

The Question of Method in Ethics Consultation

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This paper offers an exposition of what the question of method in ethics consultation involves under two conditions: when ethics consultation is regarded as a practice and when the question of method is treated systematically. It discusses the concept of the practice and the importance of rules in constituting the actions, cognition, and perceptions of practitioners. The main body of the paper focuses on three elements of the question of method: canon, discipline, and history, which are treated heuristically to outline what the question of method in ethics consultation fully involves.

The subject of ethics consultation has been a lightning rod for controversy and debate for the field of bioethics. Controversy has raged over the question of the specific competence or qualifications necessary for doing ethics consultation (Ackerman 1987; Barnard 1992; Cranford 1989; Fletcher and Hoffmann 1994; Grunfeld 1990; Jonsen 1980; La Puma and Priest 1992; LaPuma and Schiedermayer 1990; 1992; Marsh 1992; Task Force on Standards for Bioethics Consultations 1998; Thomasma 1991; Zaner 1984); the legitimacy of ethics consultants providing expert advice or testimony (Agich and Spielman 1997; Caplan 1991; Delgado and McAllen 1982; Fletcher 1997; Kipnis 1997; McAllen and Delgado 1984; Mishkin 1997; Paris 1984; Pellegrino and Sharpe 1989; Scofield 1994; Sharpe and Pellegrino 1997; Spielman and Agich 1999; Wildes 1997; Yarborough 1997); and the style or format for consultative activities, such as, committee, individual, or team (Cohen 1992; Gramelspacher 1991; LaPuma and Toulmin 1989; Ross 1990; Swenson and Miller 1992). This paper discusses one important strand running through these discussions and debates, namely, the question of method.

Debate over the professional status of the ethics consultant and whether ethics consultation is a legitimate function for a bioethicist (Ackerman 1987; Barnard 1992; Cranford 1989; Grunfeld 1990; LaPuma and Schiedermayer 1990; 1992; Marsh 1992; Morreim 1983; Thomasma 1991; Zaner 1984) or, more broadly, whether ethics consultation is a legitimate function within a democratic society (Agich and Spielman 1997; Avorn 1982; Baker 1989; Beauchamp 1982; Delgado and McAllen 1982; McAllen and Delgado 1984; No-

ble 1982a; 1982b; Pellegrino and Sharpe 1989; Scofield 1993; 1994; Sharpe and Pellegrino 1997; Singer 1982; 1988; Spielman and Agich 1999; Wikler 1982; Wildes 1997) has tended to push discussions of method away from the actual practice of ethics consultation toward theoretical political and social philosophical questions of authority, expertise, and power. This paper offers an alternative approach by discussing what the question of method involves when ethics consultation is regarded as a practice.¹

Although ethics consultation is widely regarded as a practical discipline or process of engaged or clinical ethics (LaPuma and Schieder-

1. In light of the controversies mentioned earlier, the project of treating the question of method of ethics consultation might itself appear guided by a political motive if it involved a statement about *the* method of ethics consultation. Quite to the contrary, the characterization of ethics consultation offered here delineates only the main aspects of the *question* of methodology and does not offer a statement of a specific method. There are two reasons for this limitation. First, a statement of method would require arguments and evidence supporting its validity. In the face of the deep disagreements over ethics consultation, it would be vain to expect that such evidence could be provided in the compass of a short paper. Second, because this paper focuses on the function of rules in the practice of ethics consultation and not on the goals or purposes of ethics consultation (Fletcher and Siegler 1996; and Siegler 1992), it does not set out a practical methodology. Any true methodology must include reference to the goals or purposes guiding the activities that make up the practice. The present treatment intentionally leaves out the analysis of goals or purposes in order to focus on the structural features of the *question* of method in ethics consultation.

Keywords

ethics consultation
ethics consultants
practice of ethics
method of ethics consultation

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mayer 1990; Moreno 1991; Siegler, Pellegrino, and Singer 1990; Zaner 1993), discussion has not systematically attended to the question of method in ethics consultation regarded *as a practice*.² A practice is an ordered set of activities that involve distinctive beliefs, goods, purposes, or values that shape the activities comprised by the practice. The term *rule* refers to that component of a practice that provides it with its distinctive order or structure. This paper focuses on the rules involved in ethics consultation and leaves to one side the important question of the goods internal to the practice of ethics consultation.

