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Defense Mechanisms in Ethics Consultation

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Abstract While there is no denying the relevance of ethical knowledge and analytical and cognitive skills in ethics consultation, such knowledge and skills can be overemphasized. They can be effectively put into practice only by an ethics consultant, who has a broad range of other skills, including interpretive and communicative capacities as well as the capacity effectively to address the psychosocial needs of patients, family members, and healthcare professionals in the context of an ethics consultation case. In this paper, I discuss how emotion can play an important interpretive role in clinical ethics consultation and why attention to the role of defense mechanisms can be helpful. I concentrate on defense mechanisms, arguing first, that the presence of these mechanisms is understandable given the emotional stresses and communicative occlusions that occur between the families of patients and critical care professionals in the circumstances of critical care; second, that identifying these mechanisms is essential for interpreting and managing how these factors influence the way that the "facts" of the case are understood by family members; and, third, that effectively addressing these mechanisms is an important component for effectively doing ethics consultation. Recognizing defense mechanisms, understanding how and why they operate, and knowing how to deal with these defense mechanisms when they pose problems for communication or decision making are thus essential prerequisites for effective ethics consultation, especially in critical care.

Keywords Ethics consultation · Defense mechanism · Emotion · Communication

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One significant response to ethical conflicts that arise in the everyday provision of healthcare has been the development of ethics consultation services provided by individual consultants, teams, and committees. Various approaches have been advocated, including the use of conflict resolution (Orr 2001, 2002; Orr and DeLeon 2000; Waldron 1992), facilitation (Aulisio et al. 2000), mediation (Dubler 1998, 2002; Fiester 2007a, b; Gibson 1994; Reynolds 1994; West 1992), and moral deliberation (Molewijk et al. 2008; van der Dam et al. 2011; Weidema et al. 2011) for addressing ethical issues arising in patient care and for improving the ethical quality of clinical decision making. These approaches assume that the disagreements and conflicts arising in patient care involve a wide range of value conflicts among stakeholders besides the physician and patient. Once identified, the disagreements or the underlying values that impede effective clinical decision making can be approached using the ethical analysis or communicative and hermeneutic approaches.

Remarkably, the skills identified and discussed in the ethics consultation literature are primarily cognitive in nature involving knowledge of ethical concepts, principles, and theories or analytical, communicative, and interpretive skills necessary to apply the ethical frameworks to the concrete circumstances of the individual cases. The need for so-called *clinical* experience or knowledge is recognized, but little attention has been given to actual clinical skills required for doing clinical ethics consultation (Agich 2005). In this paper, I concentrate on one set of those skills and argue that awareness of and competence in dealing with psychological defenses that impede and complicate communication surrounding important health care decisions is an important, but much neglected, clinical ethics skill.

Interestingly, much of the literature on ethics consultation also reports that attention to communication, such as, clarifying questions or helping critical healthcare providers communicate more effectively or directly with the family are central in the majority of ethics consultations. This suggests that the characterization of ethics consultation as involving the resolution of ethical conflicts or disagreements, by applying ethical concepts, principles or theories may be a less central activity than is sometimes claimed. Some bioethicists even complain that addressing communication or emotional issues in ethics consultation fails to make appropriate use of the *real* skills of the ethics consultant, which consist of analyzing ethical problems and applying knowledge of ethical concepts and theories to individual clinical cases. It appears that many bioethicists prefer the term *ethics consultation* to *clinical ethics consultation*, because they regard "the case" as an idealization made up of an ethically complex set of facts that exist outside the dynamic circumstances and settings of patient care. From this perspective, the case presents a problem for cognition, for ethical analysis and reasoning. To be sure, these bioethicists are not unaware that communication is essential for gathering the essential "facts" of the case, but the relevant ethical process consists in the analysis of the case and reasoning about the facts of the clinical ethical problem using one or more of a variety of approaches like casuistry, hermeneutics, or principlism. The communicative process in ethics consultation is thus often treated as if it were a matter of simply gathering or understanding "medical" facts and, then, placing an ethical

interpretation or framework around them in terms of which one draws an ethical conclusion or recommendation. This approach tends to give little or no attention to the complexities involved in interpretation and discernment necessary for ascertaining the structures of meaning involved in *actual* cases. It does not focus on the complex give-and-take processes of clinical communication. Hence, it is not surprising that cognitive analytical skills and the possession of any knowledge of ethical concepts, principles, and theories tend to be regarded as the most important capacities for performing ethics consultations.

