

# Doing Well or Doing Good in Ethics Consultation



Jeffrey P. Bishop

## Introduction

At one point in history, the medical record was little more than a series of notes written by a doctor to himself. In its original form, it was a short-hand that was mostly idiosyncratic, meant for one set of eyes only. As healthcare became more complex, the chart would need to change. It would become the medium to communicate with other physicians in order to permit coordinated care. It became a document written in a shared language that only a fellow practitioner could understand. Even the patient would never recognize herself in those notes, so distant the medical narrative is from the patient's lived experience.

In time, however, the medical record became the legal record, the official record of what occurred in the interaction of patient with doctor; and perhaps more importantly it became the record of what did not occur. Doctors were suddenly being judged – with severe financial penalties – for what was and was not in their notes. Thus, the medical record changed. It included not only key findings, but it now would also include the absence of key findings that might rule out certain diseases. Doctors had to prove that they had thought of and had ruled out certain diseases. And if we are to believe those lobbying for tort reform, the documentation within the medical record changed the way physicians would practice medicine. Today, the medical record, which is really a legal record, is evolving once again. It has become the record used for billing. Physicians are called by billing abstractors, who ask them questions like: “Did you do this exam or that exam? Because if you did, we could bill at the higher level.” “Why, yes,” the physician answers, “I did do that exam! So let's bill at the higher rate.” This is not to say that the doctors fabricate what goes into

---

J. P. Bishop (✉)

Albert Gnaegi Center for Health Care Ethics, Saint Louis University, St. Louis, MO, USA  
e-mail: [jeffrey.bishop@slu.edu](mailto:jeffrey.bishop@slu.edu)

© The Author(s) 2018

S. G. Finder, M. J. Bliton (eds.), *Peer Review, Peer Education, and Modeling in the Practice of Clinical Ethics Consultation: The Zadeh Project*,  
[https://doi.org/10.1007/978-3-319-90955-4\\_13](https://doi.org/10.1007/978-3-319-90955-4_13)

179

the chart, because in all likelihood they soon began doing those more highly billable exams. Again, practice can and sometimes does follow documentation.

Having read many medical records, which are also legal and financial records, I was a bit dumbfounded by “The Zadeh Scenario,” Finder’s narrative of a clinical ethics consultation case that he participated in and submitted for peer-review in these pages. I thought to myself: “Stuart, what are you doing? Don’t you know that, given the way you are presenting this case consult, your peer reviewers are going to rake you over the coals?” Of course, Finder knew how the narrative would be engaged by his peers. When Finder approached me to be a part of this project, he told me that he would present a case narrative for peer review, and that he had asked several other colleagues to comment on the peer-reviews. He asked me to provide another layer of commentary onto the commentaries of the peer-reviews. Just to be clear, we need to understand the layers involved here. First, there was the case consultation, the actual doing of the case. Then there is Finder’s narrative, “The Zadeh Scenario,” a shortened and focused version of what had been done. Then there is the layer of the peer-review commentaries on Finder’s narrative of what he had done in the clinical ethics consultation. And then there are the commentaries on the peer-review commentaries of Finder’s narrative of the case he had done in the clinical ethics consultation. Within the first lines, I knew that Finder’s narrative describing his consult was going to drive his peer-reviewers crazy.

So, why did Finder not give his peer reviewers what they wanted? Finder has been doing clinical ethics since 1991, for well over 25 years at the time this volume was assembled. Having practiced medicine and having practiced clinical ethics consultation, I also know that the chart does not contain everything – every kindness, every word, every smile, every moment of tension – that occurs between a patient and a physician, or a patient and the clinical ethicists. I also feel quite secure in believing that Finder, as a clinical ethics consultant, knows the importance of writing a coherent note in a chart, a note that can be read and understood by clinicians, a note that documents important positive findings, but also negative findings. Certainly, Finder knows that we write with various purposes, highlighting some features of a case over other features of a case. So, why “The Zadeh Scenario”; why this narrative? I think Finder, the clinical ethics consultant, was up to something very interesting when he wrote out this narrative. It was not a narrative fit for review, but a narrative fit for other purposes. The question is whether his peer-reviewers would have ears to hear Finder’s rendering of the consult.

