



Anatomy of a Clinical Ethics Consultation

BARRY HOFFMASTER

Department of Philosophy, University of Western Ontario, London, Ontario, N6A 3K7, Canada

Abstract. Theoretical accounts of the nature and purposes of clinical ethics consultation are disappointingly superficial and diffuse. Attempts to illuminate the goals, the forms, the substance, and the criteria for the success of ethics consultations need to focus on detailed reports of cases and the contexts in which they occur. The uncommonly rich description of the consultation surrounding Mrs. Rose's plight provides a splendid opportunity to explore such matters. The ethics consultant pursues a number of ventures—providing and clarifying information, improving communication, educating and counseling, and being a friend—with variable degrees of success. What the ethics consultant can do and how well he can do it are in large part constrained by three features of the hospital context in which this consultation unfolds: pervasive, perhaps ineliminable, uncertainty; communication failures; and firmly entrenched power. A fundamental issue for an ethics consultant is whether structural and institutional constraints should be accepted or challenged. Should an ethics consultant be a peacemaker or a reformer?

Personal aspects of Mrs. Rose's plight, as she lies unresponsive and connected to a ventilator in the intensive care unit of a hospital, are, of course, idiosyncratic and distinctive. Mrs. Rose's life has coalesced out of her unique engagements with others and the world; projected into the future, that life is seemingly drawing to an imminent, unenviable close. Understanding why she is in that intensive care bed, and what this experience means to her, would require an intimate understanding of her singular existence. Situational aspects of Mrs. Rose's plight are, however, more transparent because they are distressingly common in hospitals. Three features of hospital care particularly conspire against treating patients with the concern and respect they deserve: pervasive, often ineliminable, uncertainty; failures of communication; and firmly entrenched power. Mrs. Rose and her family are ensnared by all three.

The attempt to make health care more humane—the principal goal of health care ethics in hospitals—is, in large part, an attempt to mitigate the pernicious effects of those three factors. Towards that end, many hospitals now employ persons known as “clinical ethicists,” who come from diverse backgrounds and who have different kinds of training, but whose shared mandate is to handle ethical problems in the care of patients. Despite having achieved formal recognition and status within hospitals, and despite having acquired many of the trappings of a profession, clinical ethics consultation remains an amorphous activity. This is due, in part, to its brief history, to the imprecision and

vagueness of the notion of ethics it serves, and to the variability that results from tailoring its practice to an array of heterogeneous health care settings.

A perceived need for clinical ethics nevertheless persists, a need that has been projected to intensify “. . . as technological progress, moral pluralism, and legal interventions further complicate the task of clinical ethical decision making” (Singer et al., 1990, p. 265). Yet the precise nature of that need and how clinical ethics consultation can meet it are not easy to ascertain because the purpose of an ethics consultation is nebulous:

. . . [T]he central goal of an ethics consultation is identical to the goals of all medical and surgical consultations: to improve patient outcomes. . . . The central goal . . . of ethics consultations is to assist the primary physician, the patient, and the family to reach a right and good clinical decision. (Singer et al., 1990, p. 264)

Such a description is vacuous without accounts of what “patient outcomes” are morally relevant, what it means to “improve” those outcomes, what counts as a “right and good clinical decision,” and how a “right and good clinical decision” can be made. Given this haziness about the nature of ethics consultation, it is not surprising that descriptions of the people who engage in it are equally vague: “Clinical ethics consultants are professionals who help resolve ethical dilemmas which arise in the care of particular patients” (LaPuma and Schiedermayer, 1991, p. 141).

Answers to several core questions consequently are essential to establishing the integrity, credibility, and viability of clinical ethics consultation: In what circumstances is an ethics consultation appropriate? How should it be conducted? Who should be permitted to do it? What specific goals is it intended to accomplish? How does one know when it has been successful? Although convincing answers to these questions must ultimately be grounded in an appreciation of what actually happens in ethics consultations, most discussions of the practice rely on brief, superficial accounts of consultations and their results. The uncommonly rich description we have of the consultation with respect to Mrs. Rose’s care provides, in contrast, a splendid opportunity to pursue these issues in more depth. My analysis considers the context within which the consultation occurs and various aspects of the consultation itself, and then explores the implications of these points for understanding and assessing the practice of clinical ethics consultation.