So regarded, the question of method in ethics consultation can be approached heuristically by considering three related elements that might be termed canon, discipline, and history.³ The *canon* of

2. A full exposition of the concept of a practice is beyond the scope of this paper and may, in any event, be unnecessary. Since Alasdair MacIntyre introduced the concept in his well-known book, *After Virtue* (1981), many bioethicists will have at least a passing familiarity with it. MacIntyre defines a practice in the following fashion:

Any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partly definitive of, that form of activity, with a result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended. (175)

Michael Oakeshott (1978) offers the following characterization of a practice:

A practice may be identified as a set of considerations, manners, uses, observances, customs, standards, canons, maxims, principles, rules and offices specifying useful procedures or denoting obligations or duties which relate to human actions and utterances. It is . . . an adverbial qualification of choices and performances, more or less complicated in which conduct is understood in terms of a procedure. Words such as punctually, considerately, civilly, scientifically, legally, candidly, judicially, poetically, morally, etc., do not specify performances; they postulate performances and specify *procedural conditions* to be taken into account when choosing and acting. (55–56, emphasis added)

He further characterizes a rule, making clear that it does not determine action or choice: “A rule (and *a fortiori* something less exacting, like a maxim) can never tell a performer what choice he shall make; it announces only conditions to be subscribed to in making choices” (58).

3. Students of Kant may recognize these elements as three of the four elements of method delineated in the Doctrine

ethics consultation is that set of rules that guides the action, cognition, and perception involved in doing ethics consultation.⁴ The *discipline* of ethics consultation includes the rule-guided actions and behaviors comprising ethics consultation. It also refers to the specific training that produces the type or pattern of action and behavior in question. The *history* of ethics consultation is the narrative of the case in which the actions, perceptions, and judgments of the consultant and others involved in the case are told or recorded. To understand why the question of method in ethics consultation involves these elements, it is important to revisit the concept of a practice and the meaning of rules in a practice.

*The Concept of a Practice and the Rules of a Practice*⁵

In a practice rules exist in their enactment and primarily are experienced in the process of enactment. The rules of a practice are thus like the grammar of a living language: they are embedded in the myriad acts of speech that comprise the language in use. In this sense a rule is quite unlike a formal code. A rule in a practice is what guides the practitioners in the actions that make up the practice in question. A carpenter who uses a hammer and chisel does so by following a rule that is embodied in the way he has learned to hold the chisel (firmly, but not too tightly), the way the chisel is angled to

of Method, which comprises the second part of the *Critique of Pure Reason*.

4. Of these elements, the discussion of a canon of ethics consultation is likely to draw the most concern, because of the debate about whether there is or can be a canon, i.e., a set of defining principles or theories for the field of bioethics. The idea of a canon of ethics consultation, like that of the other elements, is employed heuristically to draw out what method would have to include if ethics consultation were a practice. This paper regards ethics consultation *ex hypothesi* to be a practice in order to show the complexity associated with the question of method in the context of ethics consultation.

5. The treatment of the concept of a practice in this paper is significantly abbreviated. It is focused on the function of rules. It omits discussion of the underlying beliefs and values that drive a practice, because they are not essential for the delineation of the question of method in ethics consultation. Understanding the function of beliefs and values, however, is critical for any full analysis of a practice, even though their treatment would serve as a distraction given the present focus. For some well-done examples of the analysis of practices, see Flathman (1976, 1980).

the wood (acutely for a slicing cut), and the degree of force with which the hammer strikes the chisel to make the intended cut (strongly to cut across the grain). In this case the rule is really that set of skills acquired by the carpenter in the use of particular tools of the craft for particular purposes. Of course, reflection on the actions that make up a practice can yield statements about rules including guidelines, principles, processes, or procedures that describe or explain the main activities of the practice. Just as formal rules of grammar can be constructed for a language, formal statements of the rules of a practice are possible. These formal statements of rules make up not only the cognitive stock of knowledge *about* the practice, but are often used by participants *in* the practice, for example, to provide guidance to novices. For some practices these rules are not easily expressed as formal rules but take the form of injunctions that might say “hold the hammer this way,” accompanied by the master carpenter showing or demonstrating the technique to use.