From my reading, it turns out his peer-reviewers did not have the ears to hear the story that Finder was telling. They did indeed rake Finder over the coals, as I thought they might. They did so nicely of course; after all, bioethicists are nothing if not nice. Finder knows that his case-narrative is a story about his doing of a consult. He of course knows that his narrative was not the kind of story that his peer-reviewers will have wanted. Rasmussen astutely notes that Finder’s rendering of “The Zadeh Scenario” is just that: a rendering of a kind of doing (the doing of clinical ethics consultation) and that all renderings, all telling of stories have a purpose – a point made by Tod Chambers years ago (Rasmussen 2018; Chambers 1999). She notes that absence of evidence in the narrative is not in fact evidence of absence in the

consult, despite what lawyers – and it seems clinical ethics peer-reviewers – believe about medical charts.

Finder is pointing to an insight on which Rasmussen picked up: peer-reviewers who would give attestation to quality ethics consultation candidates like Finder will need to be thoughtful about the evidence supplied to them by candidates. More importantly, however, I also think Finder's rendering of the story in just this way calls attention to the special kind of doing that clinical ethics consultation is – a kind of doing that may not fit into what proceduralist ethicists want to see. In this essay – which is now four removes from Finder's actual doing of the case – I shall argue that Finder is not only problematizing the process of attestation of quality, but that he is calling attention to the special kind of doing that is clinical ethics consultation. I shall argue that clinical ethics consultation is a kind of doing that is a local form of moral enquiry, seeking not just to achieve medical – or clinical ethical – goals, but to enact human goods. His peer reviewers want Finder to do clinical ethics well; Finder wants to do good in clinical ethics consultation.

### **Examining the Commentaries on the Peer-Reviewers' Commentaries of the Narrative of the Doing That Is Clinical Ethics Consultation**

Just to be sure we are all on the same page, I am here engaging not the case consult nor the narrative nor the peer reviews of the narrative. I am instead here examining those who commented on the peer-reviews. Bruce claims to see a new methodology emerging in the peer-reviews. Bruce surveys different methods of ethics consultation from principlism to casuistry to narrative to pragmatism. She claims that there might be a new method developing – proceduralism. While she is certainly correct that something new is emerging in clinical ethics consultation, proceduralism is not a new method. Rather, the procedures have been elevated to a normative level by virtue of the fact that clinical ethics consultants desire to have professional standards and it is nice to be able to claim procedural neutrality.

In fact, the proceduralist turn is part of a long history in philosophical ethics in the late modern period. Indeed, the principlist approach is itself a product of that proceduralist turn. Eschewing thick metaphysical moral content – after all no one likes to fight over metaphysics – Beauchamp and Childress claimed that we should turn our attention to the mid-level principles that will assist us in making practical decisions. It matters not, they claimed, whether one held to thick metaphysical moral content of the Catholics or the Methodists, or any other non-religious metaphysical schema: all morally serious people can agree on these mid-level principles (Beauchamp and Childress 2009: 2–5, 12–14).

However, as H. Tristram Engelhardt noted, Beauchamp and Childress imported too much thick metaphysical moral content under the guise of principlism (Engelhardt 1996: 57–58). The principles are merely the philosophical terms given to the kind of procedures that Beauchamp and Childress think will help us to make

moral decisions. Engelhardt, in his masterpiece, *The Foundations of Bioethics*, calls for an even thinner proceduralism than that of Beauchamp and Childress, one that focused on forbearance rights and the principle of permission (Engelhardt 1996: 121–123). Likewise, the casuists claimed that Beauchamp and Childress were really still too abstract in their principles, because they are not sufficiently practical, and thus the procedures for doing ethics were still too beholden to abstract philosophy. No one really sits around and tries to trace mid-level abstract principles from the thick metaphysical moral commitments of patients (and of health care systems); they merely repeat what they did in the last case that was similar enough to the case at hand. Thus, casuists claim that the procedures for doing ethics well up from the ground of actual cases and not from mid-level abstract principles, which remain esoteric.

Moreover, when it comes to narrative, Beauchamp and Childress would claim that narrative is completely compatible with their proceduralist ethic (principlism) because patient narratives permit clinical ethicists to specify and balance principles given the patient's values (Beauchamp and Childress 2009: 16–24). Thus, contrary to Bruce's claim that proceduralism is new methodology, it seems clear that proceduralism is at the heart of all four methodologies that she spells out. In fact, the law itself is a proceduralist institution; without appeal to thick metaphysical moral content, it focuses on the proper procedures that should be followed in order to permit people to live their own lives according to their thick moral commitments. Principles, whether derived from thicker metaphysical moral commitments or from similar cases, are part of a proceduralist ethic. Policies are proceduralist. Thus, what Bruce claims to be a new methodology is in fact very old, as old as liberalism itself.

