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WHAT KIND OF DOING IS CLINICAL ETHICS?

ABSTRACT. This paper discusses the importance of Richard M. Zaner's work on clinical ethics for answering the question: what kind of *doing* is ethics consultation? The paper argues first, that four common approaches to clinical ethics – applied ethics, casuistry, principlism, and conflict resolution – cannot adequately address the nature of the activity that makes up clinical ethics; second, that understanding the practical character of clinical ethics is critically important for the field; and third, that the practice of clinical ethics is bound up with the normative commitments of medicine as a therapeutic enterprise.

KEY WORDS: applied ethics, casuistry, conflict resolution, ethics consultation, principlism, Richard M. Zaner

I have long been impressed by Richard M. Zaner's work on clinical ethics, so I welcomed the opportunity to contribute to this issue to try to characterize why this work is important for the field. To do so, I discuss the question: what kind of *doing* is ethics consultation? This rather odd way of phrasing the question is intended to call attention to the fact that our question is itself unusual and is, remarkably, not a central theme in the literature. I will first discuss how most approaches to clinical ethics fail to seriously take up this question, second, show why the question is pivotal to the field, and third, argue that the work of Zaner points in the direction that we must proceed if we are to answer this question.

APPROACHES TO THE QUESTION OF DOING CLINICAL ETHICS

The question stresses that ethics consultation is a kind of action or doing and that the action is our thematic focus. Previous discussions of the broad topic of clinical ethics have failed to come to terms with the features that define it as a special type of action. Four broad approaches to the question are evident in the literature. The first three, namely, applied ethics, casuistry, and principlism, view clinical ethics from the perspective of ethics while the fourth approach seeks

to understand clinical ethics in terms of specific techniques for addressing or resolving conflicts or disagreements.

The *first* approach views clinical ethics, like bioethics generally, as a type of applied ethics or applied philosophy.[1] This approach assumes that clinical ethics involves *applying* ethical theory and concepts to actual cases of patient care. Some have questioned the possibility and professional legitimacy of this conception of the application of normative knowledge[2] and have pejoratively characterized applied ethics as a kind of engineering.[3] Questions about the application of ethical knowledge, normative ethics, or ethical theory have also been mired in debates over the legitimacy of individuals claiming expertise or professional competence in ethics to testify in courts of law or serve on governmental commissions.[4] This extensive debate, however, has not addressed the question of the distinctive type of doing that makes up clinical ethics. Discussion of the application of ethical theory to cases has been conducted primarily as a theoretical or political issue, not as a fundamental issue of methodology.[5]

A *second* approach views the practical functioning of clinical ethics as the dealing with concrete problems or cases. A number of authors see casuistry as the approach that can guide these activities in dealing with value conflicts and ethical dilemmas arising in medicine.[6] Despite the advocacy for casuistry as cased-based reasoning, defenders of casuistry as a method have not really characterized how casuistry is supposed to function "on the ground," in the *actual* handling of clinical ethics cases.[7] That is to say, casuistry has been promoted as an alternative to a theory-driven or principle-driven approach because it is putatively focused on the specific circumstances surrounding the problems and issues arising in individual cases. But casuists have little to say about the conditions that are presupposed such as intersubjectivity, communicative discourse, and methodology.[8] Even though casuistry may better attend to the circumstances of cases than other approaches, casuists appear to accept these circumstances as given facts of the case. Casuistic reflection accepts the case, problem, or question as given for ethical reflection without necessarily probing beyond the giveness of the case. It does not readily address how the case came to acquire the sense or meaning that makes it an ethical problem in the first place. In the typical casuistic characterization, the function and engagement of the casuist with the case material is not an essential topic for consideration, yet in the actual doing of ethics consultation how one comports oneself,

how one communicates, and how others perceive the clinical ethicist[9] bears significantly on the construction of the meanings (ethical and otherwise) of the case and situation.

The *third* approach is principlism. Principlism is a broad movement that is committed to the centrality of ethical principles and theories in ethics.[10] Despite criticism of principlism as being a "top-down approach," the best versions of principlism are not slavish to theory and do not presume that the practical process of doing ethics is something as simple as the application of principles to cases. Defenders of principlism have rightly complained that critics have vastly oversimplified what is involved in ethical theory and in the reasoning about the bearing of ethical principles on actual conduct or concrete circumstances. Principlism includes a diverse set of approaches, including Rawlsian *reflective equilibrium*[11] and specified principlism.[12] Principles are essential, in this view, because they guide the myriad complex judgments that constitute practical ethical decision making. This point is essentially correct, even though it does not establish principlism as a viable answer to our question.

Like casuistry, principlism takes the case or problem as it is found or given for ethical analysis and reasoning. It does not seriously reflect on the actual conditions under which the ethical problems have acquired their meaning in the specific clinical setting. Furthermore, principlism tends to take theories and principles for granted just as casuistry takes for granted the paradigm cases. Apparently, neither the casuist nor principlist need be involved with the case in the flow of real time to do their work. Both approaches appear to operate comfortably from a position removed from the actual on-going circumstances or experiences of the clinical case.

The *fourth* approach involves advocacy for one or more specialized techniques for resolving conflicts or disagreements. Specific techniques like arbitration, conflict resolution, and mediation are recommended for effectively addressing ethical conflicts, disputes, or disagreements.[13] Collectively, they appropriately acknowledge the engaged character of clinical ethics, but concentrate on the tasks involved in the resolution of ethical conflicts. In so doing, they overlook other actions or doings that make up clinical ethics. They focus on securing consensus or compromise with little attention given to the meaning of the ethical issue itself. Although promotion of these techniques moves in the direction of the question that we are pursuing, they do not advance us very far because they reduce clinical ethics to the task-oriented activity of resolving problems or conflicts.