Understanding ethics consultation in this way not only presupposes a rather sharp distinction between ethical analysis (along with the knowledge of ethics concepts, principles and theories that define it as a rational enterprise) and other aspects of ethical consultation such as communicative processes, including the processes of discernment and emotional response, but it also marginalizes the complexity of communication and the emotional aspects associated with actual clinical cases. For example, a medical procedure that is regarded as routine by physicians, such as a lumbar puncture, may be seen by the patient or the family as highly risky and invasive. It may be experienced with a particular emotional valence that colors its interpretation. Not only for the patient and family, but also for healthcare professionals, clinical facts are complexly overlain or shaped by emotional meanings. If ethics consultation is uncritically taken to be the application of rational analysis that are primarily academic in character, then these complex factors comprising actual clinical cases will understandably tend to drop from consideration or function in only a minimal fashion. For this reason, it is no wonder that the communicative and interpretive skills involved in the actual practice of doing ethics consultation are correlatively marginalized.

Some cases for which an ethics consultation is requested undoubtedly involve situations in which disputes, such as, over who has decision making priority or about the limits of surrogate decision making. Other cases, however, involve embedded ethical dilemmas or conflicts that are nascent and emergent in the course of the consultation. Some of the issues that arise are, to be sure, primarily resolvable through the application of the ethical standards for surrogate decision making and applying them in the concrete circumstances of a clinical case sometimes requires more than cognitive capacity. Similarly, ethics consultation cases involving standard ethical conflicts and questions certainly involve cognitive skills and knowledge of relevant ethical concepts. However, other ethics consultation cases require a complementary set of skills and knowledge that have received insufficient attention in treatments of clinical ethics. These skills are broadly communicative and interpretive in nature and uniquely feature the capacity to address effectively the *emotional* features that inevitably structure the meanings involved in the case.

In this paper, I will not attempt to identify comprehensively or classify this broader set of skills essential for doing clinical ethics consultation. Instead, I will focus on a common way that family members, in particular, deal with the stresses involving the support of a loved one who is in a critical care unit. I am not arguing that the points I will make apply only or primarily to critical illness, but simply use critical illness as a convenient and appropriate context within which to illustrate the importance of non-cognitive or emotional aspects in ethics consultation. In the same

way, I concentrate on defense mechanisms[1] arguing first, that the presence of these mechanisms is understandable given the emotional stresses and communicative occlusions that occur between the families of patients and critical care professionals in the circumstances of critical care; second, that identifying these mechanisms is essential for interpreting and managing how these factors influence the way that the "facts" of the case are understood by family members; and, third, that effectively addressing these mechanisms is an important component for effectively doing ethics consultation. Recognizing defense mechanisms, understanding how and why they operate, and knowing how to deal with these defense mechanisms when they pose problems for communication or decision making are thus essential prerequisites for effective ethics consultation, especially in critical care.

To do so, I will discuss a case that illustrates these points. The case is a composite from my experiences in conducting ethics consultation and critical care ethics liaison rounds in several healthcare institutions for over 25 years. The case contains no identifying information. It is a paradigmatic example of the way that communication is structured and even distorted by the operation of emotional reactions to critical illness.

I use the term *defense mechanisms* to refer to those common mechanisms that help to protect the ego, self, or person from stressful situations, information, and meanings with which the individual is not prepared or able to address in a more rational fashion. The concept has its origin in Freudian and psychoanalytic thought, but I use it in a more neutral, that is, non-theory laden way. Without relying on the theoretical underpinnings associated with its origin, I am claiming that *defense mechanisms* are observable and typical emotional responses to stress, especially in the context of critical illness. Such emotional responses are evident not only in communication with patients, but also families and health care professionals. They are, more broadly regarded, a set of psychological processes that are common in normal circumstances of life and are manifest as features of one's personality style, but are often most observable in circumstances of stress. For this reason, they are especially important in clinical ethics consultation situations. Although, defense mechanisms importantly serve to protect the established patterns of personality, they also can effectively impede the comprehension and rational processing of information as the person experiences and interprets information through the filters of emotion. It is thus important for clinical ethics consultants, as it is for clinicians generally, to recognize that the challenge of fully comprehending the complexity of the patient's critical illness is mixed with one's emotional reactions and feelings in the strange world of critical care.[2] By delaying one's ability to come to terms with

[1] "The term *mechanisms of defense* refers to the various automatic, involuntary, and unconsciously instituted psychological activities by which a human being attempts to exclude unacceptable urges or impulses from awareness. By excluding the urge from awareness, he removes it one step further from the likelihood of expression…" (White and Gilliand 1975) In the case we will consider, the urge is the anxiety associated with the illness and threat of the demise of a loved one, and the associated feelings about the loved one. The defense mechanism serves to keep the anxiety about the imminent death of a family member and the range of feelings about the patient away from overwhelming the self.