Rasmussen shows us the idiosyncratic requirements of the peer reviewers, telling us that we do not yet have shared procedures for writing up cases for attestation. Each of the peer-reviewers would require different things from Finder's narrative in order for his practice to be declared a good practice. The problem may not be with Finder's practice, but instead the problem might be his narrative choices (Rasmussen 2018: 151). Rasmussen makes her point in the context of discussing Armstrong's feminist critique of Finder's narrative. Finder inexplicably uses the patient's daughters' first names, but he uses "Mr. Zadeh" when referring to the patient's son. However, the discrepancy in reference doesn't give us a full picture of feminist considerations that might have been at play in this consult. There isn't enough evidence to know. The absence of evidence, Rasmussen notes, is not evidence of the absence of feminist concerns in the consult (Rasmussen 2018: 158).

However, Rasmussen's point should be extended to every clinical encounter. The plenum of any encounter, whether clinical or otherwise, can never be captured in any narrative, as Foucault noted (Foucault 1991: ix ff). Every narrative is a selection of what to include, with only the slightest of traces of what gets left out. Every narrative then is already an interpretation of the plenum of experience, and every narrative demands interpretation, because it is already an interpretation.<sup>1</sup>

---

<sup>1</sup>See Foucault's introduction to *The Birth of the Clinic*, where he notes that there is something about narratives that demand interpretation, that words beget words; interpretations beget interpretation.

Rasmussen’s point extends well beyond Finder’s use of names in “The Zadeh Scenario.” Thus, it is not only true that his peer-reviewers have somewhat idiosyncratic concerns for what Finder ought to report; Finder also chooses what to report and what not to report. Extending Rasmussen’s insight, I shall argue that the lack of standards for what should go into narratives for peer-review of clinical ethics consultation is merely a symptom of the problem; it is the surface problem, for we must first figure out exactly what clinical ethics consultation *is* before creating a standard of reporting, lest the *standard of reporting* become the *standard for the practice* of clinical ethics consultation, circumscribing what ought to happen in the practice itself, which precedes the narrative rendering of the plenum of the clinic.

This point is precisely the question taken up by Agich, both in his commentary in these pages and in previous work (see, for example, also Agich 2005, 2009). In his commentary on the peer-reviewers, Agich cites Alasdair MacIntyre’s definition 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. (Agich 2018: 139; emphasis added by Agich)

Agich gets it right on rules/procedures vs. the enactment of – indeed embodiment of – rules and procedures. Agich continues: “The rules involved in ethics consultation are first and foremost enacted and are phenomenologically manifested in and through the actions, cognitions, and perceptions of consultants” (Agich 2018: 142). Yet, Agich warns clinical ethicists to be careful about deploying rules.

The rules are not and cannot be reduced to a formal code or set of guidelines or procedures that might be followed like a recipe. Instead, the rules, even when articulated linguistically, as they certainly must be for various legitimate purposes, are just abstractions from the lived experience of the practice and, importantly, they are dependent upon that practice for their ultimate meaning and justification. In this sense, statements about ethics consultation methodology and theories of ethics consultation are *secondary* to the actual practice itself. (Agich 2018: 142)

The peer-reviewers would reduce the practice to the practice of following the guidelines. Virtually all the authors in Parts Two and Three, with the exception of Rosell & Johnson, and to a lesser extent Hynds, are applying abstract rules to the case. First, figure out what clinical ethics consultants do (Chidwick et al. 2010; Frolic and Rubin 2018) and then generalize it to be applicable beyond the case at hand (Frolic and Rubin 2018; Tarzian 2018; Bruce 2018). These are the abstractions – now not from theories, but abstracts from particular cases – that become the codes, procedures, and policies to now be applied by ethicists to all cases. Agich is warning clinical ethics consultants to be very careful.

Yet, even Agich misses something important that MacIntyre also says about practices. MacIntyre notes that practices are not just a simple form of doing; they

are in fact very complex, because all true practices are aimed at something that not one peer-reviewer or one commentator mentioned: practices are aimed at goods. MacIntyre states:

By a practice, I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of that form of activity, with the result that human powers to achieve excellence, and human conceptions *to the ends and goods involved*, are systematically extended. (MacIntyre 1984 p. 187 [emphasis added])

Thus, planting seeds is not a practice, but farming is. Throwing a ball is not a practice, but baseball is.