The concepts and linguistic statements that express rules are abstracted from the lived experience of the practice and are ultimately dependent upon it. Such formal statements of rules in a practice serve at least two important functions. First, they permit individuals without direct or relevant experience of the practice to engage in discussion about it. In this sense many educated citizens have knowledge of various points of law and legal principles. Although this knowledge is universally seen as inadequate for the practice of law, it allows citizens to understand in a general way what legal processes and procedures involve and the social purposes that they serve. Second, the generalized concepts or statements of rules provide more than a linguistic framework within which participants can reflect on the practice; they also contribute to the conscious shaping of its development. This is more evident in mature practices like law that have a strong intellectual component—in the sense that the prominent actions in the practice involve thought and judgment. In practices that involve high levels of analysis, cognition, and judgment, the framework of rules can include complex levels and domains of practical knowledge and experience and can utilize specialized scientific or technical disciplines or domains of knowledge. Medicine is a good example of such a complex practice. An emergent practice like ethics consultation, however, exhibits a less elaborate structure in comparison.

The concept of rule in a practice is thus Janus-faced. On the one side there are constructed rules about the practice. They involve abstract concepts and judgments about the practice and are typically normative in character or contain a strong normative component. They also include ethical judgments and concepts that are often expressed summarily in terms of ethical principles or other theoretical statements. On the other side there are the rules that are enacted within the practice. These rules are furtively formative of the actions or processes that actually constitute the practice in question. These rules are part and parcel *of* the practice rather than being simply *about* it.

Of these two aspects of rules in a practice, the constructed rules can be discussed apart from the actual ongoing experiences of and the doings that make up the practice. Enacted rules, however, are constitutive of the particular doings that make up the practice. They are inextricably enmeshed in it. They are evident in the actions and judgments of skilled participants in the practice but have no separate existence apart from the various doings that they guide. This double-sided aspect of rules in a practice suggests that the question of method in ethics consultation should involve a more complex approach than that provided by the formal statements or analyses of constructed rules alone.

Tripartite Question of Method in the Practice of Ethics Consultation

As identified earlier, there are three elements associated with the question of method in the practice of ethics consultation: canon, discipline, and history. A thorough discussion of method in ethics consultation would need to include a detailed treatment of each of these elements; however, that task is beyond the scope of this paper. Instead, this paper identifies what each of these elements contributes to the methodology of ethics consultation and why each of these elements is critical to a systematic treatment of the question of method in ethics consultation.

The Canon of Ethics Consultation

The *canon* of ethics consultation includes the formal statement of rules that guide the action, cognition, and perception involved in ethics consultation as undertaken by a skilled or competent practitioner. Focusing the formal rules on the functions of skilled or competent practitioners is essential, because the rules involve implicit normative

claims about the proper or best functioning. The rules concern effective and common actions rather than ineffective or deviant examples. Limiting the canon to rules used by skilled or competent practitioners suggests that rules proposed to improve the practice will have little or no effect unless they are practically feasible. In other words, they must be able to be put to effective use by practitioners who possess the relevant skills.

The canon includes, for example, statements about the application of ethical principles or concepts, process guidelines or procedures like due process, mediation, facilitation, conflict resolution, or value clarification. The importance of these types of constructed rules for ethics consultation cannot be underestimated. There is considerable discussion of the relevance and utility of using specific techniques in the resolution of ethical conflicts, disputes, or problems. Various techniques have been advocated including conflict resolution, facilitation, or mediation techniques (Casarett, Daskal, and Lantos 1998; Dubler and Marcus 1994; Hoffman 1994; Reynolds 1994; Spielman 1995; and West and Gibson 1992). For the most part, these proposals invite application by consultants and discussion of their feasibility for use in actual consultative settings. Discussion of procedures like mediation, however, has tended toward advocacy without making clear that additional process or procedural rules must also operate concomitantly. These concomitant process rules always require the consultant to act in ways that are (or at least are thought to be) best suited or most appropriate for the job to be done (Cohen 1992). Skilled practitioners always have a range of techniques at their disposal to employ based on the problem at hand or suited to the task. Experience of what has worked in similar situations guides these uses.