The Context: Uncertainty, Ignorance, and Power

The attending physician, consultants, and residents caring for Mrs. Rose are uncertain about what caused the sudden onset and acute deterioration of her

medical condition and about the extent of the damage to her lungs. They are, consequently, uncertain about how best to manage her problems. “Good medicine,” in their view, requires further diagnostic efforts to try to determine what is wrong with her, particularly whether her condition is potentially reversible. That view is shared by Mrs. Rose’s nurse: “She’s really sick, but she might get better. . . . It’s too early to just let her die . . .” (Bliton, 1999, p. 8). The unanimous professional opinion of those caring for Mrs. Rose is that efforts to determine what is wrong with her should continue.

At the same time, there is uncertainty about the wishes of Mrs. Rose. What exactly are her beliefs and values about being on a ventilator? What would she regard as “prolonged” time on a ventilator? Were her beliefs and values formed with an understanding of the various functions of ventilators, in particular, the use of a ventilator to help a patient through an acute crisis? Why did she apparently assent, if not consent, to being put on the ventilator in the first place? Did she intentionally extubate herself? And who, in fact, knows her wishes better? Her children, who have discussed matters generally with her over the phone, or her attending physician, who has had a long and apparently caring relationship with her?

Resolving this pervasive uncertainty is complicated by poor communication among all parties, a failing which, sadly, is rife within hospitals and constitutes one of the greatest impediments to good patient care and informed, sensitive decision making. The residents do not know the attending’s plans for Mrs. Rose. Consultants examine Mrs. Rose and record their findings and recommendations in her chart, for others to read as they see fit. The doctor who replaces Mrs. Rose’s attending physician over the weekend makes his own assessment of her condition and prognosis and adjusts her care accordingly. The concerns of the nurses are addressed only when and as they need to be. Mrs. Rose’s children find it impossible to meet with the attending physician responsible for her care. And the clinical ethicist gleans impressions of the situation from the succession of individuals with whom he speaks.

Amidst all this uncertainty and flurry of uncoordinated activity, there is, however, one clearly recognized constant: the unchallenged power of Mrs. Rose’s attending physician to decide what will be done to her. That power derives from the multi-faceted responsibility, and hence authority, that attending physicians possess with respect to their patients. In their discussion of clinical ethics consultations, Singer, Pellegrino, and Siegler emphasize that this is as it should be: “The primary clinical, moral, and legal responsibility for the care of the patient . . . remains, as always, with the attending physician” (Singer et al., 1990, p. 264).

Everyone acts accordingly. The consultants offer suggestions but defer to the judgment of the attending. The covering pulmonologist, when pressed by the clinical ethicist, declares Mrs. Rose “terminal.” When he is then requested

to chart that opinion, he readily agrees, but with a telling caution: “I don’t have any problem with that, . . . [b]ut, I don’t know what the attending will do – it’s his patient” (Bliton, 1999, p. 20). The residents dutifully keep the attending apprised of Mrs. Rose’s condition; their careers are, after all, in the hands of the attending physicians they serve. Mrs. Rose’s primary nurse does not question the attending about the increasing dosages of morphine he orders, despite her worry that her administration of the morphine will hasten Mrs. Rose’s death. Her concerns are deflected to the clinical ethicist. “As a matter of protocol,” the clinical ethicist meets with the attending to obtain his “acknowledgement” before speaking with Mrs. Rose’s sons (Bliton, 1999, p. 11).

The ultimate manifestation of the attending physician’s power, though, is that it is his view of what should be done that prevails. When the attending finally meets with Mrs. Rose’s children, he concedes that their mother will die soon and that medical interventions cannot prevent that. He agrees with the pulmonologist’s suggestion that “all but basic support” be withdrawn (Bliton, 1999, p. 21). Yet he writes in Mrs. Rose’s chart: “no change in treatment” (Bliton, 1999, p. 21). The clinical ethicist is baffled:

What was going on here? It had been over four days since the family had first voiced their concerns, quite clearly. Those were very explicit, had been clearly emphasized to the attending in conference, and he publicly acknowledged his own understanding of Mrs. Rose’s preferences gathered from his own discussions with her. (Bliton, 1999, p. 21)

At the instigation of the ethics consultant’s colleague, all four children go to the attending’s office and wait two hours to speak with him. That night the attending writes in Mrs. Rose’s chart that “they very strongly want her disconnected from the ventilator,” but he still does not give in: “I have asked them to wait until the morning and we will re-evaluate” (Bliton, 1999, p. 22). The next morning Mrs. Rose is extubated and dies. Why she dies then remains unexplained. What is clear, though, is that the course of her treatment and the timing of her death were determined by her attending physician.

