Ethics Consultation, Professional Praxis, and What it Means to Be a "Consultant"

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Introduction

The situation described by Finder in "The Zadeh Scenario" is a very familiar one to those of us who work as ethicists in United States hospitals. The outcome he records, however, is unusually benign; indeed, and unfortunately, in many US hospitals the ultimately unresolved/unmediated conflict he describes would almost certainly result in the patient's being subjected to futile attempts at life-prolongation and resuscitation. In this sense, the outcome of this ethics consultation might be considered "good" insofar as it did not result in such futile attempts. But that sense of "good" is fleeting given other concerns which serve as the focus of this chapter.

Specifically, what follows is a constructive critique of how Finder, and Finder's colleague Moore, discharged their responsibilities as clinical ethics consultants in the situation Finder so carefully describes. In the course of offering this critique, I will necessary advance my own views about what ought to be involved in good ethics consultation. Indeed, let me begin my observations by doing that quite explicitly, by proposing a definition of what clinical ethics consultation (CEC) is. Although there is much to criticize in the American Society of Bioethics and the Humanities understanding of ethics consultation (Hynds 2013), their definition of the practice is, on the whole, sound:

> CEC consists in helping, upon request, the consult requester to identify, analysis and, where appropriate, resolve values uncertainty or conflict which arises in the context of providing medical care to a particular patient. The ultimate goal of the consult is to help the requester determine if, how and why a certain course of action should or should not be undertaken, based upon having identified, analyzed and, if possible, resolved the relevant values uncertainty or conflict which prompted the consult request. (ASBH 2011: 2)

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In light of this understanding of the nature and goals of ethics consultation, upon which I attempt to base my own professional praxis, and although there is much to admire and emulate in the manner in which both Finder and Moore consulted in the situation Finder describes via "The Zadeh Scenario," I believe there are certain aspects of both Finder's and Moore's interactions with the staff, patient, family, and with each other that were highly problematic when evaluated in terms of their professional propriety. The discussion that follows focuses almost exclusively on these problematic aspects of their practice.

"Upon Request"

Clinical ethics consultants are, first and foremost, clinical *consultants*. Their involvement in a case presupposes that they have been invited to become involved by another person or group of persons. Only 'upon request' do ethics consultants participate *as* consultants in the care of patients. Accordingly, ethics consultants must not "self-authorize" their involvement. To do so suggests, *inter alia*, that clinical ethics consultation has a quasi-policing function: enforcing the compliance of other clinicians with some pre-existing mandatory standard of ethical behavior. Such a role has been rejected in principle (rightly, I believe) by the majority of those engaged in clinical ethics and the professional bodies that represent them (ASBH 2011: 4). Practically speaking, it is also the case that unsolicited involvement of an ethics consultant usually gives rise to a perception on the part of either the patient/family or the healthcare providers of being investigated and of being subtly (or not so subtly) pressured or even persecuted by the ethics consultant – hardly a perception likely to foster constructive relationships! It is a symptom of what ASBH calls the "authoritarian approach" to consultation (ASBH 2011: 6).

Proactivity and Continuity-of-Care

The fact that ethics consultants are *consultants* (i.e. require to be requested by another to legitimate involvement in a case) certainly poses problems for the ethics consultant who wants to ensure continuity of service over multiple hospital admissions (assuming that the same ethical uncertainties or conflicts persist) or who wants to be otherwise as proactive as possible in their consulting role. Finder and Moore, as the ethics consultants in this case, do clearly seem to be interested in continuity and pro-activity. But do they go about it in the right way?

Undoubtedly, Moore was initially consulted by the patient's neurologist (albeit after he had been dismissed from the patient's care) and latter he was consulted by

Dr. Broukhim. It is less clear, however, that Moore's involvement during the intervening hospitalizations was based on his having been formally consulted by anyone seeking his professional help. This fact may explain the rather unstructured nature of his involvement at that time, which is variously characterized as "stopping by" "checking in" or "simply following along." The lack of a formal consult request is problematic in itself and on account of the resultant sporadic nature of his interactions with clinicians and the family. 'Who was he trying to help?' may be legitimately ask.