Advocacy for particular methods or process for ethics consultation without a correlative analysis of the actual conditions of their employment in the course of ethics consultation addresses, at best, only some of the cognitive or judgmental aspects of ethics consultation. Treatment of the rules of action and perception that are correlative components of the process of ethics consultation is also needed. Treatments of *process* in ethics consultation, however, have tended to be framed as constructed rules. These treatments have not fully considered the circumstances or conditions prerequisite for the enactment of proposed processes in the course of ethics consultation (Hoffman, 1994; Task Force

on Standards for Bioethics Consultations 1998; Wolf 1992).

Other treatments of ethics consultation or clinical ethics cases involve the discussion and analytical application of concepts like futility or principles like patient autonomy to common clinical problems encountered in ethics consultation. Given the prominence of decisions to withhold or withdraw life-sustaining medical treatment, it is not surprising that ethics consultation cases often recapitulate the application of patient-rights standards, giving rise to rules like "follow patient wishes as directly expressed, articulated in advance directives, or communicated by family or other surrogates." When patient wishes are not known, the rules commonly specify reliance on known or inferred patient values, which provides a complementary framework within which the clinical decision can be wrought. When all else fails, the rule is that the appropriate decision makers may rely on best-interest considerations.

There is little doubt that many ethics consultation cases involving end-of-life decision making rely on these patterns of decision making. In the all-too-frequent paradigm cases, the medical team is reticent to consider limitation of life-saving interventions and the family or surrogate is often the champion of the patient's right to refuse life-sustaining technology. The ethics consultant is often cast as a defender of patient rights. Operating under a rule to protect patient rights, the ethics consultant proceeds to apply the aforementioned rules of ethical decision making. Without denying the importance or relevance of these rules, it needs to be stressed that there are other methodological aspects of ethics consultation besides the application of these rules.

Although autonomy-based rules are derived from well-established and widely accepted ethical theories, they provide remarkably little practical guidance to the consultant in negotiating the complex conflicts and communication occlusions that surround actual cases and that make each clinical case unique. This situation means that there is little practical guidance for consultants regarding how best to approach the disputing parties, to reestablish severed lines of communication, or, even more basically, to interpret and reconcile competing views of the clinical situation. These deficiencies are not confined to approaches that focus on ethical theories or principles. The application of casuistic methods to cases is fraught with similar limitations (Jonsen 1986, 1990, 1991). The case is

typically accepted as preformed or given. The casuistic method involves a cognitive process of thinking ethically about the case. Casuistry is a method for seeing the present case in terms of paradigm cases that provide normative ethical guidance. In the practice of ethics consultation, however, the case is seldom given or entirely settled. It is usually in the process of development or unfolding. As an agent in the case, the consultant is often able to shape the development of the case. Thus, the rules that are most useful are practical rules that provide guidance to the consultant as an agent involved in the resolution of the case. Such rules augment the constructed rules of ethics—this is true for both principlist and casuistic approaches—by providing specific guidance for how the consultant should act and see the case. It is hard to say precisely what these practical rules should actually contain, because they have been so little discussed. It is, however, clear that rules of action and perception would need to provide practical guidance to the ethics consultant regarding such actions as the formulation of a plan for addressing the case as it develops.

For example, actual clinical cases sometimes come to the ethics consultant with labels attached. When this happens the case is pre-categorized, often in terms of well-known ethical issues or problems. Patients or families, physicians, or other health professionals who request the services of the consultant typically initiate ethics consultation. In making the request, the case is usually identified as involving particular conflicts or problems. Sometimes these labels are accurate, but they can also mislead the consultant. Cases are always presented from a particular perspective. Cases come to the consultant pre-identified as cases of, for example, refusal of life support, an unreasonable demand for futile treatment, or a conflict among members of the healthcare team or between the team and the patient or family. The ethics consultant is confronted with a situation that has already been identified with labels that may or may not be relevant or useful for the effective or ethically sound resolution of the case. Experienced ethics consultants implicitly recognize not only that cases are labeled by the individuals who request the consultation, but that other parties involved affect not only the definition of the problem but the approach most likely to succeed. These factors contribute a frame of reference that can either orient or confuse the ethics consultant. Rules of consultative action or perception are thus an important but lit-

tle explored aspect of the canon of the practice of ethics consultation.

