H E C FORUM, Vol 2, No. 5, pp. 289-298, 1990.
Printed in the USA.

0956-2737/90 $3.00+.00

CASE CONSULTATION: THE COMMITTEE OR THE CLINICAL CONSULTANT?

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In 1989, John LaPuma and Stephen Toulmin published an article (1) in which they proposed that ethics consultants, not ethics committees (EC), be responsible for case consultation: the activity that, for good or ill, right or wrong, is seen as the most desirable, interesting, distinguishing, and prestigious of all that bioethics has to offer the hospital. Policy writing and education, they concluded, could be left safely to the EC. LaPuma (a clinical ethics consultant at Lutheran General Hospital, Park Ridge, Illinois) and Toulmin (a philosopher at the Center for Clinical Medical Ethics, University of Chicago Hospitals) claimed that ethics consultants were better suited to case consultation: that they had, for example, "the ability to separate the ethical issues from the social, legal, theological, economic, and political issues in a given patient's case" and that this was "a distinguishing characteristic of the clinical ethics consultant." It may distinguish them from accountants, historians, and truck drivers, but it is difficult to see how it distinguishes them from ECs.

Much of their article is devoted to explaining why ethics consultants who have clinical knowledge are superior to those who don't have such clinical knowledge. But that argument doesn't speak to why ethics consultants would be more desirable than ECs for the conduct of case review. It's solely a discussion about what qualifications a *single* individual ought to have if you think a single individual ought to be doing this kind of thing. In truth, the article goes a little farther but in the process assumes its conclusion: "If ethics consultation should primarily be the responsibility of clinicians who seek to improve patient care through clinical ethical analysis and practical advice, what then is the optimal role of the EC?" That is, if ethics consultants are to have individual cases as their responsibility, what can be found to occupy the energies of ECs? Policy writing and education, they conclude. Aware that something is missing in this argument, they append a final section on why the committee can't be a consultant.

There is an old joke in the world of bureaucracies: specifically, that a camel is a horse designed by a committee. I think that joke is the sub-text of the LaPuma-Toulmin argument. You don't have to explain why a committee can't do the work of an individual: we already know that committees can't do anything right and therefore they couldn't do this right, either. Part of the reason they can't do anything right is because they are not composed of individuals but are great aggregate and extraordinarily inefficient beasts. For example, the article alleges that ECs are "necessarily distant from the patient's bedside" and thus unsuitable for case work. In my experience, ethics consultants and the members of ECs all work in hospitals and thus all are about equally close to the patient's bed. It is as if these authors believe that ECs meet in a room somewhere and exist as an aggregated beast only at that moment. When they're not meeting in that room, they don't exist at all and thus are inevitably far distant from the patient's bedside.

LaPuma and Toulmin are also concerned about the EC's lack of clinical experience, about their inability to "evaluate the patient" themselves. They voice a related worry that members of ECs will not have the ability or the strength of purpose to read patient charts. Again, they seem to know committees composed of people who don't work in hospitals. Most ECs are almost exclusively composed of clinicians (the ethicist and lawyer are often the only non-clinicians), composed of health care professionals who are perfectly capable of "evaluating the patient," or of getting assistance in doing so if very special skills are needed, and certainly of locating and reading patient charts.

They are concerned that "clinicians may feel uncomfortable about allowing a committee to intervene in the management of their patient." Clinicians are usually equally uncomfortable about ethics *consultants* intervening in the management of their patients, and particularly so if the implied meaning of "intervening" is "interfering." Indeed, that was the earliest concern voiced about any one individual other than the physician, about any group other than the health care team itself, who might take on the role of ethical evaluator. This simply was not and is not a concern specifically applicable to committees. It is the process of case review, not the person(s) engaged in it, that has been the source of worry.

The ethics consultant, they claim, is a Johnny-on-the-spot, always available for a curb-side or three-course consultation, whereas the EC cannot be located "until the next committee meeting or until members can be found." In my experience, nobody waits for the "next meeting" if a case needs attention *now*, nor do ECs have a difficult time locating enough committee members: they are as likely to be in the hospital as is the ethics consultant, as likely to be reached at the end of a phone

or a beeper as the ethics consultant. Indeed, ethics consultants who contract with more than one hospital may be rather more difficult to locate.

