Chapter 2
Diversity in Clinical Ethics

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2.1 Introduction

In this paper, I address the question: "What implications does diversity have for the field of clinical ethics?" It is commonly recognized that development of clinical ethics and consultation was stimulated by the "the complex value-laden nature of clinical decision-making, the pluralistic context of contemporary society that is reflected to various degrees in clinical settings the world over, and, perhaps most importantly, a growing recognition of the rights of individuals and their implications for patient care" (Aulisio and Arnold 2008, 418). It is less commonly considered, however, how and why pluralism or *diversity* of the field itself might be an essential feature of clinical ethics as a practice. In this paper, I argue that diversity is more than an important external factor that gave impetus to the field or that provides the field much of its everyday challenges; in addition, it is an internal feature of the practice itself that needs to be understood in its own terms. The theme of diversity in clinical ethics is, of course, not new, but consideration of "internal" diversity is frequently subsumed in other concerns and not assessed fully as such.[1]

I argue that diversity in clinical ethics presents itself in two related, but distinguishable manifestations; first, in the largely conceptual or theoretical reflections on

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[1] To be sure, sensitivity to diversity is now a common concern in health care institutions and training in diversity is commonplace. I shall not address or assess these efforts to raise the sensitivity of health care providers to the practical problems posed by caring for patients and their families with different cultural, ethnic, or religious backgrounds, beliefs, and commitments, because they lie outside the focus of this paper.

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clinical ethics and ethics consultation and, second, in the practices, structures, and processes of clinical ethics and ethics consultation services. These aspects of diversity in the field are located across three distinguishable domains, which I characterize as the educational, process, and philosophical. Although these domains are interrelated, it is useful to distinguish them for the sake of analysis since the issues posed within these domains have different implications for the field. In discussions about clinical ethics and ethics consultation, these domains are often merged, which contributes to some of the confusions characterizing the field. For analytical and discussion purposes, I discuss these domains as *aspects* of the way that diversity is at issue and not because I believe that the domains are in any substantive sense separate. I claim that diversity within the field of clinical ethics is often taken as a problem to be corrected or as a mark of the field's immature status; hence, diversity in clinical ethics is disvalued. Diversity is seen neither as a characteristic of an innovative spirit in the field nor as a resource for improvement of practices. Finally, the fundamental and irreconcilable value commitments that are the deep challenge that diversity represents are treated, if at all, as marginal concerns.

Historically, attention to diversity in the emerging field of clinical ethics was framed first in terms of questions that have come to dominate the field of clinical ethics and consultation ever since. Should ethics committees, teams, or individual consultants provide ethics consultation services?[2] What kind of professional qualifications and education should the ethics consultant possess?[3] Should consultants be credentialed, formally certified, or licensed?[4] Does clinical ethics and consultation alter the distribution of power among families, physicians, patients, and nurses in ways that compromise patient care and subvert health professional values?[5] Should ethics consultants or advisors ever be tolerated in liberal, democratic societies since such advisors occupy positions of authority that threaten, rather than enhance, personal autonomy?[6] These questions are critical for the field given that ethics consultation services and hospital ethics committees are ubiquitous features of contemporary health care not only in North America where they first developed, but also around the world.[7] That said, it is important to note that

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[2] See, e.g., Cohen 1992; Gramelspacher 1991; LaPuma and Toulmin 1989; Ross 1990.

[3] See, e.g., Ackerman 1987; Barnard 1992; Beauchamp 1982; Cranford 1989; Grunfeld 1990; Jonsen 1980; LaPuma and Schiedermayer 1990, 1992; Marsh 1992; Morreim 1983; Thomasma 1991; Zaner 1984.

[4] See, e.g., Engelhardt 2009; Fletcher and Hoffmann 1994; LaPuma and Priest 1992; Spike 2009; Tarzian 2009, 2013; Task Force on Standards for Bioethics Consultation 2010.

[5] See, e.g., Agich 1995, 2000.

[6] See, e.g., Agich 1995, 2009c; Agich and Spielman 1997; Casarett et al. 1998; Slowther et al. 2001b; Spielman and Agich 1999; Wikler 1982; Wildes 1997; Yoder 1998.

[7] See, e.g., Aleksandrova 2008; Borovecki et al. 2005, 2006; Forde et al. 2008; Graf and Cole 1995; Guerrier 2006; Hurst et al. 2007a, b; Lebeer 2005; Melley 2001; Meulenbergs et al. 2005; Mino 2000; Newson et al. 2009; Newson 2009; Parker 2002; Reiter-Theil 2001a, b; Richter 2001; Robles 1999; Schlaudraff 1992; Slowther and Underwood 1998; Slowther et al. 2001a, b; Sorta-Bilajac et al. 2008; Steinkamp 2003; Tan 2002; Wray 2002.

the thrust of much of the literature addressing these questions is toward reducing or, even, to eliminating diversity.

In 1983 only 1 % of US hospitals had ethics committees, but, by 1989, the number had grown to more than 60 %, and to more than 93 % by 1999 (Fox et al. 2007; Youngner et al. 1983). A 2001 study found that all US hospitals with more than 400 beds, federal hospitals, and those that are members of the Council of Teaching Hospitals have some form of ethics consultation available (McGee et al. 2001). Hospital ethics committees are at least as prevalent in Canada as they are in the United States, and their presence is growing elsewhere around the world, sometimes in cultural, legal, and religious settings that are very different from where it originated. It is important to recognize that the expansion of the field of clinical ethics is due more to external factors than factors internal to the field itself. Instead of growing out of the emergence of cadres of specifically trained specialists in clinical ethics and ethics consultation, the field was populated from a wide variety of academic and professional sources: ethics and philosophy, religion, law, medicine, nursing, as well as allied health as health care institutions sought to address external pressures from accreditation, health care professional, legal, and social influences. This has resulted in a field that from its inception has been exceedingly diverse in its professional makeup and orientation as individual health care institutions addressed the growing concerns with ethical issues arising in the direct care of patients.