How, then, should an ethics consultant handle multiple admissions of a patient for whom ethics consultation was requested at one point but not at those subsequent points of admission – and during those subsequent admissions may involve parties not involved in the initial consult request or non-involvement of the initial requesters? Similarly, what is the most appropriate way to manage a clinical ethics consultation that has "unfinished elements" at the time of the patient's discharge? And behind these two questions is a more fundamental issue: are pro-activity, continuity of service, and resolution/closure important values to be pursued in ethics consultation? I believe that they are. However, there are good and bad ways to go about achieving these ends.

One laudable way is to place a final summative ethics note in the patient's chart at or before the time of discharge. Such a note can include the ethics consultant's activities to date (including recommendations for current and reasonably foreseeable future ethical issues) and an offer to be available for re-consult at a future time, upon request, if that would be thought helpful by whoever assumes the care of the patient in subsequent re-admissions. Placing this type of summative ethics notes where it is most likely to be seen by subsequent health care providers – for instance, in an electronic medical record system's 'goals of care' tab with other notes which take a more global perspective on the management of the patient's healthcare – may be particularly useful, especially if the expectation in a health care system is that a new attending physician will read these notes immediately upon the re-admission of a patient. It is an excellent way to alert a physician to an ethics consultant's prior involvement in the care of the patient and to the possibility of re-engaging the clinical ethics consultation service if one so chooses.

Another more active – and possibly more aggressive – approach to maximize the possibility of ethics consultation continuity is for the ethics consultant to directly contact the new care team upon a patient's readmission in order to inform the team of past clinical ethics consultation involvement and to let them know that the ethics consultation service remains available should they wish to utilize it. This approach presupposes that the ethics consultant has an efficient notification system for when a patient is readmitted. But beyond that, other more aggressive attempts to ensure continuity is inappropriately intrusive; requiring re-engagement of the ethics consultation service, for example, is never appropriate (mandatory consultation, after all, is surely a contradiction in terms).

The Subjectivity of Consult Concerns

In addition to concerns about a lack of 'alter-authorization' to legitimate continuing ethics consultation, self-authorization is also problematic because new players (for want of a better expression) may not in fact have any ethical concerns regarding the current situation, or may have entirely different (perhaps even directly contradictory) ethical concerns from those of the initial consulter and/or the ethics consultant, even if there has been no material change in the patient's circumstances. Indeed, there is something intrinsically concerning about ethics consultants having ethical concerns of their own upon which they follow-up; it may not even be appropriate for an ethics consultant to decide that there 'is' an ethical issue that requires to be addressed. Clinical ethics consultation exists to help other people deal with issues that cause *them* ethical concern. The role of ethics consultation is not, therefore, to objectify those ethical concerns and then adopt them.

For all the above reasons, it is unwise for an ethics consultant simply to re-insert oneself into a formerly problematic situation simply because a patient for whom ethics consultation was provided previously is subsequently readmitted and, from the ethics consultant's perspective, the patient's circumstances still or again appear to be ethically challenging. But this appears to be exactly what Moore did – on several occasions – such that, when eventually asked formally to become re-involved, Mrs. Hamadani's children are, not surprisingly, upset; this leads them to reach out to Finder. Before turning to whether Finder's response to this was appropriate, a more basic question must be addressed.

Who May Call for a Consult?

If involvement of a clinical ethics consultant is not to originate in the ethics consultant's perspective of a clinical situation, who may legitimately request and be offered ethics consultation? Generally, there is agreement among ethics consultants that the right to ethics consultation, even although it is a clinical consult, is not limited exclusively to the patient's attending physician, as is generally the case with other clinical consults (ASBH 2011: 11). And in the case under discussion, a number of persons with different roles in the care of the patient either formally or informally appear to have requested ethics consultation.

The first requester for ethics consultation for this patient was the patient's former neurologist – "former" because at the time of his request, we are told, he was no longer actively involved in the patient's care, having just been fired by the family (indeed, this fact seems to have prompted him to request involvement of the clinical ethics consultation service in the first place). The question is what justifiable limits, if any, can and should be placed on access to ethics consultation for the sake of consulting in regard to the specific care of a specific patient? This is not an easy question to answer in a definitive way.