LaPuma and Toulmin's next concern is that of "group think." This phrase is drawn from an article by Bernard Lo (2) in which Lo expressed the concern that a group, over time, may begin to function as a group with group mentality, and thus lose the advantage of diversity, the quality that made it preferable to a single individual in the first place. The problem of "group think" is one that must be kept in mind, but it's not at all clear why a committee that *thinks* as if it were a single individual is inferior to an individual who actually *is* a single individual. Is the ethics consultant able to maintain, personally, an extraordinary openness to various perspectives and values, while at the same time a group of individuals is obliged to become narrow and unified? If anything, one might expect the opposite: that individuals will think like individuals, and groups of individuals will get on a little less well as single-minded entities. One might look only to the divorce rate in the U.S. (or indeed to the institution of marriage itself) as demonstration of the fact that becoming a group (even if only of two) scarcely leads to a sheep-like unity of mind and purpose and action.

Finally, these two writers are worried about the possibility that ECs may have conflicts of interest in regard to case work. The conflicts they mention have to do with economic issues (particularly cost-containment) and with biases toward academic research values. As employees of the hospital, ethics consultants are surely subject to the same kinds of pressures and the same kinds of biases. One difference, of course, is that there is no one to call them to account for their biases or to question how they may be responding to conflicts of interest around the hospital administration's economic preferences. Ethics consultants work in a much more closeted environment than do ECs. They are seldom accompanied by observers while doing their work. Often, they meet alone with families or with clinicians in a kind of mediating role and it is only our personal trust in them that allows us to believe they are accurately representing one group's views to the other. Ethics committees tend to do fewer of these closeted sessions. Assuming they have successfully avoided Lo's "group-think," ECs' discussions and representations are regularly subject to multiple sources of correction.

At bottom, this argument of LaPuma and Toulmin seems to suggest that ethics consultants are somehow more tangibly present, more "expert," and more authoritative than are the members of ECs. They are for some unspecified reason more responsible, more knowledgeable, and better able to withstand pressures. I don't know why this is so. My own observations lead me to conclude that some

ethics consultants are really good at what they do and some are not; that some ECs are really good at doing case review, and that some are not. The EC in the *Elizabeth Bouvia* case at High Desert Hospital (if accounts that the committee made the decision to force-feed her are correct) looks to have been inadequate. The ethics consultant in the *Linares* case in Chicago who simply deferred to the hospital's legal counsel (if press accounts of that situation are correct) also looks to have been inadequate.

But this poses the question of individual competence, whether individual ethics consultants or of individual members of ECs. All can agree that knowledgeable, concerned, sensitive people with high standards of personal integrity are better choices for individual case work than people who lack these qualities. So it is not clear from the LaPuma-Toulmin article just why it is that ethics consultants *as ethics consultants* rather than ECs are superior choices for individual case work.

Rather than competence, it would be more appropriate to focus on the two *roles*, independent of the individuals who fill them, with the caveat that those individuals, singly or as a group are knowledgeable, concerned, sensitive people with high standards of personal integrity. Given that equality, I would argue that the EC, preferably with the assistance of an ethicist, is to be preferred to the ethics consultant as the hospital's main resource for ethical guidance in individual cases.

An EC is not, however, a particularly *efficient* way to handle case review. Clearly, in an administrative sense, it's more efficient to have this responsibility clearly delegated to a single individual so that his/her role in the great chain of being and command can be well understood. Indeed, it is probably more efficient to hire an ethicist to do consultation, policy writing, and education. But there are values other than efficiency to be considered: it is not obvious that efficiency is the value that should determine whether ethics committees or ethics consultants can best serve the hospital and the health care professions. Efficiency, after all, is the primary value of economics, not the primary value of bioethics.

But, some may ask, what values can there be other than efficiency in this question? Autonomy, beneficence, non-maleficence, and justice are scarcely of help here. It is difficult to imagine what it means to ask "Is it fairer (or more beneficent) to have an ethics consultant or an EC?" We might better look at the ways in which these two roles, the ethics consultant and the EC, manifest themselves in the hospital in order to see what values they represent and thus, indirectly, serve. Some years ago, Marshall McLuhan gained national attention by declaring, about television, that "the medium is the message." We could usefully apply that same statement to this question.