Framing the Consultation

The consultation requested by Mrs. Rose’s son Russell is also infused with uncertainty. None of the participants seems to have a clear idea of what the purpose of the consultation is, how it should be conducted, or what its outcome should be. Family doctors, when patients come to them, try to understand why this patient has brought this particular problem at this particular time, what the patient’s perception of the cause, nature, and significance of the problem

is, and what kind of help the patient is seeking. Ethics consultants, to be helpful, need the same kind of understanding. Why does Russell think his mother's care is ethically problematic, and what does he think the problem is? We are told only that Russell wanted to talk with a representative of the hospital's ethics committee "about his mother's treatment" (Bliton, 1999, p. 7). But what precipitated this request, and what exactly is the concern about his mother's treatment? The discussion about a do-not-resuscitate (DNR) order that the attending physician had with Mrs. Rose and her daughter, Janice, occurred four days before the request for the consultation, and Mrs. Rose's condition deteriorated that same day. Two days before the request, the attending wrote in Mrs. Rose's chart that her prognosis was "very poor" and he doubted she would survive. One day before the request, Janice requested that a DNR order be written. What has prompted the request for an ethics consultation now, and what exactly is it about Mrs. Rose's treatment that is worrisome?

Why did the request come from Russell? Is it simply because he is the only one who knew about the existence of hospital ethics committees? What relationship does Russell have with his siblings? Is he a designated or self-appointed spokesperson for them, or is he acting on his own? What is Russell's understanding of what has happened to his mother, and what kind of help does Russell expect from an ethics consultant?

The withdrawal of Janice, Mrs. Rose's eldest child and her only daughter, is puzzling. Having been involved in the initial decision making about her mother's care, why does she no longer want to participate? Why, moreover, does the clinical ethicist not investigate her withdrawal? Janice has valuable information about what happened prior to the arrival of her brothers, but for some reason the clinical ethicist does not attempt to speak with her, even by phone. Is the clinical ethicist worried about the family relationships here? Does he wonder whether he is somehow being manipulated or whether her exclusion has anything to do with her being the only sister? Is her absence after her brothers arrive fully accounted for by her need to care for their father and her unwillingness to be with her mother as she dies on a ventilator?

Trying to clarify these matters would, I think, be the clinical ethicist's first task, but that is not what the clinical ethicist does. Instead, he reads Mrs. Rose's chart and speaks with the doctors and nurses caring for her and, on the basis of the information he obtains, speculates about what the problem and the motivation for the consultation might be. In one respect this strategy is puzzling. Why not speak directly with Mrs. Rose's children to find out what is bothering them before doing anything else? Why not convene a family conference so that he can meet with them collectively and purposively, rather than haphazardly interviewing whoever happens to be present at a particular time?

In another respect, though, what the clinical ethicist does is not surprising. The clinical ethicist, I suspect, knew from the outset that there had been a

failure of communication with the family, and if that were not the whole problem, it was at least a substantial component of the problem. Given time pressures and staff shortages, multiple caregivers from a variety of professions, disciplinary rivalries and turf protection, and shift schedules and rotation systems, communication problems, among staff let alone between staff and patients and their families, are endemic in hospitals. Anticipating that, the clinical ethicist wanted to acquire as much information as possible about Mrs. Rose's condition and care.

The Roles of the Clinical Ethicist

The clinical ethicist adopts a variety of roles in trying to sort out the problems that swirl around Mrs. Rose.

i) To Provide and Clarify Information

The clinical ethicist's presentation of himself to Russell and Paul in their first meeting shows that he takes this to be one of his principal functions. He tells Russell and Paul that he is there "to talk with them about what was happening with their mother" and to try "to clarify any confusions that might have developed" (Bliton, 1999, p. 12).