Clinical ethics has been seen as a response to increasing ethical problems in health care arising from the pace of development in medical sciences and technologies and to changed health care institutional structures. But it is also a response to ethical problems associated with an increased diversity of social views on the purposes of health care services and the erosion of traditional structures of authority in medicine, primarily the authority of the physician. The dynamics of change in the cultural, ethnic, religious, and social values and beliefs impacting health care further complicates developments within medicine and creates a fertile ground for ethical questions. Although the actual responses of health care institutions to these developments are complex and variegated, they have come to be seen within the frame of clinical ethics. The claim I will explore in this paper is that the inherent complexity of the set of activities and practices that has actually developed under the rubric of clinical ethics within healthcare institutions has not been sufficiently reflected upon in its own terms. When it comes up, the complexity and diversity *within* the field of clinical ethics is dealt with either obliquely or as a problem rather than as an essential feature of the field that needs to be understood.

Awareness of diversity in the field is, of course, hardly new. It was noted quite early as a set of concerns about the way that ethics and law "intruded" into the physician-patient relationship to such an extent that "strangers" gained access to the bedside or clinical space and ultimately to some of the "control" of this space (see, e.g., Blake 1992; Fleetwood et al. 1989; LaPuma and Schiedermayer 1990, 1992; Lo 1987; Rothman 2003; Siegler 1986; Siegler and Singer 1988). These discussions or debates were sometimes acrimonious as the following titles indicate: "Reflections of a Reluctant Clinical Ethicist" (Barnard 1992); "What Philosophers Can Offer" (Beauchamp 1982); "Why Physicians Should Not Do Ethics Consultations" (Marsh

1992); and, "Why Philosophers Should Offer Ethics Consultations" (Thomasma 1991). These early discussions have mutated to seemingly less pointed discussions about the qualifications of consultants, the techniques or methods for doing ethics consultation, or about the underlying philosophical basis or meaning and scope of the practice. Here, I argue that at or near the core of these disputes is the phenomenon of diversity *within* the field, which tends, without much supportive argumentation in these discussions, to be regarded as a danger or problem. I challenge this assumption and offer an alternative take on the diversity in clinical ethics.

For convenience, I aggregate these discussions under three points: first, the educational prerequisites or qualifications necessary for doing ethics consultation; second, the ideal technique or method of ethics consultation; and third, the philosophical or theoretical underpinnings of the field of clinical ethics and consultation. The literature addressing these areas, I contend, is implicitly committed to the pursuit of consistency, standardization, or uniformity for the field, features which are valorized without much argument, thereby casting diversity as a deficiency or problem. I will show this in passing since a comprehensive literature review on these points is beyond the scope of the present paper. Instead, I argue that diversity is addressed, if at all, only obliquely through other concerns that seem to be motivated by a deep suspicion. Nowhere is this suspicion adequately defended. I conclude that this concern for and push toward consistency is misplaced and that more attention needs to be paid to the advantages that diversity brings to the field.

2.2   Educational Aspect

There is significant discussion and, even, controversy about what qualifications, specifically the knowledge and skills, individuals who provide ethics consultation services should possess or demonstrate. Correlative concerns include a) what are the best or at least defensible educational or training practices, and b) how should competence in relevant knowledge and skills be demonstrated to assure that ethics consultants are able to provide competent, quality services. Implicit is an advocacy for standardization of training and a tacit assumption that there is a real and, some would say, a pressing need to assure that a set of defensible or accepted standards[8] are met by those offering ethics consultation services. Although not explicitly stated, much less defended, there is a perception or belief that there are deep problems of quality or competence in clinical ethics that underlie the variability of the types of individuals, organizational structures, and processes and procedures used in delivering clinical ethics services. Sometimes, this is articulated as a call to professionalize the field, which implies that a consensus about the qualifications for providing ethics consultations services is either shared or achievable. It is assumed that such qualifications apparently should be universally shared by ethics consultants with

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[8] I say "defensible or accepted standards" and note that defensible and accepted are two very different visions of the validity of standards.

little regard for the differences of local culture or institutional setting in which they practice. These discussions, ironically, occur in the face of the historical development of the field, which has experienced not only an incredible expansion of clinical services, including ethics committees and ethics consultation, around the world, but an expansion that involved adaptation to local settings thereby yielding the complexity and differences that worry proponents of standardization.

This much is uncontroversial. First, the field has a set of practitioners—physicians, nurses, and other health care professionals; social workers; chaplains; philosophers; bioethicists; and those who primarily see themselves as specialists or, at least, competent practitioners in the field of clinical ethics and this set of professionals have no common disciplinary or educational background. This fact alone certainly raises a question about the knowledge or capacities of these individuals to provide clinical ethics services, but it is not clear why this question leads to the conclusion that this situation is problematic. Second, although clinical ethics is practiced in the context of patient care, the settings in which patients receive care are incredibly diverse. These settings include healthcare institutions such as general community hospitals and specialty institutions, such as those focused on cardiac or psychiatric care; they include small hospitals with limited services as well as large comprehensive medical centers providing advanced or innovative treatments with research and education of health professionals as important aspects of the institutional mission. Patient care is also provided in nursing homes and outpatient clinics as well as long term care or rehabilitation institutions. In addition, health care institutions exist and operate within widely varying cultural, political, religious, and social environments. The tendency in the literature to focus on specifically *ethical* problems or conflicts, which are seen as somehow different from cultural, ethnic, political, religious, or social commitments has obscured the importance that the actual context has in shaping the problematic that gives rise to the need for clinical ethics. So, why should clinical ethics services be standardized in the face of such a diversity of contexts? Or, not to deny that some features of the competences of ethics consultants might be universally shared across the contexts in which they practice, should context be addressed at all in determining the core competences of ethics consultants and, if so, then isn't the core more complex and variegated than is sometimes assumed?