When we are deciding whether to have an ethics consultant or an EC take on the role of helping health care professionals, patients, and families to understand and incorporate value dimensions in specific medical decisions, the medium we choose -- the consultant or the committee -- sends a message about how we conceptualize -- that is how we understand -- the activity that is going to go on. Suppose a hospital CEO is trying to make this decision about how to delegate this "ethics case review" responsibility. How he/she decides will be determined in great part by how the CEO understands the activity. Is it thought to be a technical activity requiring specialized kinds of knowledge? A practical kind of activity requiring specialized kinds of experience? A therapeutic kind of activity involving mediation about relationships and role perceptions?

If persuaded that it is like any of those three, the CEO might be very likely to prefer an ethics consultant, although who would be hired -- that is, what kind of qualifications the CEO would look for -- would be very much determined by which of the three understandings was preferred. In all three cases, however, the CEO would be looking for someone with a particular kind of *expertise*. The contemporary cult of experts and expertise -- and such deference to experts is very much a modern phenomenon -- would make this choice quite understandable.

To choose the role of *expert* to address these vexing ethical problems is to send the message to doctor, nurse, patient, and family that ethics and moral discussion generally are specialized kinds of knowledge that can be analyzed and applied only by experts -- by people who have expertise in this area. It is also to send the message that these people have been designated as *authorities* of some sort and therefore that their judgments should be accepted unless there are very good reasons for not accepting those judgments (and physicians had better be ready to explain why they think they know better than the expert/consultant does). The consultant's recommendation carries enormous weight by virtue of its being made by a "recognized" (or at least so labelled) authority/expert. The ethics consultant does not even have to present him/herself as an "ethical expert". No matter how non-directive, how non-judgmental an ethics consultant attempts to be (assuming he/she does make such an attempt), no matter how committed to being a resource, to opening up questions, to stimulating thought rather than to providing answers: such a role *in this culture* says that the individual who occupies this role has expertise and authority. . . and that others don't. That is, the role, the form in which the ethics consultant appears -- the medium -- is the real message, even if the person who is standing inside the role is trying to send a very different message.

In *The Culture of Narcissism*, Christopher Lasch described the

devastating effect of America's fondness for experts. He saw them as a "new ruling class" that has none of the sense of continuity of the old ruling class. He cautions that "new kinds of experts and professions themselves invented many of the needs they claimed to satisfy. They played on public fears of disorder and disease, adopted a deliberately mystifying jargon, ridiculed popular traditions of self-help as backward and unscientific, and in this way created or intensified ... a demand for their own services" (3). Lasch was talking about experts and expertise in a much more generalized way. Ethics consultants do not intend to play on "public fears of disorder and disease," but whenever health care professionals think or are told that they need experts, there is an implicit understanding that such fears are the basis of our need. Where there are such experts, it is understood that self-help is not possible. To bring in an expert is to say that the problems are very threatening ones and that the natural participants are not themselves capable of solving these problems because their own knowledge and abilities are too limited.

To accept a need for expertise is also an invitation to fall into someone else's need to be an expert. In a recent article about bioethics specialists, a researcher at a Canadian bioethics center commented about the "disturbing tendency [people have] to relinquish moral authority to other people: priests and rabbis in the past, now ethics committees and ethicists". He went on to say, "I shudder when I see someone quoted as an 'expert in medical ethics.' I'm inclined to say the guy's just a schmuck like anyone else." We may applaud his sentiments, but his is not the usual response to asserted expertise in everyday work life.