But what competence does an ethicist have to do this? The training of clinical ethicists generally includes exposure to clinical settings and problems, and clinical ethicists undoubtedly pick up much through experience, but do they know enough to explain and interpret medical information to patients and their families? Moreover, given all the people who already talk to patients and their families, and the different, often conflicting, impressions they take away from those conversations, does it make sense to add yet another "official" information dispenser, moreover, one who likely has no formal medical training?

ii) To Improve Communication

The clinical ethicist also offers to help the family obtain information they want and relay their anxieties, reservations, and wishes back to the doctors. He initially tells Russell and Paul that he will convey "their concerns to the physicians," (Bliton, 1999, p. 12) and he later reaffirms this role when he says to Paul, "If there is anything I can tell the people taking care of her, just let me know" (Bliton, 1999, p. 18).

Improving communication requires more than being a conduit of information, however. The clinical ethicist needs to understand why communication about the care of Mrs. Rose is so fractured. Is it because different members of the family meet with the attending at different times and derive different impressions of their mother's condition and what is being done to her? Is it because different members of Mrs. Rose's family are speaking with different doctors and nurses, who have their own guesses about her likely diagnosis and prognosis? If so, information could be presented more consistently by designating a single family member to speak regularly with the attending or a selected health care professional caring for their mother. Is it, alternatively, because different impressions are the result of changes in their mother's condition and clinical responses to those changes? Or is it that the attending, who will make the authoritative decision about what happens to Mrs. Rose, is inaccessible? To satisfy Mrs. Rose's family, the clinical ethicist has, first of all, to identify the source of their discontent.

iii) To Educate and Counsel

This consultation is not restricted to Mrs. Rose's family. When the amount of morphine being given to Mrs. Rose is increased, her primary nurse becomes worried about administering a lethal bolus of the pain-killer. The clinical ethicist steps in to clarify the nurse's understanding of what is and, more importantly, is not "natural" in health care and seemingly delves into the mysteries of the doctrine of double effect (Ashley and O'Rourke, 1989, p. 184–188) with her.

iv) To Be a Friend

Ethics, as William May (1994) reminds us, is not simply about resolving moral quandaries, that is, deciding what the best course of action is in difficult circumstances. Ethics is also about character and virtuous behavior, about how to comport oneself in and respond to circumstances that one might be unable to influence or change. To illustrate this component of morality, May cites the reaction of the wife of a college president to her husband's death: "I could do nothing about the death of my husband. . . . The only question put to me was whether I could rise to the occasion" (1994, p. 78).

This consultation is for Mrs. Rose's family as much as it is for Mrs. Rose. The clinical ethicist's remark about how "moral experience requires a kind of bearing" that imposes demands on "how individuals ought to conduct themselves" recognizes the character-testing dimension of morality (Bliton,

1999, p. 24). The clinical ethicist assures Paul that he will “stand with” him and his family as they cope with their mother’s illness and possible death (Bliton, 1998, p. 19).

The Ethics of It All

A common observation of clinical ethicists is that most of the problems they handle are communication problems, not ethical problems. Given that distinction, it is natural to wonder, in general and in Mrs. Rose’s specific situation, where the ethics is in an ethics consultation. If the difficulty for Mrs. Rose’s family is obtaining adequate information, how does that become an ethical matter, moreover, one that warrants the solicitous intervention of a specially trained clinical ethicist?

The answer is that there is no sharp distinction between communication problems and ethical problems. Bad communication, for one thing, breeds distrust. Trust between Mrs. Rose’s family and her doctors was never established here, or if it was, it has been eroded for a dismally familiar reason: the family cannot obtain the clear, comprehensive information they want from the person ultimately responsible for their mother’s care, the attending physician. Consequently, the family cannot rest confident that they have discharged their fundamental responsibility of conveying their mother’s wishes and their own wishes to the attending and insuring that he will make decisions about her care accordingly. The brothers want to know whether their mother has been put on a ventilator against her will. Perhaps they do not trust the attending to answer that question forthrightly, and they are searching for the answer elsewhere. Or perhaps they need help simply to ask the attending that question.

Within this explanation is another recognizably ethical dimension of the consultation: the attempt to make sure that Mrs. Rose’s autonomy is respected. The clinical ethicist poses the mandatory question to the three brothers: “Can you remember what . . . [your mother] has told you that might indicate what her preferences might be?” (Bliton, 1999, p. 14). John replies that over the phone his mother said that “she did not want to die hooked up to these machines” (Bliton, 1999, p. 14). That is the most explicit statement of her wishes. The sons agree that she would not have wanted to be on a ventilator for a “prolonged” period of time.