[2] I use the term *strange* to highlight that the situations of critical care and illness usually stand outside the typical range of experience for most persons following the use of Richard Zaner (Wiggens and Schwartz 1986; Zaner 1984).

clinical realities, defense mechanisms can impede communication and impair ethical decision making.

Case Example

Mrs. IA, a 70-year-old widow, is admitted to the Cardiac Intensive Care Unit (CICU) from the emergency department after complaining of profound shortness of breath, weakness, lower extremity edema, and intermittent chest pain, but no other symptoms. The patient's medical records are available in this hospital. Her medical history includes severe mitral stenosis and severe leaflet calcification, mild left atrial enlargement, mild to moderate aortic regurgitation. A recent cardiac workup also revealed right ventricular enlargement with right ventricle dysfunction and rheumatic tricuspid valve. The patient was alert and oriented in the emergency department and she reported that she had been scheduled for a mitral valve replacement several months earlier, but decided that surgery was unnecessary since she felt able to maintain her normal activities. She is currently on Lasix and Coumadin. The cardiology service was consulted and they decided that the patient should be admitted to the CICU for further treatment of her symptoms and monitoring of her mitral stenosis and congestive heart failure.

The patient reported that she lived alone in her own home, but her youngest daughter, who accompanied the patient to the hospital, said that she lives with her mother. Later, in the CICU when asked about the discrepancy, the patient reported that her daughter is no help, so that in effect she *lives on her own.* In the emergency department, the patient was asked whether she has or wants to complete an advance directive, and she declined saying that "she intends to remain in control of her life and does not want any paper telling me what to do."

A surgical consult was obtained late on the first day of her admission and she was seen on day two. The surgeon documented in the medical record that the patient adamantly refused surgery stating that she did not want to have surgery until she really needed it and despite efforts to convince her that her cardiac status was seriously compromised, she refused. Early in her third day of hospitalization, she suffered an acute myocardial infarction (MI) and subsequently developed renal insufficiency. As a result, she is now obtunded and deemed not to have decision making capacity. A second surgical consult was obtained and ethics consultation was requested by the CICU physician.

The ethics consultant came to the CICU and reviewed the medical record and nursing notes before a scheduled meeting with the family, which consists of three children: a son and two daughters. The son is the eldest and he lives alone. The older daughter is married with two young children and lives in another state. The youngest daughter lives in the family home with the mother. After introductions, during which the ethics consultant explained his role, the CICU physician reviewed the patient's medical situation, the surgeon's report and the patient's competent refusal of surgery, as well as the recent myocardial infarction and its significance. After answering questions, the physician raised the question of a Do-Not-Resusitate (DNR) order explaining that although the resuscitation after the MI was successful,

the patient's prognosis is dismal and another cardiac arrest is likely. Surgery, at this point, would not likely improve the prognosis for meaningful recovery. Therefore, the physician asked the family to agree that a DNR order be written.

It quickly became evident that the family disagrees significantly over the appropriateness of the DNR order. The son (T) and youngest daughter (P) thought that the order is appropriate given the medical situation as described at length by the cardiologist, but the oldest daughter (M) disagreed arguing that her younger siblings have "had it with mom." She stated that even though she lives in another city, has a full-time job and two young children, she is prepared to provide the necessary follow up care since her siblings are evidently not willing. She said this with considerable anger, which elicited silence but strained looks from the other siblings.

The ethics consultant in an effort to diffuse the situation informed the family that since the patient lacks decisional capacity, then a surrogate decision maker would be empowered under state law to make the decision. He asked whether the patient had an advance directive since the medical record indicated negatively. He did not tell the family at that time about the patient's own statements about such a document. The younger children stated that it was never discussed, which elicited a response from daughter M, who stated that her mother clearly wanted her to be the decision-maker since she is the oldest and, of course, her mother would not discuss an advance directive with the younger siblings. "That's a matter only mom and I would discuss. Anyway, since there is no document then I'm decision-maker." The statement elicited an exchange of frowns and raised eyebrows from her siblings, but, again, neither spoke. At this point, there was a palpable tension in the room with anxious glances among the CICU staff.