Beyond the institutional level, there are many different types of units or services in which patients receive care for a wide variety of medical or health problems. In these settings, practitioners function with specialized skills and confront clinical and value problems and concerns that are frequently unique to the particular setting. For example, despite the overlaps and commonalities in end of life decision-making, the clinical, emotional, psychosocial, and, indeed, ethical features of the cases for which ethics consultation services are sought can vary widely from pediatric to neonatal critical care no less than from general pediatric to adult (including varying specialized units). In addition, the underlying "philosophies" and operating procedures of the units themselves, which include the personalities and communicative practices on said units, contribute to, if not shape, how ethical problems arise and are expressed. So, should the core qualifications of one deemed to be qualified to do

clinical ethics in a specific patient care setting address these complex factors that contribute to the emergence and articulation of ethical concerns, conflicts, and questions or just some representative range of them? If so, then perhaps the focus on defining qualifications to do *clinical ethics as such* is insufficient and the conversation should further attend to the specific knowledge or skills that are prerequisite for an ethics consultant to function competently *in defined settings*.

Finally, the cultural, religious, social, and legal context in which patient care is provided also varies widely. The diversity of patient populations as well as health care providers themselves represent a wide spectrum of economic, ethnic, political, and religious beliefs and values that further obfuscate a rather murky picture. In light of these points, I conclude that it is not surprising that clinical ethics displays a striking degree of both complexity and diversity since it has emerged as a response to an inordinately complex set of needs and circumstances. These needs and circumstances share a family resemblance, but not necessarily a set of essential features. Clinical ethics and ethics consultation may be a heterogeneous rather than a homogeneous concept. Although commonalities may exist, stressing them to the exclusion of the deep differences that comprise the field of clinical ethics may seriously distort the reality of clinical ethics.

It might be rightly objected that even though diversity undoubtedly is present in clinical ethics, it does not represent an ineliminable problem since there is a core knowledge of ethical concepts, principles, and theories that should be shared by all clinical ethicists. This core knowledge should be the main part of the basic education for being a clinical ethicist and demonstrated proficiency in ethical concepts, principles, and theories should be required of all who operate in clinical ethical roles. This view, which is implicitly held by many commentators, however, overlooks the deep disagreements that characterize the field of bioethics and ethics regarding ethical concepts, principles, and theories. At the level of concepts, theories, and principles, one is hard pressed to point to a demonstrable consensus on these matters. Some might point out that the law or, in its absence, health care ethics policies and/or professional ethical guidelines cuts through this problem by providing socially approved frameworks and substantive guidelines for decision-making. But even if one accepts such a view that social consensus expressed in laws, institutional ethics policies, or professional guidelines provides a reliable and normative guide in clinical ethical matters, we have to recognize that the law, institutional ethics policies, and even professional guidelines are dynamic and are somewhat shaped by clinical ethics itself. These sources of normativity are complex and sometimes inconsistent; furthermore, they are invariably subject to interpretation and application. The appeal to consensus at this level is thus fictive at best, since at the point of interpretation and application complexity and diversity again rears its head. Controversies surrounding the ethical and logical status of the fetus, the questions of access to health care, and end-of-life decision-making such as assistance in dying represent divisions and disagreements that are culturally, ethnically, legally, religiously, and, of course, ethically distinct and seldom reconciled. I do not doubt that there are cases and situations in which resolution is possible since the success of clinical ethics attests to this possibility, but to assume, even tacitly, that this can be

brought about simply by a canonical appeal to some normative foundation that underlies the field and comprises the core knowledge base for clinical ethics is preposterous. Controversies about foundational normative commitments are resistant to resolution, because of deep and irreconcilable beliefs and values (Engelhardt 1996, 2006), though they are, of course, subject to discussion and refinement even if not resolution on the theoretical level. Practical or pragmatic accommodation can occur, but such accommodation will not satisfy and will possibly offend those with dogmatic normative value commitments. However, there is a remarkably wide range of interpretations and understandings about what one's beliefs and values involve, especially when one is confronted with a loved one in an experientially novel clinical situation. To achieve situation-specific resolution—and what this means—is a practical problem of the first order that is highly influenced by communication and the empirical facts of the case, but it is ridiculous to assume in advance that any particular theory will be decisive.

The skills for seeking common ground or reasonable accommodation in the face of clinical circumstances can, of course, be achieved, but there is no evidence that there is a best or ideal approach for all of these various contexts and types of situations even at the practical level. Some features of many approaches might be useful and identified for wide adoption by clinical ethicists, but no one has shown that a single best approach exists, though there is enthusiasm for a number of approaches, such as mediation (Dubler and Marcus 1994). There are many reasons, however, to doubt that a standardized approach could work across the wide range of ethical concerns, conflicts, and questions that come to the attention of ethics consultants.