But concentrating on what Mrs. Rose’s wishes allegedly were or would be is misguided, given the uncertainty surrounding the causes and nature of her condition and her apparent agreement to be put on the ventilator. The principal medical and moral issue for Mrs. Rose’s doctors and family is how aggressive the attempt to diagnose what is wrong with her should be. How much should they do, how long should they persist, and how much suffering should she be forced

to endure to try to find out, with some rather imprecise degree of confidence, whether she has an acute condition that is potentially reversible? Mrs. Rose probably never thought about that specific question, so whatever wishes she did express are, at best, tangentially relevant to answering it. What it might mean to respect her “autonomy” in these circumstances is, therefore, unclear.

Another ethical issue inherent in this constellation of questions about Mrs. Rose’s care is candor. Given the progressively dismal prognoses for Mrs. Rose, are the physicians being honest, with themselves or with Mrs. Rose’s family, about their motivation for continuing to “treat” her? Is the quest for a diagnosis that will indicate whether she has a potentially reversible acute problem the real reason for not stopping, or is there something else going on?

So communication problems, even if they are not transparently ethical, nevertheless conceal and create ethical problems. They preclude or dissipate the trust between health care professionals and patients and their families that is the foundation of a mutually respectful and reciprocally satisfying relationship. In doing so, they impede or even invalidate a morally responsible process of decision making about the care of a patient. For these reasons communication problems should not be rigidly segregated from ethical problems; rather, they should be recognized as a generous fount of moral concerns.

Assessing the Consultation

How successful was this consultation? An assessment of it has to consider its various facets.

i) Communication

How can a clinical ethicist improve communication? An ethics consultant who is personable, sensitive, tactful, and familiar with the hospital and its personnel might be able to help, but so would anybody else with those generic skills. What could a clinical ethicist do to improve communication that a social worker, say, could not do and perhaps do better? That is a pertinent question here because the clinical ethicist’s strategy is to regard the communication difficulties as discrete problems to be dealt with in isolation. The clinical ethicist talks to the attending by himself, the resident by himself, and the nurse by herself. That seems like an unsatisfactory, inefficient approach, but it most likely is a strategy imposed on the clinical ethicist by the way the delivery of care is organized within the hospital. There seems to be no notion of a health care team that would bring the professionals caring for Mrs. Rose together to discuss her condition, plan a course of treatment, deal with potential problems

in implementing that plan, and formulate a consistent explanation of what they propose that could be presented to the family for approval. There then could be a conference between the health care team and the family at which Mrs. Rose's condition would be explained and explored in depth and a plan that incorporates the values she expressed and the values of her family would be formulated. Would such a meeting not be better, and much more efficient, than the serial individual meetings the clinical ethicist has in an attempt to sort out and solve all the different problems created by the uncertainty surrounding Mrs. Rose's condition and care?

ii) The Care of Mrs. Rose

Did the clinical ethicist, in focusing on and emphasizing Mrs. Rose's own wishes, ask the right question? The standard bioethics alternative to making a decision on the basis of how one thinks the incompetent person herself would have made it – the “substituted judgment” approach – is to try to determine what is in the “best interest” of the patient. The clinical ethicist never switches to the best interest of Mrs. Rose, however. When Russell comes back to see him more than a month after his mother's death, the clinical ethicist reassures him by telling him, “As I saw it, the real issue was one of choosing among relative harms according to her stable convictions, which you did” (Bliton, 1999, p. 24). But is that “the real issue”? Mrs. Rose had no discernible “stable convictions” about the matter of how aggressively she wanted her condition to be investigated. She did not want to die on a ventilator, and she did not want to be on a ventilator for a prolonged time, but neither of those wishes precludes putting her on a ventilator for a limited time to try to determine whether her problems can be reversed.

Nor should any appeal be made to Mrs. Rose's apparent agreement to be put on a ventilator. That is the mistake of the attending physician. Mrs. Rose might have acceded because she thought the risk was worth it, or she might have acceded out of fear. Perhaps nobody, including Janice, knows why she acquiesced. Although the attending admits that he understood Mrs. Rose's general desire not to be put on a ventilator, he regards her acceptance of intubation as overriding. Consequently, he claims, “it had been necessary to be aggressive in her management” (Bliton, 1999, p. 21). But that sweeping inference does not follow, particularly when the specific decision upon which it is founded is so opaque. The attending's appeal to the doctrine of “substituted judgment” is equally misplaced.