Although, the consultant thought that this was a logical point to introduce information about the Order of Decision-Making law,[3] he recognized the agitation and anger of daughter M and the tension among the siblings, so he decided that the first task was to try to diffuse this escalating emotional situation. The consultant said that he understood daughter M's position and asked whether her siblings felt the same way, M spoke instead in an agitated way saying that "The doctors need to bring in consultants and specialists who can treat her mother before we have any more talk about limiting treatment. After a brief silence, during which the consultant looked around the room at the expressions of everyone present, he again asked for the thoughts of the other siblings. Both were reluctant to speak, but daughter P finally spoke directing her comments to her sister rather than the ethics consultant. "You think you know mom, but you are never with her. She was difficult to know and to care for. I know I did not do a lot for her, but I was there for her as much as I could be, but she never wanted me there and resented needing help. She's here and we are fighting because she did not want treatment anyway and I don't know why you want to put her through what she did not want." The daughter M started to respond, but she was cut off by son T who rebuked his siblings saying that you two are always "at it," but the issue is not us, but mom. He turned to the ethics

[3] The Order of Decision-Making law in the state takes effect when a patient lacks decisional capacity and an advance directive. The law provides an ordered list of decision-makers. Since the patient was a widow, the *majority* of her adult children became the decision-makers. No priority was given to adult children by age.

consultant and said, "You want to know what I feel. I'll tell you what. I'm pissed at mom. No matter what anyone tried to do for her, she resented it. Ever since dad died, she's not happy with us and not happy with her life. It wasn't our fault dad died and it wasn't hers, but I sometimes think she's really resentful that she and we couldn't save his life. Maybe that's why she neglected her heart condition; she just didn't care about life anymore. It's been going on for so many years that I guess none of us noticed it, but it's clear now. Why are we fighting?" Neither the sister said anything.

The ethics consultant, again, thought that it was a logical time to introduce the Order of Decision-Making law into the discussion, which he thought would "put things to the vote" and allow him and the busy CICU staff to move on to other matters. Instead, recognizing the emotional distress of the family members and the anger of daughter M, he asked the CICU staff if they had any other matters to discuss with the family and if not, then perhaps they wanted to return to their other duties. The CICU physician said that she had fully reviewed the patient's history and situation. She reiterated her recommendation that the family should consider agreesing to a DNR order as in patient's best interest. Since the family did not want to further discuss the patient's situation or have further questions, the CICU team members left the room.

After the CICU team members left, the ethics consultant continued the discussion with the family during which there were several acrimonious outbursts and anger was displayed by daughter M toward her siblings which they reciprocated. Finally, daughter M apologized to the ethics consultant for their behavior and stated that she felt so isolated and out of touch with her mom since her husband got his new job and they moved to another city just before her father died. She said tearfully that her mother had accused her of abandoning her father. She expressed a deep and confused of guilt. The ethics consultant understood her situation because he had lived away when his own mother died, but he did not say that. Instead, he stated that the death of a parent was always hard for children no matter whether the child lived away or near home. Interestingly, the younger siblings remained silent during this conversation watching daughter M. Finally, daughter M spoke. She said that she understood that it was difficult for her younger siblings to deal with their mom and that dad's death was a shock to us all. "I guess I'm like mom, really bossy and want to be involved, if not in control, but it's really hard when you're so far away." Daughter P laughed and said that if it was hard to be away, it wasn't easy to live with mom, adding "as you well know" and both daughters laughed. The mood in the room lightened considerably. The consultant discussed the father's death with them and asked how the mother had handled of his loss. The ethics consultant segued the conversation back to the issue at hand and asked the children to describe their mother as a person and what she would want under present circumstances.

Son T spoke up that he knew mom wanted control and that she had avoided medical care probably to her detriment. "I know she should've had the operation before and it's no one's fault in this room. We each tried to convince her, each in our own way. But she didn't listen. She didn't want it and that's that and now we have to deal with her decision. I know I'm not happy with her because of that," he

stated. Daughter T said, "Not happy?" That puts a positive spin on it since you were "pissed off" at her before! Son T reluctantly agreed, then they all laughed again.