Access to ethics consultation should not simply be available to everyone, *simplex*. Rather, an appropriate requester (who may indeed occupy any position within the hospital, or none) must nevertheless demonstrate some degree of 'moral proximity' to ethical concerns that prompted the request. They must, in some sense, have a moral stake in the outcome of the ethics consultation: their own rights, responsibilities or legitimate interests must be significantly affected. This is something analogous to the idea of 'legal standing' which is used to determine if a prospective litigant has sufficient legal proximity to raise an action in Court. Whether the requester in fact demonstrates the necessary moral proximity is a matter of fact to be determined by the ethics consultant in exercise of his or her professional judgment. Determining moral proximity, in other words, is to be part of the ethics consultant's expertise. In relation to medical, nursing, and other staff involved in the care of a patient, it may well be that the requester either be or recently have been actively involved in the patient's care. The existence of clinical ethics consultation services in an institution must not be a blank check for unfettered good samaritanism.

Ethics Consultation: A Structure Engagement with the Issues

In regard to other formal (or process-oriented) deficiencies of Finder and Moore's consulting style, the seemingly unstructured or semi-structured way, at critical junctures in the process, which both consultants chose to engage the various issues/participants, is striking. On the part of Finder, this also appears to have been purposeful. Two examples of the seemingly unstructured or semi-structured process utilized by Finder and Moore stand out.

First, at no point in the extended involvement of Moore and then Finder with Mrs. Hamadani's situation was an interdisciplinary meeting suggested by Moore or Finder. The primary purpose of such a meeting would have been to ascertain directly from those with an interest (i.e. having moral proximity) if there was unanimity or at least a broad consensus among them concerning what the ethically appropriate course of action was with regard to Mrs. Hamadani's care, what that consensus was and, most importantly, why they thought it was the right thing to do *morally*. For many who provide ethics consultation, such a meeting is part of their being willing to consult in a case of this sort.

In addition to the above stated goals, such a meeting also allows clinicians with very different ethical perspectives and proposed solutions to share these and to receive feedback from their colleagues. Without such a forum, misunderstandings multiply and unspoken resentments can grow among team members. If a broad consensus does in fact exist among the clinicians (which is very often the case), that fact should be made clear to the family by having all the key players attend key meetings with them. This way of approaching things has the important benefit of minimizing the opportunities for 'splitting' that frequently characterizes family interactions with multiple clinicians.

In the case of Mrs. Hamadani's care, the momentum was (almost inevitably) in the opposite direction. Instead of bringing together the various interested parties, and seeking to establish if there was a consensus and what principled compromises, if any, could be made to achieve one, a process of fragmentation and exclusion seems to have occurred which appears to have been at very least tolerated, if not intentionally encouraged.

Second is the way in which Finder and Moore preferred to interact with Mrs. Hamadani's family. Throughout the narrative, both consultants meet with or talk to the family on multiple occasions alone, i.e., without the involvement of the consult requester or other persons having an interest in the resolution of the case. This is not to suggest that meeting one-on-one with a patient or the patient's family is never appropriate. Rather, the point is that the effectiveness of the ethics consultation process is always enhanced if interventions are kept to a minimum and all main participants in the situation are generally present. With regard to the frequency of ethics consultants' interaction with patients or families, the rationale for keeping interventions to a necessary minimum is to reduce the intrusive nature of the clinical ethics consultation process, respecting the need of the family to focus on their loved whose death (in this particular case) is relatively close and hence their opportunity to spend time with their loved one limited. Frequent interaction distracts from this and justly causes resentment. Moreover, constant meeting with the family has the appearance of being coercive, may be experienced as such, and may be undertaken by those who see their role (inappropriately, it must be added) as persuading the family to accept the ethical superiority of some particular plan of care the ethics consultant or the ethics consultation-requesting team happen to favor.