That said, it is important to recognize that clinical ethical concerns, conflicts, and questions may cluster and that specific settings of healthcare institutions or individual patient care units tend to localize these types of clinical ethics problems. Recognizing such clustering, it is important to stress that one can always develop or tailor approaches to address recurring problems. Identifying such "best practices" for clinical ethics and consultation is, of course, desirable. Doing so, which I certainly support as one proper focus in the field, however, does not warrant the conclusion or fortify the hope that an ideal approach will emerge over others which might in some way be standardized. In my view, commonly occurring ethical problems or issues might best be approached not primarily through individual case consultation anyway, but through the development of procedures that are expressed in ethics policies, unit guidelines, staff development, or unit quality improvement projects.

Some would undoubtedly respond that even when irreconcilable differences or conflicts occur, they can be resolved, because the principle of patient autonomy and the concept of patient rights can cut through the morass. Therefore, education of the clinical ethicist in patient advocacy and the promotion of patient rights should be a primary element in the education of clinical ethicists. But surely this does not cut deep enough. For example, a woman who autonomously decides for an abortion or assistance in dying still needs compliant health care professionals to provide such services and also a permissive legal and institutional framework that provides the services. So, again, the commonly assumed normative priority of patient autonomy may in some settings actually cause the clinical ethical issue to arise, but have lim-

ited utility in its practical resolution. It is hard to see how, given the diversity of actual clinical settings and social contexts, a reliance on patient autonomy can provide practical traction in non-supportive circumstances.

The ethics consultant is often called to negotiate how the competing rights or, more often, values can be accommodated. Defending a patient's autonomous decision-making is ethically acceptable when deep concerns about the motives of or reasons for a patient's decision are not in question or when health professionals are acting paternalistically. However, when it is reasonably clear that a patient's decision, for example, to forego a clearly beneficial intervention is primarily based on a mistaken assessment of the burdens that impaired survival might pose for loved ones, cutting through the complexity of conflict with the family by appeal to patient autonomy alone would be irresponsible and Procrustean. Similarly, when family or surrogate decision-making is itself compromised by misunderstandings, emotional or other conflicts, but health professionals have reliable knowledge of patient wishes expressed during the course of earlier treatments, then simply accepting the legal surrogate's decision would be as unjustified as would acceding to the preferences of health care professionals based on their "professional" assessment that fails to take into account patient/family values. Much more analysis and discussion is needed for the ethics consultant to ferret out the layers of value conflicts or misunderstandings, a process that surely should accommodate respect for autonomy, but which involves processes of communication and interpretation not derivable from patient autonomy in any standard bioethical understanding.

The assumption or hope that one primary and canonical ethical content can enable the clinical ethics consultant to successfully address the wide range of ethical concerns that arise in the course of patient care is naïve or, at its worst, dangerous. Some conflicts will be irreconcilable just because the beliefs and values are at bottom incompatible and in conflict. As a matter of fact, these kinds of cases are handled in a variety of ways by clinical ethicists and their health care institutions; some of these approaches are arguably based on standard normative or theoretical ethical commitments, but it is another matter to understand how these normative principles or theories actually drive the solutions that are reached. No single principled approach will reliably enable one practically to cut through the empirical morass in all cases and health care settings. Even when there is apparent consensus at the normative level, diversity in approach is not only practically unavoidable, it is necessary. Psychosocial considerations and personal preferences or existing operating procedures will complicate and shape the ways that the cases are handled by ethics consultants. In point of fact, these kinds of restraints cannot be reliably removed or overcome by appeal to any known procedure or theory. Success in clinical ethics as in any practical undertaking is an empirical matter that has to be achieved repeatedly in different circumstances. Success depends both on the actual clinical setting and circumstances of the case and the actual ways that the ethics consultant approaches the case and not on some gold standard approach or method.

For example, a liberal commitment to support autonomous patient choices, defensible though it may be, should not be applied without qualification. Cases in which patient's choices differ from that of the family or health professionals, who

find the patient's choices to be unethical and, so, unacceptable because of their understanding of the patient or patient's clinical situation, need an assessment and handling that is more nuanced than simply applying the principle of patient autonomy. For this reason, some have advocated that the education of ethics consultants and clinical ethicists should primarily consist in developing a set of skills that allow the mediation or resolution of value conflicts. This response moves the worries about the disagreements on the normative or substantive value foundations of clinical ethics to one side and instead attempts to address diversity and complexity in clinical ethical situations through a uniform practical approach.

I mention only two problems with any approach that relies on a single technique to the exclusion of others. First, although I have spoken of conflicts and disagreements, which admittedly appear to call forth a set of skills at mediation or resolution, there is no reason to believe that clinical ethics only, or even primarily, deals with conflicts as such. The literature, sparse on this point though it is, does not support this belief nor does informal or personal communication among ethics consultants. If the ethical question is one of the application or interpretation of a law or institutional ethics policy, which the involved patient, family, and health care providers readily agree they will accept and follow, it is hard to see how the skills at mediation or conflict resolution would be helpful. Rather analytical, communicative, interpretive, and educational skills would be necessary and they, of course, would need to be grounded in a firm knowledge of the relevant laws or policies. This is especially important since it is widely recognized that communication problems much more than conflicts in ethical beliefs and values predominately underlie requests for clinical ethics involvement. Clearly, expertise in approaches to resolve conflicts, disagreements, or disputes alone would not be sufficient and, in fact, might be disruptive. Other skills—indeed, a rich and diverse tool bag of skills—are needed to allow the ethics consultant to respond effectively to the wide set of communicative occlusions over patient care decision-making that comprise clinical ethics consultation work. Conceding that such a tool bag would need to include some capacity to arbitrate disputes, mediate conflicts, or settle disputes, however, does not imply that reliance on any of the formal techniques of arbitration, conflict resolution, or mediation would be primary or sufficient. Indeed, such reliance might be seriously disruptive. The important point is that interactional skills that round out knowledge and communication skills are essential in any practical domain, clinical ethics included, but these are not well understood (Collins 2004; Collins and Evans 2002, 2008).