I would argue that if clinical ethics consultation is a practice, it has to have normative goods toward which it aims. What are the goods of clinical ethics consultation? I do not mean the *goals*, but rather the *goods*. Are those goods allied with medical goods? How are they different from medical goods? From whence do the goods come?

First, as Agich discusses, we must focus on the actual doing of clinical ethics, not on the procedures which are post-hoc derivations from practice, or prescriptions by so-called experts. Tyrannies of proceduralism can arise from the bottom up or from the top down. When doing clinical ethics, a master practitioner is not just following a set of rules. She enacts, enlivens, indeed embodies the rules such that they are not mere rules applied, but have become actions aimed at goods. It is even odd to refer to them as embodied rules or procedures at all. She knows which rules to follow and which to reject. She knows which guidelines and policies are unnecessary and which guidelines or policies are indeed made ridiculous given the particulars of an encounter. That means that, second, the rules cannot and should not be reduced to a formal code. The rules, guidelines, processes, policies, and procedures are not formulae to be followed. The rules, guidelines, processes, policies, and procedures are codified for other purposes, which are tangentially important to the actual doing of clinical ethics. I shall return to this point a little later, but before I do I want to turn our attention to the peer-reviewers themselves.

## **A Commentary on the Peer-Review Commentaries of the Narrative of the Doing That Is Clinical Ethics Consultation**

Finder begins “The Zadeh Scenario” (which is an interpretative summary of the actual consult) *in media res*, the action already afoot. In fact, the narrative begins with the concluding statement of a family whose mother has been in the hospital for weeks and sick for several years. Of course, peer-reviewers would prefer to have things begin at the beginning and to end at the ending. By beginning in the middle, Finder already disrupts the procedural flow that his peer-reviewers expect. Who

initiated the consult, and for what purposes was it initiated? Several commentators (Hynds 2018) noted that beginnings always matter in case consults. But do they really? That may be where one wants a narrative to begin, but consults themselves are mired in the middle of the ongoing action, in the midst of the plenum. Everyone in medicine also knows that all consultants – clinical ethics consultants or medical consultants – like to have a delimited question. What does the requestor of the consult want the consultant to address? Thus, as Hynds points out, getting the question right is of first importance, and most assuredly Hynds is correct. Of course, Finder knows that getting the question delimited is of first importance; but he does not begin “The Zadeh Scenario” in this way. He does not lay out the value conflict for his peer-reviewers to see it very clearly, because in the actual doing of a consult it is often the case that the value conflict has not yet emerged, even while the clinicians caught up in the midst of the plenum may feel the resultant uneasiness. Much of the time, the request for a consult emerges because something does not feel right. In this case, it was the family that did not feel things were right. Finder is pointing to the fact that the clinical ethics consultant is the mid-wife bringing forth into clarity the uneasiness felt by those in the midst of the action.<sup>2</sup>

Every clinical ethics consultant – including Finder – knows that the first order of business is to establish the stakeholders, gathering their views on the case. Of course, the most important stakeholder is the patient. Many of the reviewers note that Ms. Hamadani is missing from “The Zadeh Scenario” (Frolic and Rubin 2018; Armstrong 2018; Tarzian 2018; Rosell and Johnson 2018). How could Finder have missed this? Of course, absence of evidence in the narrative is not in fact evidence of absence in the consult, as I (and Rasmussen) have already noted. Still, as tort law has taught medicine, naming absences is of utmost importance when regulating behaviors.

Yet, perhaps attuning to what matters, attuning to the particulars, Finder already knew that Ms. Hamadani could not participate in the conversation about her care. Finder, attuning to what matters – as all good consultants do – turns to the family, who are present and are actively engaged and are concerned. But to the hermeneutics of suspicion that tends to accompany the individualism regnant in American culture, something is strange about the zealotry of the family’s concern (as Armstrong points out). Why didn’t Finder’s narrative tell his peer-reviewers that the family did indeed have the patient’s best interests at heart? After all, one of them was at Ms. Hamadani’s bedside night and day. Or could it be that ethics consultants are really just Western individualists who are always suspicious of family-members meddling in the individual patient’s business? Surely, Finder knows that he should have bowed his head to autonomy, and traced out whether the patient had advance directives, powers of attorney, stated preferences – all the legal procedures meant to create the kinds of freedoms important in clinical ethics consultation.

---

<sup>2</sup>By bringing forth, I am meaning something akin to what Heidegger means in *The Question Concerning Technology* (1993 pp. 307–342). Technology challenges forth what it desires from the world, where Heidegger notes that in a *techne* something is brought forth.