This focus on Mrs. Rose's indeterminate wishes is not, however, neutral because it probably made it easier for the doctors to continue to search for the causes of her deterioration and, in doing so, to feel that they were fulfilling

their professional obligations. If Mrs. Rose had registered no clear, compelling objection to being on a ventilator, why could they not press on with their diagnostic efforts? A “best interest” approach could have been used to challenge that persistence by posing some penetrating questions. What kinds of information were the doctors seeking? How might that information make a difference to Mrs. Rose’s treatment? What is the probability of obtaining that information? And what kinds of harms, discomforts, or pain might Mrs. Rose have to endure in the quest for this information? Health care professionals, like all of us, find it difficult to cope with uncertainty. That difficulty is compounded, of course, when uncertainty beclouds decisions about life and death. Nevertheless, the potential value of clinical information must be assessed not simply in terms of what might be done with it, but also in terms of the burdens that searching for it would impose on patients.

The legitimacy of the diagnostic imperative becomes particularly troubling when the interests of patients and health care professionals might diverge. More information could have been in the interest of Mrs. Rose, but it was clearly in the interest of her doctors, who are acculturated to be active, to do something for their patients, (Payer, 1988, pp. 124–143) and who understandably do not want to overlook a vital aspect of her condition. Disentangling what is in the best interest of Mrs. Rose and what maintains the professional and personal comfort of her doctors is not easy. Nevertheless, the aggressive diagnostic efforts to which Mrs. Rose was subjected had to be definitively in her best interest, and it is hard to see how that was ever established.

In response, it might be suggested that the clinical ethicist merely used the language of Mrs. Rose’s wishes and convictions to pursue what was best for her and her family. If so, this stratagem failed in two ways. The attending physician usurped it to support his own position, and an examination of the deeper issues and values driving the diagnostic imperative was foreclosed. A direct route to Mrs. Rose’s best interest might have been more successful.

Did Mrs. Rose die in any less pain because of what the ethics consultant did? In what way and to what extent, if at all, did the interventions of the clinical ethicist influence the increased dosage of Mrs. Rose’s pain medication? The clinical ethicist rightly attends to this crucial matter, but the upshot of his overtures on Mrs. Rose’s behalf cannot be determined.

iii) Moral Education

Nurses can be understandably distressed about administering large, potentially lethal, quantities of drugs to patients. Thinking about this issue in terms of what is “natural” and “unnatural” is, however, misconceived and unproductive. Keeping a patient breathing on a ventilator is, as I am sure the clinical ethicist

pointed out to Mrs. Rose's nurse, as "unnatural" as bringing about a patient's death with an injection. But whether the intent with which one acts in injecting a large bolus of morphine can bear all the moral weight that the doctrine of double effect assigns to it is debatable. Nurses might, equally understandably, be suspicious of the doctrine's crucial distinction between the primary intent of desiring the relief of a patient's pain and the secondary intent of foreseeing, but not desiring, the possibility of hastening a patient's demise.

Regardless, such intellectual arguments miss the point. What troubles nurses, as Mrs. Rose's primary nurse emphasized, is what it feels like to inject that bolus of a drug, with the fear that the patient might die soon thereafter. In the face of those feelings, conceptual distinctions and arguments pale and seem mere rationalizations. The clinical ethicist's "subtle point" that "[h]er purpose was to relieve suffering, . . . not to hasten . . . [Mrs. Rose's] death" was of little comfort to the nurse (Bliton, 1999, p. 22). Given that, the solution is not to import a clinical ethicist whose moralizing reassurances will sound hollow. The solution is to develop alternative methods of administering potent pain medications so that the injection of a large bolus is no longer required.

iii) Being a Friend

The clinical ethicist helped Paul and Russell through a troubling time and provided solace to them. But, as William May also points out, in a professional relationship there is "a reciprocity . . . of giving and receiving": "The young rabbi or priest has more than once paused before the door of the sick room, wondering what to say to a member of his congregation, only to discover the dying patient ministering to his own needs" (1994, p. 89). The clinical ethicist here, too, seems to have received at least as much as he gave. The candor and trust of Russell and Paul taught him much and, perhaps, deepened his faith in what he is doing. They were as much friends to him as he was to them.