Second, some cases come to the attention of ethics consultants not because patients, their families, or health professionals lack effective communication or understanding and so need help in finding an ethically defensible course of action. Rather, they arise even when there is no conflict. For example, patients, family members, or health care professionals can be confused or uncertain about the ethical justification for certain clinical choices. There is acceptance, sometimes tacit, of the relevant ethical values and/or applicable institutional policy or law, but uncertainty about how to apply them or to draw out the implications that these normative guidelines or principles have in the particular circumstances of the case. They do not seek

help to reconcile differences, much less conflicts, but *assurance* about the ethics of a certain course of clinical action. Again, it is hard to imagine that specialized training in mediating disputes or resolving conflicts would be sufficient, much less relevant.

In short, I am both arguing and suggesting that the diverse backgrounds of those providing clinical ethics services, including both their knowledge and their practical skills of analysis, communication, discernment, interpretation, mediation, and a wide array of other specific skills that ethics consultants draw on, might at least be regarded as a strength of the field rather than a weakness or deficiency that needs to be corrected through some process of standardizing the education and training of clinical ethicists. If such diversity is correctly regarded as a strength, which I believe it is, then the project of advancing the field of clinical ethics and consultation is better served by undertaking the difficult task of identifying the *typical* knowledge and skills that effective ethics consultation services in specified or particular settings or contexts rely upon. The complexity and unpredictability of cases coming to the attention of ethics consultation services suggests that the ideal consultation service would include not only a range of expertises—possessed either by expert individuals or a team—but also a commitment to and, perhaps, formal processes for collaboration and consultation among ethics consultants on cases and problems that challenge the responding clinical ethicist. Individual consultants must, too, have flexibility in approaching cases. It is doubtful that any rigidly applied normatively justified approach would work across a wide range of cases.

How can such a capacity be developed? Experience is clearly needed, either direct or indirect. That is why the practical purposes of improving ethics consultation can be partly achieved through the practice of monthly or quarterly review of cases. However, it should be pointed out that such review occurs after the fact and so is removed from the actual dynamic of the clinical circumstances. Such discussion, though useful for learning about ethics consultation, is often regarded, without foundation in my view, as oversight or supervision of the clinical service when done by an ethics committee as a whole. Even so, this practice is a move in the right direction, but it is incomplete if the ethics consultants themselves are not *reflective practitioners* (Schön 1983).

Nothing in what I have said should be taken to imply that I think there is no common knowledge or no basic set of skills that are fundamental to ethics consultation. I am simply questioning the grounding for the claim that there is a single ideal set of such skills. Since the circumstances of clinical ethics practice varies so widely, it may be that a variety of "core" or "basic" skills could—and should—be enumerated and defended as features that a competent clinical ethicist in a particular set of clinical situations should possess. However, this point should not be interpreted to mean that no set of universal "basic" or "core" content for the field exists, but only that we should be open to a range of understandings of what actually constitutes this "core." Rather than defending skepticism about the existence of a basic knowledge and skills for doing clinical ethics, since that is an empirical matter, I am arguing that the field should focus on trying to identify what knowledge, process, and skills are actually essential for competently addressing typical kinds of ethical problems arising

in specific types of clinical settings. We should be open to discovering that the "core" is differentiated or variable for various practice settings. We should also recognize the limits of such core knowledge for actually doing ethics consultation since practitioners must learn from experience to mature in competence. Unfortunately, efforts to define an ideal core or common curriculum have overshadowed attention to the varieties of ethics consultation experiences. The American Society for Bioethics and Humanities Clinical Ethics Task Force rightly recommended that the particular education needs for ethics consultants should be framed in terms of a personal assessment of the individual's particular setting and situation (2009), but the significance of this point is seldom appreciated. The relevance of any putative knowledge or skills should be determined at least in part by reference to the practice setting and consultant's existing knowledge and skills. Thus, a solid appreciation of the typical settings and the typical clinical ethics problems faced is needed before we can design effective programs of training ethics or credentialing consultants. We should not be surprised or alarmed if training programs emerge that have different visions of clinical ethics. Proponents of standardization have failed to appreciate that the diversity of ways in which clinical ethics is actually practiced in clinical and healthcare institutional settings may be an asset. A careful and thorough examination might show that differences that first appear questionable or even objectionable may actually be adaptations to specific circumstances. Understanding how ethics consultation is actually practiced would thus provide a more reliable basis for identifying what might be a defensible "core" knowledge base or skill set for clinical ethics. Instead, the tendency in discussions of clinical ethics education is to propose a requisite content without linking that knowledge and skills to the demands of actual practice settings.[9]

Above all, one needs to accept that clinical ethics is a *doing* (Agich 1990, 2005, 2009); it is a practice and the rules that guide its performance are internal to the practice and so need to be internalized by individual clinical ethics consultants and put into action as they engage in doing the various activities that comprise the work of clinical ethics consultation (Agich 1995, 2001, 2009a). Too much attention, in my view, has been devoted to statements of curricular design and content for the education or training of new ethics consultants in abstraction from the performative acts that comprise a successful clinical ethics practice. Furthermore, there is insufficient discussion regarding how to implement ethics consultation services that foster the commitment to continued improvement of the requisite knowledge/skills.