Of course, clinical ethics consultants are always looking out for the best interests of patients. Finder points out that the patient is Persian. In fact, she is from Iran and is a traditionalist like her youngest daughter (Finder 2018: 33). Tarzian praises Finder for bringing up this important fact. She even notes the importance of the Persian concept of *T'aarof*, “a ritual politeness code that governs behaviors between individuals of different hierarchies and imposes obligations to mitigate emotional distress by way of avoiding negative feelings through specific culturally-engrained social etiquette” (Tarzian 2018: 78). Clinical ethics consultants should always demonstrate their cultural competency, an important indicator that they are not deploying colonial power structures on their patients, permitting patients to have their own ethical value systems; unless, of course, those ethical value systems and hierarchies violate Western understandings of individualism and autonomy. After all, ethics consultants are there mostly to deal in value conflicts, and clearly knowing the patient’s values from the patient’s own mouth would go a long way to be sure there were no conflicts between family members and to alleviate the distress of those who do clinical ethics consultation.

Yet, it seems to me that Finder mediated the case very nicely, mostly by listening and reflecting what was said back to the family. Finder did not intervene to *do* anything, prompting several of the peer reviewers to ask whether this was an ethics consultation at all. (Hynds 2018) I would argue Finder’s peer-reviewers questioned this precisely *because* Finder’s narrative had not documented the procedures. In short, Finder’s narrative gave no attention to the typical things that his expert peer-reviewers would want to see. That is because Finder’s narrative focused more on the kind of doing that clinical ethics consultation is as opposed to focusing on the procedures that the experts would want to see.

Thus, while I agree with Rasmussen that we must understand exactly what goes into an appropriate narrative for peer review, I also think that we should reflect upon the kind of doing that clinical ethics consultation is, a doing that exceeds any narrative documentation, including procedural narrative documentation. Put differently, the peer-reviewers have already committed the error against which Agich warns us, namely that deploying the procedures and following them with rote vigor renders the doing of ethics more like planting seeds than like the practice of farming. In short, they are focused on doing clinical ethics consultation well. As such, his peer-reviewers kept judging him as if he were merely planting seeds. But Finder was doing something more akin to farming; accordingly, Finder was focused on doing good in clinical ethics consultation.

## **A Commentary on the Narrative of the Doing That Is Clinical Ethics Consultation**

It is important to understand that Finder belongs to the philosophical tradition of phenomenology. Phenomenology is itself a kind of methodology within philosophy. It begins with Edmund Husserl, who himself was attempting to ground science

(Husserl 1970).<sup>3</sup> On one hand, science had been caught between two philosophical ways of grounding understanding – rationalism and empiricism; this scientific grounding, because it had eschewed metaphysics, collapsed science into a positivism – where scientists began to think that they could have a one-to-one correspondence between a word and a thing. On the other hand, because science could not ground its knowledge in the world, Nietzschean irrationalism took hold, where reason had become a mask for power relations. Husserl held that if we could bracket our plain everyday stances toward the world – which are often mistaken – and attune to the things as they appear to us, we might ground science. Out of that bracketing, Husserl argues, we might be able to give an account of the eidetic features of experience so that we can ground science in intersubjective experience, which is a kind of very careful peer review. Thus, science need not be secured in rationalism or empiricism, nor in positivism. Nor does it succumb, Husserl thinks, to irrationalism.

Husserl's insights went way beyond securing science; in fact, his phenomenological methodology gave birth to several philosophical insights about the nature of existential experience, ethical experience, embodied experience, among many other aspects of human experience.<sup>4</sup> Richard Zaner – a major figure in the American phenomenological tradition – can be credited for bringing phenomenology into the clinical ethics arena. Finder's practice of clinical ethics consultation is greatly informed by Zaner.<sup>5</sup>

One of the things that phenomenology asks us to do is to bracket our preconceptions – even our procedural preconceptions – about what we think matters in a case, and to attend to the things that matter to the patient, to the patient's family, and to the patient's caregivers. It asks us to pay attention to contexts and spaces and times and situations, and how those contribute to our perceptions of what matters. Because patient concerns are idiosyncratic and highly particular, we must bracket universalizing theories, whether those be deontological or utilitarian, or our cultural notions of liberalism or proceduralism. We must bracket our theories of autonomy and understand the way actual, particular people conceive themselves, which usually happens to be in contextual relationships of families, contrary to the dogmas of individualism, upon which Western bioethics – including clinical ethics – is built.