Furthermore, whether or not there is demonstrated clinical competence, to the extent that the ethics consultant's expertise is seen to lie in his/her specialized knowledge about ethical theory or theological analysis, a second, equally strong message is sent saying that moral values in health care lie for the most part and perhaps exclusively outside the health care professions. Leon Kass, in Chapters 6-9 of *Toward a More Natural Science*, has most fully articulated the claim that medicine (and health care more broadly) is an inherently moral activity with an ethic that arises from the nature of the activity itself rather than one that is imposed from without by what might be seen as a kind of "secular" ethics squad of philosophers, theologians, and lawyers from outside the health care professions. To separate the healing professions from their moral basis is a very risky endeavor, especially in a world in which few medical students have the faintest notion about how one might distinguish between a vocation, a profession, a career, and a job.

The message that the *form* of the EC sends, by contrast, is very

different. It is, first of all, that ethics and moral discussion lie within the community and are the concern of the community. The EC is composed primarily of individuals who are a part of the hospital community, who daily come to the hospital to work with patients and with one another. They are not outsiders or unconcerned about the moral condition of the hospital. The EC is not the source of ethics but merely one place in which the hospital community focuses its ethical concerns. It is an issue of organization only, not of special authority. An EC sends the message that the hospital community is one of ethical concern, not one of economic or technological concern that must be tempered by procuring ethical expertise.

A second message sent by the EC as a role or form is that ethics and moral discussion arise from love of the issues and from "perilous experience" with the human realities of sickness and the stress of lived moral dilemmas. Ethics committees, it is sometimes alleged, are mere amateurs, not to be considered in the same light as expert philosophers or ethicists (that most abysmal and least euphonious of words). *Amateur* is a word that has fallen on hard times. In the sense that EC members are not professional philosophers or ethicists, that they do not spend their working lives exclusively involved in the study of ethical issues in health care, they are indeed amateurs.

But they are amateurs in a very different and more basic sense. The word *amateur* derives from the Latin *amare*, to love. It means *one who acts from love*. Those EC members who have been most fully involved in their committees, who have put in many hours of private study and of additional committee work, have indeed acted from love of the issues, from love of their institutions and of their need to see their institutions demonstrate a commitment to maintaining the dignity of patients and families, as well as of health care professionals. It is for them no career, no job, as it is for the ethics consultant. So if they are amateurs, that is to their credit and they should be honored for it, not criticized.

Even further, as they are amateurs in the original sense of the word, so are ECs also *experts* in the original sense of that word. *Expert*, related to experience and to experiment, is also of Latin derivation, and means one who learns from experience (not one who learns from academic training). The more basic derivation, however, is "from danger" (*ex* + *peril*). The expert is one who has learned in the face of danger and of risk, and it is that meaning that very much separates the expert in its original meaning from the academically trained. Because the members of ECs are almost always clinicians themselves, they are experts in this sense: their knowledge of the ethical dimensions of health care is gained every day of their lives through their work and often at peril, at least in the sense of enduring

considerable psychological stress in the face of uncertainty and conflicting desires.

A third message sent by the form and role of ECs is that ethics and moral discussion are most responsive to multi-dimensional/interdisciplinary understanding. The EC, as a message, actively denies that any one can hold within him/herself all the perspectives that are needed to untangle, comprehend, and resolve ethical issues in patient care. It is a denial of the hubris that is inherent in the position of the ethics consultant. Walt Whitman said, "I am large, I contain multitudes," and it is very possible that he did, but ethics consultants are unlikely to measure up to that standard. They may encompass more than one perspective, but the ethics committee team -- made up of more than one individual -- can always encompass more. Furthermore, as health care becomes more sensitive to the polycultural values that affect decisionmaking, the emphasis on multidisciplinarity can only become more important.

A fourth message sent by the form and role of ECs is that ethics and moral discussion are best conducted in a collegial setting. This is a particularly important message in the hospital, dominated as it has been by hierarchical structures in which physicians sit atop the pyramid, with staff aesthetically arranged at various levels below them. It is obvious that taking care of sick patients is a matter of team work; although duties are different, each role is critical to ensuring that compassionate and competent care is given. In the EC, almost alone among hospital committees, floor nurses and chiefs of service are able to speak to one another as equals. They may not always do it. The nurses may speak to "Dr. Jones," while Dr. Jones responds to "Carol;" the physicians may *all* be "doctored", whereas everyone else goes by first names, but it is possible to do otherwise in the EC because where there is a focus on the dignity of individuals, there must first and foremost be a recognition of the equal respect owed to every member of the committee. The ethics consultant may stand on a level equal to the physicians, but collegiality with others lower on the hierarchy is not required and may even create difficulties in retaining physician-like status for the consultant.