This is evident in discussions around the topic of credentialing or certifying ethics consultants where it is often granted that individuals already doing ethics consultation will or can be "grandfathered" into the field of "qualified" or "certified" practitioners. Although this may be politically expedient, it surely avoids the

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[9] Many might point out that many programs accomplish this point by requiring a "clinical" component. But some of these clinical tracks are merely observational experiences in clinical settings led by clinical colleagues. It is hard to understand how an effective clinical ethics training program could succeed in developing competent clinical ethics practitioners without a significant experience in a supervised clinical ethics consultation practice.

important need for ongoing education and improvement and provides no real assurances regarding the competence of those grandfathered into the field. Too much of this discussion is focused on training novices in clinical ethics or setting minimum eligibility requirements for being called a clinical ethics consultant and too little on the need for continued education and improvement. The use of quality improvement (QI) projects in the field is likely a more promising approach for the field to undertake as a measure to improve its stock of competence. Such projects have the virtue of translating ideas into actions that are observable, measurable, and focused on the achievement of specific clinical ethical outcomes or goals in particular patient care settings. In QI the outcomes are achieved through *changes in the practices of patient care*, which is, after all, the central purpose of *clinical* ethics.

Thus, the challenges of education in clinical ethics will not be exhausted even if or when a core curriculum or set of minimal standards for the field is formally established since the singular importance of continuing education and refinement of skills that is the hallmark of competent practitioners in a field as dynamic as clinical ethics would still need sustained attention. In all of this, it is hard to see how a single canonical approach will provide substantive help. To be sure, a common approach would provide a standardized vocabulary and shared framework, but that will not *substantively* resolve diversity. It may cover it up, but that is not a defensible outcome. In the end, responses to the educational needs of clinical ethics will understandably continue to mirror the complexity and diversity of clinical settings and clinical ethical challenges that clinical ethics services are intended to address.

2.3   Process Aspect

This discussion leads me to the second theme that can be discerned in discussions about ethics consultation services, namely how they should be organized and delivered, and which methods, processes, or techniques should be followed in providing and improving clinical ethics services (Agich 2009b, d; Dubler et al. 2009; Swiderski et al. 2010). Clearly, this is correlated with the concerns about the educational requirements or qualifications for doing ethics consultation—the so-called content of the field—but it goes beyond the matter of prerequisites of either knowledge or skill to the procedures or techniques that are actually put into practice in doing ethics consultation. These concerns about the process aspects of ethics consultation are often characterized as methodological concerns, but this is a mistake since the question of method in ethics consultation is a much more complex and involves an elaborate set of issues beyond the practical rules that guide clinical ethicists as they go about their work (Agich 2001). For this reason, I term this aspect the *process* aspect, though many of my comments can be seen as addressing what others would call the methods of doing clinical ethics or ethic consultation.

A common way to respond to questions about which model(s) or approach(es) should ethics consultation services adopt is often expressed in terms of an advocacy for one or another approach to the exclusion of others. There is, of course, little doubt that the skills imparted in various approaches to doing ethics consultation can be helpful, but as the literature on expertise amply shows, skilled or competent consultants draw on a variety of techniques or approaches to a presented problem rather than relying on a single, canonical one (Agich 2009b; Collins 2004; Collins and Evan 2002, 2008; Dreyfus and Dreyfus 1991; Schön 1983). Competent practitioners tailor their actions and responses to the elements of the question or problem at hand and are deployed in an organic rather than mechanical fashion. They do not force problems into preconceived formats. Judgment or discretion is used and often it is exercised unreflectively or even pre-reflectively.

Saying that does not imply that clinical ethics consultants function best when they lack a framework or style of approach, but rather that any style or technique will need to enacted (Agich 2001, 2009a). Furthermore, the approach must be *appropriate or suitable* to the *circumstances of the clinical case*. Consider the following. An ethics consultant finds a health care professional who has moral concern or qualms about a particular clinical decision and decides to address this simply by providing an analytically apt and philosophically sound argument about the ethical justification for the decision. In some situations and for some health care professionals, achieving intellectual clarity on the question would undoubtedly be appropriate, but for others the concern or qualms might require more than cognitive clarification. Instead, assurance that involves a personal or emotional communicative engagement with the distressed individual is needed. So, one should not be surprised if the consultant who merely and routinely offers only analytically sound advice finds that the advice is ignored.

The same situation would be poorly handled by criticizing the health professional for an ill-informed and unjustified belief. Also, simply informing a distressed health care professional that because a clinical decision had already been reached or action already undertaken—say by the attending physician—that there is no conflict of decision-making and therefore no reason for an ethics consultation would be equally questionable. The moral distress of the individual would be thereby devalued and the perception that ethics consultation has nothing to offer in future cases could be reinforced. One could give many other examples of the inappropriateness of a particular approach to a distressed health professional. The lesson here is that application of *any* approach without a careful assessment of its appropriateness to the circumstances is risky. Nonetheless, there is a tendency in the literature to promote preferentially certain approaches in clinical ethics consultation over others.