What Finder does with “The Zadeh Scenario” defies the typical framing of clinical ethics consultants, who are bent on procedures and Western ideals of individualism. Finder offers us what he has judged mattered in the case, not what most clinical ethicists think should have mattered to him. What ethics consultants think matters floats above all cases and seems to emerge from no particular case. Is it not possible

---

<sup>3</sup>Actually, many philosophers think that phenomenology begins with Aristotle, but that point is unimportant for what follows.

<sup>4</sup>Husserl started many philosophers off on many different trajectories, for example, Martin Heidegger, Emmanuel Levinas, Alfred Schutz, Edith Stein, Hannah Arendt, Jean-Paul Sartre, and Maurice Merleau-Ponty just to name a few.

<sup>5</sup>Finder, hired by Zaner and then serving as his colleague for the final 11 years of Zaner's career at Vanderbilt University Medical Center, was also mentored by Zaner – and the two remain personal friends.

that in the careful attunement of Finder's phenomenological reduction, he figured out that the patient was too gravely ill to participate in decision-making? Or perhaps through the reduction, he recognized immediately that the patient wanted her family to take all decisions on her behalf, because that is how a Persian family shows love in their particular cultural context. Shouldn't "The Zadeh Scenario" have just said so, then? No, not if Finder wanted to highlight other features that are more important to the actual doing of this particular case.

Or perhaps "The Zadeh Scenario" is an act of opposition, a subtle commentary on Western bioethicists. After all, Finder kindly, gently, and subtly chastises Dr. Moore's somewhat more aggressive adherence to hospital procedures. Moore constantly presents the question of code status repeatedly to the family, driving them to question his motives, asking that Moore no longer be the ethics consultant on Ms. Hamadani's case at all. It seems to me that Finder is saying that any of the peer-reviewers would have been drummed out of the room as well given their procedural concerns.

Finder's telling in "The Zadeh Scenario" is pointing to what was going on with a particular family, who lived and moved and had their being within a particular culture with its own particular rich resources for problem solving. Finder is pointing to the fact that this family was asking everyone not to prejudge. This family was asking everyone to bracket their concerns and to attune to this particular family's concerns. Finder points out that the family did not want anyone to prejudge the situation with their mother: they did not want the consulting doctors to prejudge; they did not want Dr. Moore to prejudge; and as Finder's narrative points out, they did not even want Finder – or any other clinical ethics consultant – to prejudge. This family indicates repeatedly that they know what is really happening with their mother in the excess of their experience with their mother. The weight of their mother's dying did not need the added pressure of proceduralists wanting clear directives. They knew all along that they would not ask for CPR when the time came. However, for whatever reason, that could not be said by them or to them until that time arrived.

Finder's participation was not, therefore, necessarily without warrant; this family might have needed him for another purpose: to act as witness and perhaps even midwife, bringing forth what really mattered to them. And this is what "The Zadeh Scenario" repeatedly shows us, i.e., what matters to the family, and that the doing of clinical ethics consultation might mean that the ethics consultant's prejudgments need to be bracketed so that she can attend to what matters to the patient in the moment, and if not the patient, then those who love the patient and have repeatedly demonstrated it.

In fact, "The Zadeh Scenario" is a narrative of what matters to the patient and the family. This narrative is a narrative describing the bringing forth of goods possible in dying. With this narrative, Finder challenges us to bracket our procedures and policies and guidelines. Finder even describes his own marginalization. Dr. Brouhkims turns to Finder essentially asking him to endorse what he and the family have enacted. Finder does so, rather uncomfortably, and the family has to assert

once again, that they know what is happening, and what decisions must be taken to do right by their mother. They do not even need Finder.

So, “The Zadeh Scenario” has a purpose. The purpose seems to be two-fold. First, it is a phenomenological account of what matters to a particular family caring for a particular patient with all of the attendant idiosyncrasies. What matters is highly dependent upon the particularities of a case, particularities that do not admit of the generalizations – of the abstractions – of the policies and procedures of clinical ethics consultation. The second purpose of is to highlight the kind of doing that clinical ethics consultation is. It draws our attention to the doing of clinical ethics consultation by marginalizing the clinical ethics consultant. Finder notes that he is bearing witness; but bearing witness to what? I believe it is to the kind of doing that clinical ethics consultants have not really begun to understand, especially those who would judge the practice according to a set of pre-conceived standards, by which all ethics consultants are to be judged – the attestation procedures.