Institutional Dimensions of Clinical Ethics Consultation

Because clinical ethicists work in and for hospitals, what they do and how they can do it are, in many ways, determined and constrained by the structures and organizations of their institutions.

i) Access to Clinical Ethics Consultation

This consultation began unusually, with a summons from an executive secretary in the hospital's administration. It was requested by the son whose

acquaintance with health care facilities led him to infer that this hospital would have an ethics committee. One of the most serious moral problems in health care is access to limited resources, and those limited resources now include ethics consultation.

How is access to an ethics committee or an ethics consultation obtained? In principle, access might be open to virtually everyone imaginable: patients and their families, health care professionals, support staff, and administration. The procedures and policies on the books might look liberal and inviting. In practice, though, they are likely to be much more restrictive. Health care professionals struggling with the demands of economic cutbacks and staff layoffs may have neither the time nor the energy to fill out forms, meet with members of an ethics committee, or attend meetings. Ethics committees that meet during the day or consultants who work during the day may not be available to those who work other shifts.

And what about patients and their families? Even if the existence of an ethics committee is announced in admissions materials or advertised in elevators, how many patients will comprehend what an ethics committee does, why they might want to use one, or how they get access to it? I suspect that, in terms of whom ethics committees serve, this consultation is typical. Those who come to ethics committees are the well informed, the well connected, and the well heeled. They are people who are knowledgeable, aggressive, and not intimidated by impersonal bureaucracies. To what extent do those who are disempowered and disengaged come to ethics committees?

Moreover, the clinical ethicist reports that most of his consultations come from intensive care. That matters of life and death raise agonizing moral issues is not surprising. And given how heavily health care resources are invested in the technological preservation of life, it is not surprising that the resources for ethics consultation repeat that pattern. But the moral problems that arise in, say, chronic care and rehabilitation are just as daunting if much less spectacular, and perhaps are more enduring because patients must live with and through them. Why, then, do ethics consultants not roam the halls of nursing homes or rehabilitation centers? How do we determine what counts as a moral issue, and when those issues are sufficiently important that they warrant the presence of a clinical ethicist? In trumpeting the values of justice and fairness within health care, ethicists must be cognizant of how their own work fares in this respect.

ii) The Perception of a Clinical Ethicist

How does the job of an ethics consultant fit into the structure of health care, and how is an ethics consultant perceived by other health care professionals?

A simple answer to the former question is that an ethics consultant functions just like any other specialist consultant, providing assessments of and recommendations about a particular dimension of a patient's care. Ethics consultants, in other words, have simply been plugged into the existing organizational and professional structures of health care. There is, however, an important difference with an ethics consultant. Most medical consultations are requested by the attending and are at the discretion of the attending. But this ethics consultation, requested by Mrs. Rose's son and endorsed by the administration, is imposed upon the attending. Obtaining the attending's "acknowledgement" of it is a formality and a courtesy; he cannot realistically refuse. But that does not mean he has to like it, and he clearly does not. He is described as being "nonplussed," and he is curt with the ethics consultant (Bliton, 1999, p. 11). Even if part of that reaction is due to anxiety about his impending surgery, there is more to it. To the attending, and to other health care professionals, the ethics consultant is an emissary of mistrust. The presence of an ethics consultant is a clear and unmistakable signal that something has gone awry in the relationship between health care professionals and the patient or the patient's family. For that reason it is also a clear and unmistakable signal of failure. The residents, it is reported, feel "undermined" when the clinical ethicist becomes involved in the care of a patient (Bliton, 1999, p. 8). Other consultants are invited in as allies to help a physician deal with uncertainty and the unavoidable limits of knowledge. The ethics consultant here is, in contrast, not an ally but an intruder, thrust in to try to remedy a problem.

How does this perception affect the ethics consultant's job? He is, to begin, multiply vulnerable because he depends upon the attending physicians, consultants, residents, and nurses for the information and good will he needs to do his job. Given the importance of maintaining cordial, productive relationships with the health care professionals upon whom he depends, how does knowing that he already is greeted with regret and misgivings influence how he interacts with those professionals and how far and how hard he might push them? The clinical ethicist is in an awkward, ultimately untenable, position. On behalf of patients and their families, he must risk challenging and becoming adversarial with the very health care professionals upon whose trust and openness the effectiveness of his work ultimately depends. The institutional responsibility for rectifying moral problems is vested in a person who has a deep, uneasy institutional conflict of interest.