This tendency to advocate one way over others of doing ethics consultation seems to rest on the belief that a diversity of approaches and ways of handling a problem is a sign of weakness or, worse, incompetence. One reason for this assumption is that many such advocates appear to have vested interested in promoting their way of doing things or simply do not have a broad enough experience in clinical

ethics to appreciate that diversity may represent a mark of maturation in a consultant or the adaptation of the field to local circumstances over time. Proficiency in the techniques that they promote is tacitly taken to provide the tools sufficient for competency in clinical ethics as such. They naturally think that diversity in the field represents a failure to adopt and perfect a particular approach rather than being a reflection of the adaptability of the field or of ethics consultants. In addition, it is doubtful that successful consultants who advocate a particular approach over others do in fact *only* use the recommended approach in all cases. That is, of course, an empirical point that is certainly worth investigating, but I will observe that in my experience as a consultant to ethics consultation services and clinical ethics programs success often involves a more complex and wider set of behaviors than the practitioners themselves actually profess.

A more defensible alternative to advocating any one singular approach is to recognize that a tool bag or repertoire of skills and knowledge is a necessary rather than a fashionable accoutrement for the ethics consultant. This implies that the techniques that are best in clinical ethics are those that *work* in the context of the given clinical case situation.[10] It also implies that competent clinical ethicists will be able to recognize not only what is needed, but also what to do if the appropriate approach to the problem is beyond their capacities. In this instance, as I have pointed out, they should have access to and support for collaboration or referral. Deciding what approach will work best cannot be known in advance, which is why flexibility and adaptability is a desirable character trait of competent ethics consultants. Saying this is consistent with trying to identify what are typical clinical situations or problems and what approaches actually tend to work best. That is possible only if there is a detailed body of case reports that document the actual processes and procedures of the ethics consultation. Such a body of case reports can enlarge the experiential basis for ethics consultation. Too often, case reports highlight theoretical ethical points and only summarize or condense the actions of the clinical ethicist, if they document them at all, or the reports follow a format which repeats the mantra of the subscribed approach. For instance, a report that records that a family meeting occurred and that a particular decision was reached, but not a narrative of the actual discussions, is misleading. Even when a narrative is provided, it tends to focus on what others say, is the "content" of the case, but not the actions of the consultant and the reasoning underlying the particular actions. In this regard, the literature on the reflective practitioner might provide valuable insights for how the field of clinical ethics might think about its activities (Schön 1983). Rather than promoting a single best approach to clinical ethics and consultation to the effacement of others, the field needs to create a space for dialogue about common kinds of challenges that clinical ethicists face and the techniques shown to be effective in dealing with typical challenges.

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[10]This point, of course, needs considerable discussion. A wide range of questions are immediately raised such as are there normative standards for "what works" or how and by whom is success determined. These are, unfortunately, beyond the scope of this paper to explore.

2.4 Philosophical Aspect

Third, advocacy for a particular methodology and training regimen is paralleled by a concern to establish or clarify the philosophical foundation of the field. A firm theoretical foundation is thought to be essential for establishing the legitimacy of clinical ethics generally and ethics consultation specifically. This concern has a long history, originating with the emergence of bioethics as an interdisciplinary field, and this concern has understandably been ported to clinical ethics and consultation (Arras 2009; Beauchamp and Childress 2001; Gert 2004; Gert et al. 1997; Jonsen 1991; Jonsen and Toulmin 1988; Kuczewski 1998; Toulmin 1982, 1981). I find this concern paradoxical to say the least given the attack on foundationalism by so many contemporary thinkers.

Perhaps more to the point, the field of clinical ethics and consultation has by all measures done exceedingly well without a foundational theory.[11] It has expanded greatly from its origins in the United States and Canada to the rest of the world, a development which would seem improbable at best and impossible at worst if a canonical method or philosophical foundation was essential. Interestingly, none of the proponents of a unified method or philosophical foundation for clinical ethics have taken the trouble to show that a meta-method or meta-account of clinical ethics is possible for a field as diverse as clinical ethics operating across such diverse clinical and cultural settings. Principlism, casuistry, common morality, reflective equilibrium, among others, have their devotees who aim to tame the unruly field of clinical ethics. They are like evangelists proselytizing for converts to their position. But none of these approaches has achieved demonstrated ascendency in bioethical theory (Arras 2009). There is also a more important set of deeper divisions over fundamental beliefs and values within contemporary societies that philosophical theories will not resolve. So it is unreasonable to expect bioethical or clinical ethical theory to make headway in resolving these contradictory commitments at the level of theory. The public space is to an extent, but not as universally as Engelhardt has insisted, a place of moral strangers (Engelhardt 1996, 2006). It includes not only moral strangers, who share no fundamental moral commitments, and moral friends, who do, but also moral acquaintances who share much more than a libertarian theory such as Engelhardt's will allow (Loewy 1993, 1997). It is unsurprising, then, that ethics consultants confront cases in which there are deeply divergent beliefs and values in conflict, yet are able in many cases to find accommodation. In these

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[11] Some might object that this claim is untrue since there is a broad set of commitments such as promotion of patient rights that underlies the clinical ethics movement. I agree, but only to a limited extent. This set of commitments are quite general and do not comprise a normative foundation or theory. Talk of the principles of bioethics, for example, does not make for a theory, and principlism in itself is not really a foundational theory. Common morality theory is, of course, another alternative with enthusiastic proponents. Alleged foundational values like patient autonomy, patient rights, or respect for life are too vague and contested to provide the stable base that foundationalists desire, so it is fair to say that very idea of a solid theoretical foundation for bioethics is highly contested (Arras 2009). My point is that there has been no compelling theory of the field of clinical ethics and consultation and I doubt that there could be one.

situations of deep sectarian commitments, it is vain to think that *philosophical or ethical theory* as such will provide the traction needed. Since, even in circumstances of deep conflict, some *ad hoc* practical accommodations seem to be achievable, resolution of conflicts of fundamental value commitments or beliefs might be sought at either of two levels different from theory. As Engelhardt stresses repeatedly in his work, no moral accommodation is possible at the fundamental level when there is incompatible commitments; however, this does not mean that important values such as tolerance for the divergent views of others cannot be ethically invoked in practical terms. The important function for clinical ethics would then be to help devise a plan that minimizes disruptions to the process of patient care in the involved unit and that also respects the patient or family position while it preserves the integrity of the health care providers.