Awareness of how the problem is presented for consultation, for example, is a critical component of the practical perception of the qualified ethics consultant, who will reinterpret the case as information is gathered. For the experienced consultant such reinterpreting occurs without the need for reflective awareness. In oral and written communication the ethics consultant can shape the case into one leading toward intractable conflict or into one more readily amenable to resolution. This is one of the important acquired skills of experienced ethics consultants. The perceptual judgment of the skilled ethics consultant thus enacts rules that have been built up through education in ethical concepts and principles, but which have also been learned through experience with particular cases. This experience is initially institution and unit specific, but skills acquired locally are also generalizable to a considerable degree. Saying this does not mean that generalization is automatic, but that skill acquisition contributes to the establishment of more general competencies. However, without a fairly comprehensive analysis of the practical rules of action or perception comprising consultative skills, generalization is less reliable than it might be. Lack of attention to these matters means that the skills acquired by one consultant in one institutional setting are less likely to improve the performance of other consultants in other settings. Practical experience combined with a generalized practical knowledge of effective rules or strategies for dealing with ethically difficult clinical situations is essential if the practice of ethics consultation is to be improved.

Because ethics consultation occurs in circumstances that are unique and dynamic, the consultant must, of course, be open to the circumstances and somewhat flexible in handling the case as it unfolds. Cases sometimes involve multiple problems, so the consultant must rely on pragmatic rules for prioritizing the issues to be addressed. It is well recognized that ethics consultations often revolve around communication occlusions of various sorts, yet requests for consultation infrequently identify communication as the problem. Ascertaining or diagnosing that a communication problem exists and identifying the nature or source of the problem can more readily promote effective corrective action than can relying on formal ethical rules. Developing a knack for timing discussions with families, deciding who should be involved,

and utilizing techniques for establishing effective communication when emotions run high also involves complex rules that are integral to doing ethics consultation. Identifying the myriad types of operative rules utilized by skilled consultants is an important area for further exploration and discussion.

What experienced consultants do in the course of their work thus involves a reliance on complex rules of action and perception that are seldom discussed. These rules guide the consultant in interpreting the information received about the case. They guide the consultant regarding how the case is seen initially as well as how it is should be seen in light of information gleaned while engaging in the consultative process. For example, some consultation requests are made by individuals able to accurately identify the salient problems and issues. In these instances the rule might direct reliance on the initial characterization based on trust in the requester's characterization of the case. Such trust must be earned through experience, but a rule expressed in advice to a novice—such as, “You can usually rely on the director of the medical intensive care unit to identify what's really at stake”—can transmit this experience to other consultants. The experienced consultant usually possesses a large repertoire of skills and a large stock of pragmatic rules. Although these rules are infrequently analyzed or discussed, they have a central place in the method of ethics consultation.

One useful way of thinking about these rules of action and perception is to think of the skill requisite for doing ethics consultation. Enumerating these skills as general capacities or competencies, however, provides only the most general index for ethics consultation and does little to assure anything like success or effectiveness. The skill possessed by experienced practitioners is always (partly) founded on and gained through experience (Dreyfus and Dreyfus 1991). The question of method in ethics consultation cannot be adequately answered by the identification of broad competencies (Task Force on Standards for Bioethics Consultation 1998). Consultants must be able to *enact* the rules of ethics consultation, not just possess the capacity to do so. Some of these rules are implicit in the talk of skill or capacity, but explicit identification and discussion of the core rules for ethics consultation and the circumstances conducive to their successful application is needed. Much recent attention to ethics consultation has focused on the qualifications of the ethics

consultant, when the effective practice of ethics consultation might depend as much or more on the institutional or social circumstances of the consultation (Agich 2000). Considering the requirements of the canon of ethics consultation can help to show why this is true.