## **Conclusion (The Kind of Doing That Is Clinical Ethics Consultation)**

I have pointed out above that clinical ethics consultation is a practice and that practices are aimed at goods, and not merely at goals. All but one peer-reviewer of “The Zadeh Scenario” mentioned goals, sometimes in terms of goals of care, sometimes as the goals of ethics or ethical goals. Not a single essay, whether those of the second-level commentators or the first-level peer-reviewers, used the terms “goods,” “goods of care,” or even “the goods of medicine.” Clinicians know that goals are important for the practice that is medicine. But everyone seems to avoid the question of the goods of medicine, let alone speaking of the goods of clinical ethics consultation. We have to go back to the writings of Edmund Pellegrino to find a sustained treatment on the goods of medicine (Pellegrino 2008:147–159). People do not seek out medicine because it has goals, but because it has goods that they desire for their lives, goods that they want embodied. In fact, those of us who sought to become nurses or physicians – and even those of us who desired to become clinical ethics consultants – did so because we thought that through these practices we were pursuing goods for patients, not merely goals. Planting is a goal-directed activity; farming is aimed at bringing forth goods – fruits and vegetables. Planting seeds is a procedure; growing fruits is a practice. Procedures that might help us do well at clinical ethics consultation might get in the way of doing good through clinical ethics consultation. So, here we have it: in order to be a practice, clinical ethics consultants must pursue goods, not goals.

Buried inside “The Zadeh Scenario” are the goods of clinical ethics. Those goods are subjective, idiosyncratically named and defined by patients, embedded in an institution of health care that purports to be of service to the goods of health. The clinical ethics consultant, at her best, acts as a careful mid-wife, attempting to bring

forth the goods desired, the goods possible, and perhaps even the goods that are not possible for patients. After all, some goods pursued by patients are not possible due to the limits of medicine. Some goods pursued by medicine are not desired by patients. Some goods pursued by clinical ethicists might be limited and provisional, like the desire to limit clinical ethicists to doing what the guidelines and procedures say. Some things thought to be goods by anyone involved in healthcare may not be good at all. “The Zadeh Scenario” acts to problematize the goals of clinical ethics consultation, asking it to focus on the goods that the practice might bring forth.

I occasionally travel to Rome. When in Rome, I often stay with the Irish Dominicans of San Clemente near the Colosseum, on via Lubicana. And since I love to walk, I often walk everywhere I go. If you walk west along via Lubicana passing to the north of the Colosseum you end up on the Via dei Fori Imperiali, which runs up to the Piazza Venezia which is essentially a huge intersection and roundabout in front of the monument to Vittorio Emanuele.<sup>6</sup>

Hundreds of pedestrians attempt to cross the intersection/roundabout while an endless stream of cars and buses enter and exit. There is even a large bus stop at one of the roundabout entrances. So hundreds of cars, buses and pedestrians are all crossing at once. There are no lights, no walk signs. Everyone is crossing and driving and hesitating and starting and stopping. To my American mind and to my North Atlantic desire for rules and laws to govern even the simplest of intersections, that roundabout seems utterly chaotic and dangerous.

To the Romans and those immersed in a kind of personalist culture, the chaos is ordered by the subtlest reading of faces and movement. The drivers are watching facial and bodily expressions of the pedestrians. The Roman pedestrians are watching the drivers of busses and cars. There are no rules and procedures; or rather the rules and procedures are embodied, and thus can only be called rules or procedures in a highly abstract, post-hoc way.

Foreign pedestrians in time come to see what the locals are doing. The Roman pedestrians look to see what the drivers are doing. They see that the drivers are looking to see what the pedestrians are doing. The Roman pedestrians read the movement of the cars and the faces of the drivers. The drivers are reading the bodily expressions and faces of the pedestrians. There is an informal turn-taking between pedestrians and drivers. In short, these pedestrians and drivers see what an American cannot see in the subtlest of movement – a tilted head, a nod, a nonchalant wave of a finger, a gesture. And it all works. It is a different way of interacting from the Anglo-Germanic way and from the American proceduralist way of interacting.