It was at that point of the ethics consultant revisited directly the question before them asking them if they were willing to discuss the DNR order afresh and to begin making decisions about continuing life support. He offered to ask the physician to return to answer any further questions about her medical situation, but the family refused saying they had all their questions answered. It was at this point that the ethics consultant explained that a DNR order is not a withdrawal of all treatment though such a discussion might be appropriate soon. He said that given their account of the patient's personality and her continued refusal of medical care, a DNR order seemed ethically justified. The children looked at each other and agreed with daughter M who asked whether they needed to sign a document to that effect. They were told that their verbal approval was sufficient. The ethics consultant expressed his sorrow at the situation and told them he would visit the unit each day. He also passed out his card with contact information. He was about to leave the room when daughter M asked whether they would need to meet again to discuss stopping treatment or could they continue and talk about it now. Her siblings agreed.

Discussion

So often, ethics cases are regarded as matters of ethical analysis and argumentation. The analytical goal is to identify the issue involved in the case and the procedure for resolution is to provide arguments and reasons for following the ethically permitted or required approach. In this case, the issue was analytically simple. Since two of the three children concurred with the DNR order, the ethics consultant could have simply authoritatively informed them of the law and that the physician was authorized to write a DNR order given the agreement of the two children. Such an approach would have yielded the same result with the advantage of being more efficient. However, it had the significant disadvantage of inflaming emotional wounds among the family members and it would have provided a powerful negative example for the critical care team, which included residents, that sensitivity to the emotional needs of a family in distress is less ethically important than reaching a justified result. Such teaching, which can be regarded as part of the "hidden curriculum" (Hafferty and Franks 1994), can profoundly undermine formal teaching designed to develop communicative and emotional capacities in health professions students.

Because the ethics consultant recognized that the family decision making and communication was emotionally charged, he decided that it was important to attend to these emotional valences hopefully to prevent their undermining ethically sound decision making. He did so with the full knowledge that if the family meeting deteriorated and daughter M persisted in her angry insistence that full code status should be maintained, then the order of decision making law could have been used to effect the ethically sound decision at a later point. This approach was both ethically and clinically justified since the ethics consultation was called early in the

case, so the time for attending to the family's emotional needs did not impede important medical decisions.

Especially in times of stress, emotions cloud and complicate rational decision making. They can contribute to a filtering effect in which relevant information is dismissed or misinterpreted. This is a well-recognized feature of everyday decision making that effective salespersons use to influence our purchases. It is no surprise that such a mechanism comes into play in situations of critical illness, especially with a family member with whom there might be latent "emotional baggage." One need not accept the psychoanalytic theories of defense mechanisms, which hold that these processes protect the ego from assault, in order to recognize that certain emotional reactions to critical illness can importantly impede communication and decision making.

One common mechanism that often goes undetected by clinicians and ethics consultants alike is intellectualization.[4] For example, a family quickly adapts to the critical care setting and begins to "understand" the various technical aspects of critical care that mark progress or regress in the patient's care. These families will become familiar with and ask specifically about ventilator settings, amounts of medication drips, and other markers of treatment. This can persist for days or even weeks leading caregivers to conclude that the family is "on the same page" as they are. However, when those markers deteriorate, families might not draw the appropriate clinical conclusions; when problems suddenly arise, families can assume that they should have been foreseen. Such families are also prone to insist that a medical error must have occurred which caused the "sudden" alteration in the patient's status, not recognizing that the clinical signs had been deteriorating steadily over time. When these developments lead to discussions about limiting treatment, the caregivers can be confronted with a very angry and confused chorus of family members. Understanding defense mechanisms in these settings thus helps us to appreciate that clinical and technical indicators were simply not meaningful for the family members. The fixation of family members on these indicators helped them to avoid confronting their own emotions about the potential loss of a loved one. The clinician who unsuspectingly begins the conversation about stopping treatment in this situation can be caught off-guard by staunch resistance and anger. Such families appear suddenly not to recognize what was so evident all along. This problem is the result of a pattern of communication that is insensitive to defense mechanisms. It is often encouraged by young clinicians, who dutifully discharge their obligations with respect to informed consent by maintaining communication at a technical level never attaining a true comprehension by the family and thereby avoiding the emotional sphere where the potential loss of a loved one is located.

[4] In Vaillant's (1977) categorization, defenses form a continuum related to their psychoanalytical developmental level. In his scheme, intellectualization, reaction formation, dissociation, displacement, and repression represent *neurotic mechanisms* (Level 3 in his developmental schema), and are distinguished from Level 4- defenses, which he categorizes as *mature mechanism:* i.e., humor, sublimation, suppression, altruism, and anticipation. The function of defense mechanisms in the overall personality is not, however, our concern, but rather how they can impede the reception and understanding of information and ultimately obstruct ethical decision making.