Rules of action and perception involve a myriad of interpretive rules. A brief listing illustrates the complex variety of rules that guide action and perception in a practice like ethics consultation. There are, for example, rules regarding how the consultant should interpret the case; how to communicate with the individuals involved (whether orally, in writing, via telephone, in person, or via intermediaries); how what is said or unsaid to doctors, nurses, family members, and patients can materially affect the resolution of a case; how to interpret the psychological and political circumstances of the case; or, finally, how and when to “give voice” or standing to others who cannot speak for themselves or be heard in the case. These types of rules can contribute significantly successful consultation, because they provide pragmatic guidance in transiting the shoals of clinical cases.

Because these rules of practical action and perception are embodied in the various doings of the consultant, they are apt to go unnoticed. Yet, they are as important as rules of ethical cognition or deliberation in the practice of ethics consultation. However, they tend to become prominent only when consultants reflect on their ongoing consultative actions or engage in training a novice in ethics consultation. Identifying the practical rules of ethics consultation is a prerequisite to improving the quality of ethics consultation and should be a part of the methodological treatment of such practice. These considerations illustrate why the treatment of method must be more practical than theoretical and why the canon of ethics consultation, even if it were to fully include rules of action and perception, would be systematically incomplete. As a practice ethics consultation requires that the rules be *enacted*, not simply invoked. So, simply talking about these rules can never improve the quality of ethics consultation. A treatment of *discipline* wherein application is the central concern is also required.

The Discipline of Ethics Consultation

The discipline of ethics consultation involves the practical actions, behaviors, cognitions, communications, deliberations, judgments, and perceptions that normatively comprise ethics consultation. The

discipline of ethics consultation is, however, not a catalog of these points, but rather the practical enactment of the rules normatively embodied in them. Unlike the canon of ethics consultation in which the rules are treated in a primarily cognitive fashion—this is true even for the rules of action or perception—the discipline of ethics consultation focuses on the exercise of rules. Rules of action, cognition, and perception in the practice of ethics consultation exist primarily in their employment in doing consultations, so omission of the conditions that promote or thwart their employment creates a serious gap in any treatment of method. The enactment of rules gives rise to and sustains the validity of the rules, but the success of the application is contingent upon institutional and social circumstances that have been inadequately explored. Only as far as the rules are ingredients in the successful doing of ethics consultation can they have a practical validity, so attention to the context of their use is hardly optional.

Judging the validity of the rules involves seeing their enactment as guided by an overarching normative framework of purpose(s) without which the operative rules could not be judged to be effective or not. From the perspective of the analysis of practices, one can say that the normative framework of a practice reflects the beliefs and values operative in the practice. These beliefs are themselves part of the practice of medicine and the institutions that sustain ethics consultation. The *discipline* of ethics consultation thus resides not in the formal statement of rules, but in their exercise in the doing of ethics consultation in determinate practice and institutional settings.

Like all practical disciplines, ethics consultation is underdeveloped with respect to theory, because theory primarily involves thought and thought can never fully capture action or experience. Thus, the central aspect of discipline is the propensity to exhibit rules effectively in doing ethics consultation. The discipline of ethics consultation, simply put, involves the effective enactments that are formative of ethics consultation as a distinctive practice in its practice location. Thus, the practice of medicine in a tertiary academic medical center is remarkably different from the practice in a rural setting far distant from contemporary medical technology. Fitting the action to the setting is part of the discipline that a practitioner learns.

A characteristic of any discipline is the ordered process by which an experienced practitioner goes about his or her work. Because the rules of a prac-

tice primarily exist in their enactment, one learns ethics consultation in large part by doing ethics consultations. Through such doing, the consultant acquires and hones the skills in which the rules are exhibited. This fact points to an apparent paradox in any knowledge that involves the experiential acquisition of skill. The rational part of ethics consultation is expressed in rules that are themselves part of the practical doing, yet learning ethics consultation is itself largely a matter of doing (Dreyfus and Dreyfus 1991). How, then, can it be taught? This is an ancient paradox about practical knowledge or skill. A discipline can, of course, be taught, but it cannot be learned by reflection or thought alone. Discipline, thus, involves training, as opposed to education. Discipline thus involves the repetitive practice through which the type or pattern of action and behavior in question can be learned and produced. Identifying conditions that sustain or thwart this development is an essential element in any discipline.