With “The Zadeh Scenario,” Finder is depicting a phenomenological – indeed a personalist – engagement; he is trying to read the subtle clues given by the physicians and nurses, and the patient and the patient’s family, subtleties that slip through the coarse sieve that is proceduralism. He is trying to get across the roundabout/intersection, or perhaps better, he is trying to help a family of pedestrians navigate

---

<sup>6</sup>I am not dropping names here or attempting show off how cultured I am. The details matter and I suspect that these details seem foreign to the reader, which is precisely the point. But they are details that challenge our settled visions about intersections.

the complexity, walking them across the roundabout/intersection. But he has to know where they want to go, and whether crossing here is the right place to cross to get there. He is helping them to read the subtle clues of the drivers and other pedestrians, paying attention to what matters – to what is the matter at hand – rather than to the rules articulated by proceduralists. But Finder has to know what the goods are that his practice is trying to enable. He has to know how the goods of clinical ethics consultation are related to the goods of medicine, and how the goods of medicine might enable (or disable) the goods of a patients. He has to focus on the doing of clinical ethics, which is a kind of bringing forth of goods. That is the primary kind of doing that is clinical ethics consultation.

Clinical ethics consultation is, as I have argued (with colleagues) elsewhere, a kind of particularist and local form of moral enquiry; it is a kind of non-rule governed floundering about (Bishop et al. 2009). The peer-reviewers of “The Zadeh Scenario” are kind of like me – standing at the roundabout in Rome waiting for a light to turn, or for traffic to stop, claiming that these Romans don’t know what they are doing. “Finder should wait to cross until there is a light... oh, there are no lights. Well then we should put some lights in here, because how can anyone know what to do.” Meanwhile, a family has been asked to make their decisions about when to cross the roundabout/intersection on their own, and Finder now realizes that he must bear witness to the fact that they did not need his help after all; they just needed some time away from the people telling them how to cross the intersection. Finder’s peer reviewers want to do well at the process of clinical ethics consultation; Finder in “The Zadeh Scenario” is trying to do good in clinical ethics consultation. The difference is an important one on which clinical ethicists should reflect.

## References

- Agich GJ (2005) What kind of doing is ethics consultation? *Theor Med Bioeth* 26(1):7–24
- Agich GJ (2009) Clinical ethics as practice. *J Int Bioethique* 20(4):15–24
- Agich GJ (2018) Narrative and method in ethics consultation. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 139–150
- Armstrong K (2018) Telling about engagement is not enough: seeking the “ethics” of ethics consultation in clinical ethics case reports. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 63–73
- Beauchamp TL, Childress JF (2009) *Principles in biomedical ethics*, 6th edn. Oxford University Press, New York
- Bishop JP, Fanning JB, Bilton MJ (2009) Of goals and goods and floundering about: a Dissensus report on clinical ethics consultation. *HEC Forum* 21(3):275–291
- Bruce CR (2018) Not principlism nor casuistry, not narrative ethics nor clinical pragmatism: a case for proceduralism. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 113–125
- Chambers T (1999) *The fiction of bioethics*. Routledge, New York
- Chidwick P, Bell J, Connolly E, Coughlin MD, Frolic AN, Hardingham L, Zlotnik Shaul R (2010) Exploring a model role description for ethicists. *HEC Forum* 22:31–40

- Engelhardt HT Jr (1996) *The foundations of bioethics*, 2nd edn. Oxford University Press, New York
- Finder SG (2018) The Zadeh scenario. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 21–42
- Foucault M (1991) *The birth of the clinic: archaeology of medical perception*. Translated by A. M. Sheridan Smith. Vintage Books, New York. Originally published in 1963 as *Naissance de la clinique* by Presses Universitaires de France
- Frolic A, Rubin S (2018) Critical self-reflection as moral practice: a collaborative meditation on peer review in ethics consultation. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 47–61
- Heidegger M (1993) The question concerning technology. In: Krell DF (ed) *Basic writings*. Harper Collins, New York
- Husserl E (1970) *The crisis of European sciences and transcendental phenomenology*. Translated by David Carr. Northwestern University Press, Evanston
- Hynds J (2018) Ethics consultation, professional praxis, and what it means to be a “consultant”. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 85–97
- MacIntyre A (1984) *After virtue*, 2nd edn. University of Notre Dame Press, Notre Dame
- Pellegrino PD. 2008. *The philosophy of medicine reborn: a Pellegrino reader*. H. Tristram Engelhardt, Jr Fabrice Jotterand. Notre Dame: University of Notre Dame Press
- Rasmussen L (2018) Standardizing the case narrative. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 151–160
- Rosell T, Johnson B (2018) This may, or may not, be an ethics consultation. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 99–107
- Tarzian A (2018) Ethics consultation for Ms. Hamadani: a focus on process. In: Finder SG, Bilton MJ (eds) *Peer review, peer education, and modeling in the practice of clinical ethics consultation: the Zadeh project*. Springer, Cham, pp 75–84

**Open Access** This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter’s Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter’s Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.