One could, of course, focus on either side of the conflict to the exclusion of the other. In philosophical terms, the dispute is irreconcilable, because it is grounded on moral values or views that conflict in principle; however, in practical terms, the ethical problems posed by the conflict, such as the distress of health care professionals or the resulting disruptions to the care of other patients might still admit temporary or ad hoc solutions. Faced with insurmountable obstacles in the way, one can always alter one's path or direction of travel. Such practical adaptation is, it can be concluded from the success of ethics consultation, possible despite the existence of divergent beliefs. This can occur precisely because no single theory normatively constrains the clinical ethics consultant to achieve workable solutions in all cases and because individuals espousing a commitment to values that are irreconcilable do so more often as a matter of living than in theory. Ethics consultation functions in this existential realm of living with tragedy and choosing in the face of the brutal reality of empirical conditions, and not in the sphere of theory.

It is important to stress that diversity manifests itself not only in situations of irreconcilable moral difference, which is commonly discussed in the literature, but also in the more common situations in which ethical conflicts, problems, and questions arise in patient care among individuals who share a set of beliefs and values. For example, typical ethics consultation cases involving conflicts among family members and health professionals occur not because there are irreconcilable moral values at issue, but because there is uncertainty or disagreement about how the accepted values apply. A son and daughter might each say, "You must respect my father's wishes and values," but they cannot agree about what those wishes and values are. Coming to a resolution of this conflict is a problem of ethical discourse involving an incorporation of the clinical facts within their decision-making as conversations ensue about who the patient was and what were the patient's commitments. This often entails a narrative approach to understanding how values were lived in a parent's life. In such cases, no single ethical theory or method provides a reliable guide. The ethics consultant who effectively assists in this situation uses a customized combination of analytic, communicative, interactional, and interpretive skills along with knowledge of applicable normative guidelines to help the children and the health care team to come to a decision, *a decision that is their own given the circumstances*. It is important to stress that this is not to say that ethical concepts,

principles, or theories are irrelevant, but only that none uniquely to the exclusion of others have any reliable practical precedence in the variable circumstances of the case.

This leads one to question why commentators find diversity in the field so problematic. Many reasons will surely occur to any thoughtful reader, but I will mention only one: it seems that commentators abhor the diversity of approaches and find comfort in the idea of a clear theoretical underpinning for the field because they see lack of such a foundation as a weakness or flaw. If diversity is regarded from the start as a problem or flaw, then it is not surprising that diversity *in* clinical ethics becomes a trait that should be erased. Diversity in clinical ethics, however, might not be a blemish, but an asset. When a diversity of values presents itself in clinical cases, it is a problem that can be addressed not at one fell theoretical swoop, but only in a practical way. The problem of diversity as it arises *for* clinical ethics can only be approached by experienced judgment. That is why I suggested earlier that collaboration and the use of quality improvement might help ethics consultation services to develop a shared competence in the absence of a sufficient caseload. As with any practice, experience in doing ethics consultation is required for refining the practical skills that an expert has. The practical problem of a diversity of issues arising in a clinical ethics practice is that it makes acquiring such a broad experience more difficult, yet essential. Diversity in the way clinical ethical problems are handled, however, might be a symptom that best practices are either not identified or widely shared. The differences in approach to addressing ethical problems, however, should not be uncritically assumed to be a weakness, since the differences might be adaptations to particular features of the circumstances of the case in which the problems occur. But this is an empirical matter and, frankly, the field has been remiss in not devoting resources to identifying and eliminating inelegant and inefficient ways of handling common or typical problems.

2.5   Conclusion

I have argued that diversity in clinical ethics can be regarded from the perspective of education, process, or philosophy. Each of these aspects has theoretical as well as practical dimensions, which need to be distinguished. Failure to do so foments confusion about the field of clinical ethics, and these confusions create a fertile ground on which the efforts to consolidate the field through the political mechanism of professionalization seem to germinate (Spielman 2001). In doing so, I am not arguing against professionalization or standardizing credentialing or certification procedures. My concern is simply to bring attention to the ways that diversity in the field is tacitly approached and how these taken-for-granted ways of dealing with diversity support the movement toward standardization. Too frequently, diversity is seen either from a developmental perspective as a symptom of immaturity, where maturity represents a phase characterized by consensus and standardization, or from a normative perspective, where diversity is seen as a fatal flaw in the field because of

the belief that without a normative foundation the field lacks legitimacy. I am a skeptic when it comes to the efforts to professionalize the field, because these efforts seem, like all movements toward achieving the status of a formal profession, to harbor the goals of dominance and control over clinical ethics work. Because there is scant sound evidence that clinical ethics and consultation are rife with incompetence and riddled with problems, attaining professional status does little to actually improve the practice. Improvement is nonetheless possible and needed, but not because of demonstrated systemic failure or weakness, which seems to be the common view. Rather improvement is both possible and desirable because clinical ethics is first and foremost a practice (Agich 2001, 2005, 2009a).

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