The process of acquiring discipline through supervised experience points to a second aspect of the discipline of ethics consultation, namely, the application of pedagogical procedures or techniques for the sake of teaching and learning. In ethics consultation, as in all practices, there is a limit to the degree of effectiveness that can be achieved through mere demonstration for the novice. Learning must be more than observational, which suggests that observation-based education in clinical ethics is misguided. Similarly, learning must be more than a studied learning, that is, learning through thought, reflection, or reading. It must involve an engagement in the practice by doing ethics consultation under supervision. Acquiring the knowledge and, especially, the skill requisite for doing ethics consultation thus requires a disciplined program of learning that includes a supervised experience of performing ethics consultations in settings appropriate to the eventual practice setting. However, no matter how effective supervision or other education in ethics consultation is, if the student does not gain sufficient practical experience, the skill requisite for successfully doing ethics consultation cannot be attained.

The History of Ethics Consultation

The practice of ethics consultation grew out of the engagement of philosophers and others identified as ethicists or bioethicists in the clinical practice of medicine at (primarily) academic medical centers (Ackerman 1987; Agich 1990; Agich and Young-

ner 1991; Barnard 1992; Cranford 1989; Fleischman 1981; Freedman 1981; Grunfeld 1990; Jonsen 1986; 1990; 1991; LaPuma and Priest 1992; LaPuma and Schiedermayer 1990; Marsh 1992; Moreno 1991; Ruddick 1981; Siegler 1981; Siegler, Pellegrino, and Singer 1990; Thomasma 1991; Veatch 1987; 1989; Walker 1993). It appeared as a natural and corollary extension of what was primarily a teaching role. The story of this development is an important feature of any full treatment of methodology of ethics consultation, because the history of any discipline or practice is an important aspect for understanding its present method.

Method is always dynamic, so understanding the factors that created the present state of practice is essential for assessing its status, as well as shaping its future directions. Many of the early issues and problems of method that arose in ethics consultation revolved around questions of role identity and differentiation as (primarily) nonphysicians assumed clinical roles in the care of patients. This led to a predictable debate over who should be allowed to do ethics consultations, a debate that divided primarily along professional lines (Cranford 1987; LaPuma and Schiedermayer 1990; Marsh 1992; Siegler 1992; Thomasma 1991). This history is an important factor shaping the methodology of ethics consultation. Discussion of whether individual consultants, teams, or ethics committees should perform ethics consultation has similarly affected the processes and procedures that have come to be accepted parts of the practice. The implication of these developments for consultative practice, however, has been less than systematically treated. Nagged by political and professional boundary questions, ethics consultation has not sufficiently looked beyond its internecine struggles to the wider conditions that make its functioning feasible, such as the conditions that permit acceptance of ethics consultation (Agich 2000). Understanding the specific institutional and social conditions that thwart or support ethics consultation or affect its style and process is an essential aspect of the methodology of ethics consultation.

The concept of *history* in ethics consultation methodology also points to the character of the ethics consultation process (Charon and Montello 1999) and the primarily interpretive or hermeneutic processes that shape and are themselves shaped by the actions, perceptions, and judgments of the consultant and other individuals involved in an ethics consultation case. Ethics consultation is a