Despite the best will of the clinical ethicist, the insidiousness of his position shows in this consultation. This first instinct when he is apprised of the request for the consultation is to read Mrs. Rose's chart. He behaves just like any other health care professional in the hospital would. When he becomes uncomfortable in his conversation with Paul, he lapses into the stance of a professional

helper and falls back on the impersonal institutional voice. And, most important of all, neither he nor his colleague confronts the attending physician. His colleague advises Mrs. Rose's four children (when and how did Janice become involved again?) to speak directly with the attending, and they wait in his office until they can do that. Neither clinical ethicist accompanies the children nor participates in the meeting. They hear about the meeting from the children.

iii) To Save the Institution

How ambitious should clinical ethics be? A modest approach to ethical problems in health care is to patch them up: try to rectify what has gone wrong by mitigating the harm that has resulted and pacifying the bad feelings that have arisen. Any attempt to prevent future recurrences is limited to the individual situation and the involved parties. A clinical ethicist, in this view, is a peacemaker. The clinical ethicist keeps the peace for hospital staff by smoothing over conflicts. The clinical ethicist puts patients and families who have to make agonizing choices at peace by easing the burden of that decision making.

A more ambitious approach is to identify the underlying institutional or structural features that generate ethical problems and change or remove them in a more sweeping effort at prevention. A clinical ethicist, in this view, is a social activist. The claim that the point of "doing ethics" is social and institutional reform and that the clinical ethicist is a moral reformer, while nobly hortatory, has always struck me as false to the facts of clinical ethics. The report of this consultation on Mrs. Rose's care simply reinforces that impression. All the underlying forces that conspired to keep her connected to a ventilator – professional uneasiness with uncertainty, poor communication, and entrenched power – are untouched by the ministrations of the clinical ethicist. The belief of the health care professionals that "good medicine" requires an aggressive, determined search for the definitive causes of a patient's deterioration remains untempered. The possibility that families in similar circumstances in the future will have to "camp out" in the attending's waiting room in order to see him still exists. Physicians will continue to write orders for large dosages of morphine, and nurses will continue to administer those dosages with trepidation. And, most important of all, the fate of patients will remain unequivocally in the hands of their attending physicians.

The consultation did put Mrs. Rose's family at peace, an eminently worthy contribution. At the same time, though, the consultation saved the fragmented, authoritarian structure of health care that makes it so difficult in the first place for patients to go, and their families to let go, in peace.

Conclusion

The practice of clinical ethics is both generated and constrained by the organization and structure of health care. Given that context, what can reasonably be expected of it, and of those who do it, is seriously limited. Effective communication is hard in the midst of shift schedules, rotation systems, multiple caregivers from diverse sectors of health care, increasing workloads, and decreasing resources. And despite having the responsibility, in theory, for making health care decisions, patients and their families still must, in practice, fight the traditional ethos of medicine and the hierarchy in which it is embedded to make their voices heard and to have their values respected. Ethics consultants do what they can to help patients and their families escape the clutches of complexity, hierarchy, and power. What they can offer more successfully, though, is consolation. By providing comfort, ethics consultants do much to fulfill their mandate of making health care more humane.

Acknowledgements

I thank Mark Bliton, Stuart Finder, and Richard Zaner for inviting critical assessments of their work and for their commitment to improving the enterprise of clinical ethics consultation. I also thank all three for their helpful critique of a draft of this paper.

References

- Ashley, B.M. and O'Rourke, K.D. (1989). *Healthcare Ethics* (3rd ed.). St. Louis: Catholic Health Association of the United States.
- Bliton, M.J. (1999). Ethics Talk; Talking Ethics: An Example of Clinical Ethics Consultation. *Human Studies* 22(1): 7–24.
- LaPuma J. and Schiedermayer, D.L. (1991). The Clinical Ethicist at the Bedside. *Theoretical Medicine* 12(2): 141–149.
- May, W.F. (1994). The Virtues in a Professional Setting. In K.W.M. Fulford, G.R. Gillett, and J.M. Soslke (Eds.). *Medicine And Moral Reasoning*. New York: Cambridge University Press.
- Payer, L. (1988). *Medicine & Culture*. New York: Henry Holt.
- Singer, P.A., Pellegrino, E.D., and Siegler, M. (1990). Ethics Committees and Consultants. *Journal of Clinical Ethics* 1(4): 263–267.