Thus, defense mechanisms should be recognized and addressed by competent ethics consultants. One thing, however, is clear from the psychoanalytic and psychological literature, namely, that ideally defense mechanisms should not be attacked head on. To do so exposes the ego or the person to significant distress and causes inordinate and unjustified suffering. In the case discussed, the ethics consultant delayed introducing the order of decision making law in order to address the immediate emotional needs of the family. Fortunately, this was accomplished easily, but many cases require a building of trust and a gradual adjustment on the part of family to the complex problem of the imminent death of a loved one. For that reason, ethics consultation in critical care settings should ideally be augmented by ethics liaison services (Agich 2003; Richter 2009) that support early recognition of and interventions to address the communicative and emotional stresses associated with emergent ethical concerns.

References

Agich, G. J. (2003). Joining the team: Ethics consultation at the Cleveland clinic. *HEC Forum, 15*(4), 310–322.

Agich, G. J. (2005). What kind of doing is clinical ethics? *Theoretical Medicine and Bioethics, 26*, 7–24.

Aulisio, M. P., Arnold, R. M., & Youngner, S. J. (2000). Health care ethics consultation: Nature, goals, and competencies: A position paper from the society for health and human values–society for bioethics consultation task force on standards for bioethics consultation. *Annals of Internal Medicine, 133*, 59–69.

Dubler, N. N. (1998). Mediation and managed care. *Journal of American Geriatrics Society, 46*, 359–364.

Dubler, N. N. (2002). Mediating disputes in managed care: Resolving conflicts over covered services. *Journal of Health Care Law Policy, 5*, 479–501.

Fiester, A. (2007a). The failure of the consult model: Why "mediation" should replace "consultation". *American Journal of Bioethics, 7*, 31–32.

Fiester, A. (2007b). Mediation and moral aporia. *Journal of Clinical Ethics, 18*, 355–356.

Gibson, J. M. (1994). Mediation for ethics committees: A promising process. *Generations, 18*, 58–60.

Hafferty, F. W., & Franks, R. (1994). The hidden curriculum, ethics teaching, and the structure of medical education. *Academic Medicine, 69*(11), 861–871.

Molewijk, A. C., Abma, T., Stolper, M., & Widdershoven, G. (2008). Teaching ethics in the clinic. The theory and practice of moral case deliberation. *Journal of Medical Ethics, 34*, 120–124.

Orr, R. D. (2001). Methods of conflict resolution at the bedside. *American Journal of Bioethics, 1*, 45–46.

Orr, R. D. (2002). Working toward peace in the clinical setting: The role of clinical ethics in conflict resolution. *Today's Christian Doctor, 33*, 26–30.

Orr, R. D., & deLeon, D. M. (2000). The role of the clinical ethicist in conflict resolution. *Journal of Clinical Ethics, 11*, 21–30.

Reynolds, D. F. (1994). Consultectonics: Ethics committee case consultation as mediation. *Bioethics Forum, 10*, 54–60.

Richter, G. (2009). Clinical ethics as liaison service: Concepts and experiences in collaboration with operative medicine. *Cambridge Quartely of Healthcare Ethics, 18*, 360–370.

Vaillant, G. E. (1977). *Adaptation to life*. Boston: Little, Brown.

van der Dam, S. S., Abma, T. A., Molewijk, A. C., Kardol, M. J., Schols, J. M., & Widdershoven, G. A. (2011). Organizing moral case deliberation experiences in two Dutch nursing homes. *Nursing Ethics, 18*, 327–340.

Waldron, E. E. (1992). Ethics committees, decison-making quality assurance, and conflict resolution. *Journal of Clinical Ethics, 3*, 290–291.

Weidema, F. C., Abma, T. A., Widdershoven, G. A., & Molewijk, A. C. (2011). Client participation in moral case deliberation: A precarious relational balance. *HEC Forum* (Published on-line July).

West, M. B. (1992). Mediation and communication techniques in ethics consultation. *Journal of Clinical Ethics, 3*, 291–292.
White, R. B., & Gilliand, R. M. (1975). *Elements of psychopathology: The mechanisms of defense*. New York: Grune & Stratton, Inc.
Wiggens, O. P., & Schwartz, M. A. (1986). Techniques and persons: Habermasian reflections on medical ethics. *Human Studies, 9*, 365–377.
Zaner, R. M. (1984). Is 'ethicist' anything to call a philosopher? *Human Studies, 7*(1), 71–90.