two. *Cambridge Quarterly of Healthcare Ethics* 1994;3:10–26.
9. Self DJ, Skeel JD, Jecker NS. A comparison of the moral reasoning of physicians and clinical medical ethicists. *Academic Medicine* 1993;68:852–5.
10. Thornton BC, Callahan D, Nelson JL. Bioethics education: expanding the circle of participants. *Hastings Center Report* 1993;23(1):25–9.
11. McGee GE. *Phronesis* in clinical ethics. *Theoretical Medicine* 1996;17:317–28.
12. Purtilo RB. Ethics consultations in the hospital. *New England Journal of Medicine* 1984;311:983–6.
13. See note 4, Glover, Ozar, Thomasma 1986.
14. See note 1, Agich 1990.
15. See note 1, Agich 1990:431.
16. See note 1, Agich 1990:432.
17. Bosk CL. The fieldworker as watcher and witness. *Hastings Center Report* 1985;15(3):10–4.
18. Churchill LR. The place of the ideal observer in medical ethics. *Social Science & Medicine* 1983;17:897–901.
19. Finder SG, Fox MD, Frist WH, Zaner RM. The ethicist's role on the transplant team: a study of heart, lung, and liver transplantation programs in the United States. *Clinical Transplantation* 1993;7:559–64.
20. See note 1, Agich 1990.
21. Zaner RM. Voices and time: the venture of clinical ethics. *Journal of Medicine & Philosophy* 1993;18:9–31.
22. See note 11, McGee 1996.
23. Kane RA, Caplan AL, eds. *Everyday Ethics: Resolving Dilemmas in Nursing Home Life*. New York: Springer Publishing Co., 1990.
24. Forrow L, Arnold RM, Parker LS. Preventive ethics: expanding the horizons of clinical ethics. *Journal of Clinical Ethics* 1993;4:287–93.
25. See note 24, Forrow, Arnold, Parker 1993:71.
26. See note 24, Forrow, Arnold, Parker 1993:71.
27. See note 21, Zaner 1993.