Involving as many of the interested parties as is reasonably practicable is also important since a central goal of ethics consultation is to seek to resolve conflict among these very persons. The mediating role of the ethics consultant is more easily exercised when everyone is sitting down at the same table. "Shuttle diplomacy" is generally unhelpful, except in situations where relationships have irretrievably broken down. Often ethical conflict is in fact the result of either poor or insufficient communication. This is more easily identified as a problem and resolved when the ethics consultant can directly observe how the parties are communicating or failing to communicate with each other. Meeting together also reduces the risks of "splitting" which often happens in these situations.

Whether as a non-clinician or a clinician who is not serving in that clinical role for the given patient, the ethics consultant also benefits from having the patient's physician(s) in attendance when meeting families in order to help the ethics consultant understand and address concerns arising from the specific clinical situation at that time. In the absence of the physician, the ethics consultant is likely to incorrectly state the clinical case or delay further discussion while re-consulting the physicians to bring the ethics consultant up to date with current clinical circumstances. Meeting the family with the physician in attendance (and ideally with the primary physician leading the meeting) also prevents the family from attempting to exclude input from the ethics consultant. The physician is entitled to invite whomsoever he

feels will help him manage his patient appropriately – and this includes consulting with an ethics consultant.

Another deficiency of the process Finder's reporting presents concerns the failure to reference, discuss or invoke relevant hospital policy. At one point in the narrative, Finder mentions the fact that his institution has what is commonly known as a "futility policy" (Finder 2018: 23). Notwithstanding the existence of such a policy, it seemed to have played little if any explicit part in how the case was managed. But the policy and the processes for conflict resolution it contains (including the possibility of a clinical ethics consultation) should help frame and structure the whole process of engagement, including the ethics consultation itself.

Professional Collegiality

Consider now a final problematic aspect of this case in relation to the formalities of the ethics consultation process. Specifically, attention must be turned toward the appropriateness of the interactions between Finder and Moore following – and apparently in response to – Mrs. Hamadani's family's request that Moore be relieved of his duties by Finder in the latter's capacity as 'Director' of the clinical ethics consultation service.

In coming to a judgment about whether it was appropriate for Finder to replace Moore (which he seems effectively to have done), the following question must be asked: What is the appropriate way to understand the relationship between Finder and Moore (and by extension, the relationship between directors of clinical ethics consultation services in general and the ethics consultants who discharge the consulting function of those services the directors direct)? Is it a hierarchic relationship? Does a consultant *qua* consultant work "under" the director, and at his direction as Mrs. Hamadani's family appear to believe, and as Finder's replacement of Moore at the family's request might reasonably be interpreted to confirm? And even if Moore is related to Finder in such a way, was it appropriate for Moore to be replaced as the consultant at the request of the family in the particular way that Finder ultimately did? These issues are organizational issues and at the same time ethical issues. We need to remember that ethics consultation itself has its own organizational ethics issues to address – issues which have to date attracted too little attention, especially when considered in terms of the professionalization of our discipline.

If clinical ethics consultation is a truly professional undertaking,[1] and if the individual ethics consultant is a professional practitioner in the full sense of that term (both of which are loaded questions) then it is highly problematic to characterize the relationship Finder and Moore are in as one in which the latter, in the discharge of

[1] Much of the debate on whether ethics consultation can properly be understood as a professional undertaking is focused on the question of whether clinical ethicists possess ethics expertise. An excellent introduction to the question is provided by Rasmussen (2016).

his consulting responsibilities, works “under” the former. Having been consulted by a legitimate requester, Moore assumes the responsibilities and, in consequence, the rights associated with his professional status, the core of which is the exercise of professional judgment. It is in the exercise of individual judgment (having perhaps freely sought advice from colleagues) that professionalism consists and for which a professional is properly held accountable. If the consultant is a professional, he must be free from undue influence or, worse, interference in the exercise and execution of his professional judgment, including direct interference from the director of the ethics consultation service.

In this regard, an ethics consultant should enjoy the same type of relationship with his director as other professional members of the staff. The most apt clinical analogy to the proper relationship between a director of a clinical ethics consultation service and an individual ethics consultant is that between the director of a particular medical service (e.g. the Director of an ICU) and individual attending physicians who care for patients in the unit managed by the director. It would clearly be inappropriate in almost every circumstances for the unit director to attempt to involve himself directly in the medical care of a particular patient without the knowledge and consent of the attending physician.