primarily interpretive practice. History raises basic questions for method such as the proper format for recording recommendations, the core ingredients in the consultative record, and the question of who is properly empowered to write the case story. Thus, beyond the question, initially perceived as a question of status or power, of whether ethics consultants should write in the chart lie more substantial questions about the responsible structure of ethics consultation services. This includes the maintenance of consultation records for research and quality-improvement purposes or procedures for assuring that ethics consultation does not contribute to the communication occlusions that are commonly associated with ethical conflicts in medicine. The involvement of narrative and interpretive process in ethics consultation is methodologically essential and deserves a fuller treatment than has heretofore received. Attention to these processes must expand beyond attention to the case narrative to include the consultative process as a whole within which the consultant is involved in a construction of meaning. For this reason limiting discussion of ethics consultation to the interpretation of cases as literary artifacts is apt to mislead. The consultant does not simply interpret cases as narrative artifacts but is often engaged in the task of reconciling stories about the issues or problems as a case unfolds. The ethics consultant thus functions in at least three discrete ways. First, as the author of the case (at least insofar as the case is properly said to be an *ethics consultation case*) for educational or other purposes, ethics consultants shape the ethical or narrative themes as they weave their consultation narratives. Second, as an actor or agent in the ongoing case, the consultant's interpretations and communications alter the case. Third, as a commentator who uncovers or discloses the central narrative lines from the welter of commentaries or piecemeal stories that make up a complex clinical case for which ethics consultation is sought, ethics consultants give an ethical sense to the case. They place the clinical case within the discourse of ethics.

As author of the clinical ethics case, the ethics consultant is obliged to identify interpretive bias and develop methods to assure that it is conscientiously controlled (Rubin and Zoloth-Dorfman 1996). As actor in the case, the ethics consultant must be aware that he or she is not a mere watcher of clinical events (Agich 1990), but an individual engaged in a practice with role-related expectations. Analysis of the ways that the consultant's in-

terpretations of clinical cases succeed or fail to meet the role expectations (as well as succeed or fail ethically) is an important component of any quality-improvement program for ethics consultation. Ethics consultants, like other healthcare professionals, must learn to identify and deal with the failure and error that are inevitable features of any practical discipline (Bernal 2000; and Reitemeir 2000). Since there is little attention to the historical aspect of ethics consultation, there is little attention to the important phenomenon of error or failure.

Because ethics consultants function authoritatively as the editor/interpreter of clinical ethics case, the question of the legitimacy of the consultant's functioning as an authority needs fuller discussion (Agich 1995, 2000). How this authority is responsibly exercised is a next-generation issue that is important for the maturation of the practice. In the retelling of ethics consultation cases, the narrative standpoint of the consultant needs more critical attention. As suggested earlier, treatments of ethics consultation that focus primarily on the application of ethical principles or theories often fail to incorporate the consultant's own interpretive or narrative contribution or voice in the case. The consultant's voice is always expressive of determinate existential, evaluative, and psychological commitments (Rubin and Zoloth-Dorfman 1996), and it would be arrogant to assume that these are always benign. They deserve careful examination and explication, because consultation is never conducted from an evaluative ground zero, but rather from a value-laden perspective that itself requires elaboration.

Conclusion

Ethics consultation is the practical engagement of an ethicist in the care of patients. Even though bioethicists have been involved in patient care as educators for decades, ethics consultation represents a newer role that has engendered considerable controversy, much of it over legitimation. This role is complicated because healthcare professionals who would not ordinarily identify themselves as bioethicists or ethicists are involved in consultation. It is not surprising, then, that there has been more discussion of who can or should do ethics consultations or over the qualifications prerequisite for doing ethics consultation than regarding how ethics consultation should be conducted. To be sure, there is no dearth of proposed models of ethics consultation; but there is little sound method-

ological analysis of what is involved in actually engaging in the practice of ethics consultation. Even models like ethics facilitation, mediation, or conflict resolution address ethics consultation at a relatively abstract plane or are usually advocated as discrete techniques. It is difficult to find systematic treatments of the process of actually conducting a consultation. As a result, we understand far better the differences between approaches than we do the common features of doing ethics consultation.

A systematic answer to the question of method in ethics consultation would certainly provide a conceptual, if not a fully theoretical, framework. More importantly, it would provide an analysis of the complex rules involved in doing ethics consultations and would treat the elements of canon, discipline, and history in a thorough fashion. Such an account would make possible the integration of much of the published analytical discussion of ethics consultation in a way that would display the richness of this emerging practice and the practical challenges involved in its execution. No such treatment of method, however, would be complete without a full discussion of the beliefs and values that underlie the practice. These beliefs and values are primarily social in character and have less to do with the qualifications of the individual consultant (Task Force on Standards for Bioethics Consultations 1998) than with the way that the consultant accords with the expectations of the patients, families, and health professionals who establish the consultant as someone worth listening to (Agich 2000). ■

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