Finally, the form and role of EC sends a message about the democratic nature of moral discussion in the moral community that is the hospital. Robert Veatch (4) describes three different roles that an ethics consultant might take. First, he/she might be a *moral analyst*, able to apply a range of moral theories to a specific case. Second, he/she might be a *moral advisor*, prepared to speak with authority about the moral position of a particular tradition, say that of the Catholic Church, or the Jehovah's Witnesses. And third, he/she might act as a *moral adversary*, seeing the job as questioning whatever conventional

wisdom seems to be dominating the discussion, asking probing questions, and forcing the participants to think more deeply about the case at hand.

Howard Brody (5) offers a different view: that is ethics as conversation in which all parties to the conversation are obliged to continue discussing the case until everything has been said that can be said. He argues that this method permits answering the essential question, "What, all things considered, ought to be done in a given situation?" This is the kind of democratic approach to ethics and moral discussion that the ethics committee has to offer. It is democratic in the sense that it is ethical wisdom derived from the voice of the people, specifically the people who represent at that moment a particular hospital's ethical community. It is a shared judgment, a shared experience. It arises from within the community; it is not brought down from above or from without. The EC, as committee, speaks of and contributes to an ethical standard created by the community that must live by those standards.

An EC member recently said that the EC is the place where you go if you want to remember why it is that you went into health care in the first place. It is, in that sense, the holder of the institution's and the professions' best traditions, less the conscience of the institution than the memory of its enduring values, the spokesperson for their continuity. An ethics consultant cannot be seen in the same way, for an ethics consultant, competent and beloved as he/she may be, cannot be the symbol of that kind of continuity, and must not be the single repository of an institution's values.

These are the reasons that a CEO should choose an EC rather than an ethics consultant. Then, having chosen the committee, the CEO should ensure that the committee has the resources, including the services of an ethicist if necessary, to fulfill this mission. If an EC's form and work are to send the same message -- the hospital's commitment to human dignity -- the committee must have educational resources and resources of time and money to find its own best ways of fulfilling its role.

This is the kind of EC that would make a difference to individual patients, to hospitals, and to society more generally. The ethics consultant, as useful as he/she may be, seems to be something very different, trying to achieve something much more specific, much more limited. It is not clear, however, that this is the vision many ECs have of themselves. But, if they do not understand themselves within this *kind* of vision, they will offer the world nothing more than ECs that are undistinguished collections of ethics consultants, with all the inherent narrowness of that role. When it is the EC that takes on individual case work as well as education and policy recommendation, the hospital

communicates, in a very direct and visible manner, its commitment to the creation of *an ethical community*. In such a hospital, all actions, all decisions, and all lives are a part of its moral vision because all actors, all decision makers, and all participants are the creators of the moral community.

REFERENCES

1. LaPuma J. and Toulmin C. Ethics Consultants and Ethics Committees. *Archives of Internal Medicine*, 1989; 149(5): 1109-21.
2. Lo B. Behind Closed Doors: Promises and Pitfalls of Ethics Committees. *New England Journal of Medicine*, 1987; 317(1): 46-50
3. Lasch C. *The Culture of Narcissism*. W.W. Norton & Co., Warner Books Edition, 1979; p. 385.
4. Veatch R. Clinical Ethics, Applied Ethics, and Ethical Theory, in *Clinical Ethics: Theory and Practice*. Hoffmaster B, Freedman B, Fraser G, (eds.), Humana Press, Clifton, N.J., 1989.
5. Brody H. Applied Ethics: Don't Change the Subject, in *Clinical Ethics: Theory and Practice*. Hoffmaster B, Freedman B, Fraser G, (eds.), Humana Press, Clifton, N.J., 1989.

This paper is adapted from a presentation made at "Keeping Ethics in Ethics Committees", a conference sponsored by the College of Physicians, The Hastings Center, and the Delaware Valley Ethics Committee Network, April 1990, Philadelphia, Pennsylvania.