One can, of course, envision certain circumstances where a director may feel the need (and indeed may have the responsibility) to intervene in a particular case, on his own initiative or upon the request of a third party. The justification for so doing in a professional model, however, would be based presumably on a well-founded concern on the part of the director regarding either the competence of the consultant or accusations of professionally inappropriate behaviors. In other words, the director’s intervention would be justified, and can only be justified, precisely in terms of safeguarding the professional nature of the service the consultant, as a member of the department, is legitimately expected to provide. Neither justification, however, would appear to have been invoked (explicitly or implicitly) by Finder when he intervened (interfered?) in Moore’s serving as an ethics consultant for Mrs. Hamadani’s situation.

Having said all this, it is not inappropriate for a director to inform a consultant that a patient or a family has asked him to relieve the consultant of his consulting responsibilities. He may ask the consultant if he wants to withdraw from the case on account of the family request, and may offer to replace him. He may even recommend (strongly) that the consultant step aside to be replaced by another consultant (including himself if he ordinarily fulfills that role) who is more likely to achieve the ends of that ethics consultation. But short of evidence of negligence or improper behavior on the part of the ethics consultant, the director should not, as a general rule, require an ethics consultant to withdraw from a case or worse yet, become actively involved in the case without the ethics consultant’s knowledge or consent. To do otherwise is to cultivate a non-professional profile of the service he directs and of those who offer it.

Nor is it clear that such an intervention (i.e. replacing the consultant) would as a matter of fact relieve a consultant of the (legal) responsibilities they had undertaken by entering into a consulting relationship. If this is the case, it would appear to be a

highly imprudent move on the part of a consultant to allow another individual (including the director) to effectively take over operational control of a consultation for which the consultant continues to have some degree of on-going professional responsibility. But this seems to be exactly what transpires between Finder and Moore.

Similar dangers exist where a director may from time to time informally involve himself in the consultations of his colleagues, a habit more likely to be found where curbside consultation is tolerated or encouraged in a department. In the same vein, a director should probably avoid giving informal advice to colleagues about what should be done in a case lest the advice be interpreted by the consultant as an instruction to give effect to the director's recommendations. Ethics consultants would do well to remember that 'superior orders' are unlikely to be accepted as a defense to a claim for professional negligence or misconduct.

A different evaluation of Finder's intervention in this case may very well have been reached if there was some evidence to suggests that his department was differently structured or staffed. If, for example, Finder was the only professional ethicist in the department and/or Moore was very significantly less professionally qualified or expert than Finder, it may have been appropriate for the former to interpose himself in the way he appears to have done. The obvious example of such an occurrence would be in circumstances where team consultation is the norm in an institution and where the level of ethics competence often varies among members of the team.[2] In those circumstances, it could be appropriate for the director on his own initiative or upon request of another to either supplement or replace the initial ethics consultant(s). A professionally adequate response to the challenges involved in a particular ethics consultation might demand a higher level of expertise and/or experience than the initial ethics consultant happens to possess. In this light, it is regrettable that team consultation as it is envisaged by ASBH continues to be acceptable: it is hard to see how it is compatible with the evolving understanding of clinical ethics consultation as a professional practice.

Be that as it may, if the possibility exists within a department, for whatever reason, of an ethics consultant being replaced by the director of the service, the circumstances in which it may or will happen should be clearly delineated and known to the consultant in advance. Similarly, if a decision is made by the director to jointly consult with an ethics consultant, then it is important to delineate the respective roles, responsibilities, and rights of each of the professionals involved.

Nothing in this section should be taken to disparage the propriety of an ethics consultation requester asking for and obtaining a second ethics opinion. Indeed, in some circumstances, it might be appropriate for an ethics consultant himself to suggest that the requester formally seek a second ethics opinion. The possibility of

[2] ASBH accepts that ethics consultation may be carried out by 'teams', the members of which need only collectively embody the full range of core competencies. The Society explicitly talks about individual team members who, possessing basic competence, are authorized to perform ethics consultation *"only under the supervision of a more senior member of the HCEC service."* See: ASBH 2011: 19–20.

obtaining a second opinion is well known and accepted in other professional practices and generally serves to reinforce, rather than erode, the centrality of the exercise of judgment in the giving of professional advice. This practice remains rare in ethics consultation – nor is it widely discussed in the literature – but where it exists, it should be appropriately regulated as it is in other professional disciplines (for example, by the AMA; see AMA 2016).

Given all of the above, there is no obvious evidence that considerations of Moore's competence, level of expertise or professionalism motivated Finder's intervention in the case at hand or that the scope and limits of his intervention were discussed, understood or agreed to in advance. This I think is highly regrettable when viewed through the lens of professionalization of clinical ethics practice. Few interventions bespeak so forcefully an inherent, if unintended, rejection of professionalism than intrusion into the relationships it exists to serve through the exercise of expert judgment.

The Scope and Limits of Ethics Services

Consider now some of the substantive challenges related to the nature of ethics consultation to which this case also gives rise. Finder, Moore, and the various authors contributing to this book, are all 'ethics' consultants and give ethics advice. This much seems obvious. But the reality on the ground (even among ethicists) is quite different.

Ethics consultants' job is to *"help the consult requester determine if, how and why a certain course of action should or should not be undertaken"* by *"helping the consult requester to identify, analysis and, where appropriate, resolve values uncertainty or conflict"* (ASBH 2011: 3). This is the specific professional service ethics consultants offer. If this is the help that the requester of ethics consultation wants, then a clinical ethics consultation is appropriate. If some other help is sought or is obviously required, then ethics consultation is *not* appropriate. More importantly, that other service should not be rendered by the ethics consultant. In light of these considerations, at least two types of interaction (or more accurately *non*-interaction) engaged in by Finder and Moore require critical comment.

Firstly, not one of the ethics consultation requesters is ever asked by either Moore or Finder how these requesters think ethics consultation might be helpful to them. This is problematic. A major difficulty faced by ethics consultants is a wide-spread lack of knowledge on the part of those who request ethics consultation regarding what it is that ethics consultants actually do. Indeed, there is a lot of positive misunderstanding about the proper scope and limits of the ethics consultants' role and expertise (e.g. the pervasive belief that ethics consultants are or ought to be moral police). Given this fact (or perception), ethics consultants should almost always ask requesters immediately after the facts that form the basis of the consultation request have been narrated," How, as an ethics consultant, might I be helpful to you?" Doing so aims to establish: (a) whether ethics consultation is being appropriately requested

and (b) what specific help the requester actually wants. Clarifying requestor expectations at the start of an ethics consultation is vital for avoiding potential misunderstanding on the part of the requester regarding the role of ethics consultation as well as to clarify to the kind of help being sought. It also affords the ethics consultant the opportunity to educate colleagues about the exact nature of the professional expertise ethics consultants have and the services they offer.

In "The Zadeh Scenario," Dr. Broukhim asked Moore for "help" which is rather vaguely characterized as help with talking to the family, providing support to the family, and offering more care for the family. (Finder 2018: 23) At one point, Dr. Broukhim more appropriately characterizes the role of ethics consultation and presumably the 'help' offered as trying to delineate ethical issues in the care of the terminally ill for the family (Finder 2018: 30). Moreover, in the final meeting between Dr. Broukhim, Finder and the family, it is unclear what help Dr. Broukhim wants Finder to provide. Nor is it clear what help Finder intends to provide Dr. Broukhim. In addition, some of the "help" actually provided by Finder and Moore is strikingly inappropriate.

For example, there is Moore's effort to "help" the family by finding a new physician for them when they sacked the neurologist who consulted him. Or again, Moore's actually proposing a clinical plan of care (NG tube placement) as an interim clinical compromise. Finally, Dr. Broukhim's asking Dr. Finder whether providing dialysis would be "reasonable" is another example of a potential confusion on the part of the requester about the role of the ethics consultant and about his own role is an ethical physician. Whether an intervention is 'reasonable' is presumable in the first instance a matter of clinical indication in which regard the physician is the expert, not the ethicist. If the question seeks to address underlying issues related to quality of life, it is not clear that the ethicist has either expertise or authority to give a definitive or even advisory answer.

Interestingly, Dr. Broukhim is aware and informs the family that the reason for ethics involvement is not to "persuade" the family to agree to his preferred treatment plan. He is, of course, right in this respect. And yet it is extremely common for ethics consultants to be consulted to do exactly this, and indeed some of Moore's behaviors toward the family seem designed to do exactly that – and were subsequently perceived by the family to be attempts at persuasion: *"He simply came to get us to say what he wanted to hear"* (Finder 2018: 29). Attempting to persuade patients or families to agree to a particular plan or course of action, presumably because the ethicist has determined that it is the most ethically appropriate course of action in the circumstances is one of the more egregious lapses in professionalism that an ethics consultants may commit. The ability to resist the temptation toward moral partiality (moralism) is perhaps the first and most important endowment of the professional ethics consultants.

Secondly, and most problematically, is the fact that there is little actual "ethics" consultation occurring in this case, i.e., there is little or no attempt made by either Finder or Moore to explicitly identify, analysis or resolve values uncertainty or conflict *qua* its being value uncertainty or conflict. It is one of the primary functions of an ethics consultants to render explicit the ethical or value laden aspects of the

uncertainty or conflict which are usually implicit and poorly identified and reflected upon by those who are involved in the case.

In this situation, Dr. Broukhim needs to be specifically asked why he does not want to provide more aggressive treatment to the patient. Does he think it would be ethically wrong to do so? Why does he think it would be ethically wrong? Nothing should be assumed. Ethic consultation should help Dr. Broukhim reflect upon and perhaps develop or mature his own understanding of the goals of his own profession (medicine) and how this does or should influence his own practice of medicine in relation to this particular patient, Mrs. Hamadani. The family needs to know (preferably from Dr. Broukhim himself and not from the ethics consultants) that it is explicitly for ethical reasons (i.e. reason of professional value or core commitment) that he does not want to offer more treatment. The ethics consultant's role consists in facilitating this disclosure in such a way that a practical dilemma is understood in moral terms.

In a similar vein, if the hospital has a futility policy and Dr. Broukhim (or any other physician wants to invoke it), or Finder or Moore recommend that it be invoked, the reasons for the policy's existence, its substantive contents and the conditions for its invocation should have been carefully explained to Mrs. Hamadani's children as an instantiation and application of the institution's values and moral commitments, including a moral commitment to due process. The family too should have been helped to articulate their own values and beliefs and to explain to Dr. Broukhim and his team how those values inform the manner in which they are making decisions for Mrs. Hamadani and their various requests of Dr. Bourkim as her physician.

Each 'side' should have been, in other words, invited to engage the others' concerns precisely as *ethical* concerns, concerns related to core personal and professional values. It is here that an important commonality can be discovered (i.e. a shared commitment to core values) which may enable each side to understand and respect the other better and to move forward, if not *in tandem*, then at least without acrimony and recriminations, each respecting the sincerity with which a position different from their own is held.

For Moore and then Finder, as ethics consultants, not to act intentionally and explicitly in this way is simply to fail to do *ethics* consultation itself. Facilitating moral discourse, specifically understood by participants in the conversation as *moral* discourse, is at the heart of what ethics consultation is about. It is the *telos* of the *praxis*. Ethics consultants exist to help individuals find their moral voice and to listen to the moral voice of others. In and of itself, creating the circumstances for the possibility of authentic moral dialogue represents a singularly successful outcome and is the outcome proper to the consultants' role. Nor is this outcome primarily clinical (i.e. a better choice, because it is a choice of a better medical intervention or better/more reasonable health state). Indeed, in some respects, it is not a clinical outcome at all. It is a moral outcome achieved in and through clinical circumstances. In this regard, professional statements which suggest that the goal of clinical ethics consultation is ultimately improved health care (ASBH 2011: 3) are mistaken.

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