The utility of these techniques for clinical ethics is not in question, but rather the adequacy of a technical rather than a reflective approach for addressing the meaning of the full range of activities that make up clinical ethics.

Clinical ethics is an activity that is deeply engaged in the clinical setting. Clinical ethics consultants are *involved in* the cases on which they consult. They communicate with the patients, family members, physicians, nurses, and other health care professionals about the case. They are thus part of the action, on stage, as it were, and not separated from it by the proscenium. They are consultants and not just commentators on the ethical aspects of the case. They use ethical concepts and theories, reason from paradigmatic cases, derive guidance from ethical or bioethics theory for their actions and recommendations, and negotiate and arbitrate, still none of these characterizations fully captures what is distinctive about the *doing* of clinical ethics.

WHY THE QUESTION OF DOING IS CENTRAL FOR THE FIELD OF CLINICAL ETHICS

Clinical ethics involves actions that shape the underlying structures that give meaning to the case. This involvement changes the case in ways that can be irrevocable and significant. Being involved in real time, the clinical ethicist's actions and interactions with others in the case shapes the very circumstances that give meaning to the case; clinical ethics thus becomes part of the social construction of meaning that is the clinical case. For example, ethics consultants sometimes shape not only the recommendation or interpretation of the value aspects of the case, but the very terms by which patients, families, and health professionals see and experience the situation or problem. In other words, clinical ethics regarded as an action or doing contributes to the social constitution of the *meaning* of the problems seen as ethical as well as to the mechanisms for their resolution or accommodation. Thus, to be adequate, an account of clinical ethics as an activity needs to make sense of this fundamental involvement of clinical ethics with and in the clinical setting. Making sense of this involvement is critical for the field because controversies about professional status or qualifications hinge on an adequate understanding of the essential nature of what it means to *do* clinical ethics.

Stephen Toulmin[14] claimed that medicine saved the life of ethics by giving it a relevancy that was lost as twentieth century philosophical ethics focused on the analysis of concepts and the justification of theories. This fixation on the formal, theoretical aspects of ethics eclipsed the traditional attention to practical ethical concerns. Medicine may have "saved the life of ethics" by giving it a new relevance, but it did so by drawing individual philosophers from the safe academic waters of conceptual analysis, theory construction, and justification into the more treacherous and uncharted seas of patient care. Medicine caused ethics to become re-engaged with the practical world and to address questions that impact on human well-being.

From the classrooms and lecture halls in colleges and universities, philosophers moved into professional education, where philosophical teaching in courses and seminars had to give way to isolated lectures or modules in the medical school curriculum. They had to adapt to the pedagogical innovations in medical education including the use of simulated patients and problem-based learning. Beyond these educational adaptations, philosophers found themselves serving on committees charged to protect the rights and welfare of research subjects. They were not called upon to criticize, analyze, or to elaborate theoretical distinctions, but to minimize harms or improve consent forms and the process of consent.

Drawn even further away from their home port, some philosophers found themselves in the midst of patient care – in hospitals – serving on ethics committees and providing ethics consultation services at the bedside and during ward or unit rounds. Philosophers became "strangers at the bedside" by coming into the private space of patients and the professional world of medical work, though they did so in a far less intrusive way than Rothman[15] would have us believe.[16] They were often called to the bedside by physicians who genuinely sought ethical advice on patient care problems or dilemmas just as they were previously invited into medical education by deans and department chairmen committed to "humanize" the next generation of physicians, who would have to face the complex questions posed by the expansion of biomedical technology and scientific findings.

Clinical ethics brought ethical reflection into the pilothouse and clinical ethicists acquired the disquieting responsibility to guide the ship of patient care safely through the shoals of ethical conflict and into the port of ethically sound clinical decision making. This new role was filled with risk and ambiguity, especially for academics, who

traditionally dealt with cases of ethical conflicts from a vantage solidly on the shore. Clinical ethics thus put these academics into positions of responsibility far beyond the calm and safe waters of the harbor and lecture hall. This role transformation (and its associated anxiety) that is at the heart of much of the controversy over the legitimation of clinical ethics[17] remains stuck at the level of politics, however, because the field has not systematically faced the radical nature of this transformation and the responsibilities that it entails. A deep and understandable uncertainty about the engagement of ethics with the clinical world complicates our understanding of this transformation and the responsibilities of clinical ethics. Indeed, the claim that the philosopher or clinical ethicist can or should become so engaged has been highly controversial.[18] The issue of expertise and professional qualifications, which has been the lightening rod of this debate,[19] has unfortunately obscured the difficult question about the methodology of being so engaged[20] which, in turn, has obscured the deeper and important question about the responsibilities involved in doing clinical ethics. Unfortunately, the widespread attention to and debate over the qualifications for doing clinical ethics[21] has actually diverted attention from these questions that are so important to the field of clinical ethics.

UNDERSTANDING THE DOING OF CLINICAL ETHICS

In this context of contention and confusion, Richard M. Zaner's writings on clinical ethics are especially important for reassigning the proper priority to the question of the meaning of doing clinical ethics. Zaner has devoted a good deal of his work in clinical ethics to a consideration of the *clinical* nature of clinical ethics. In an early paper in the field, he provocatively asked the question: "Is 'Ethicist' Anything to Call a Philosopher?"[22] In it, he set out the historical context of the question, but skirted the "political" concerns to address the ways in which the specific meaning of being clinical is constituted for ethics in the world of medicine.

The answer that he gives provides a solid foundation for addressing what doing clinical ethics involves. He offers the following characterization. First, clinical ethics issues arise (and must be understood) within the context of their occurrence, that is, within the specific clinical case and setting. Second, each case is characterized by uncertainty and ambiguity that is unique to the case.

Third, the case and its issues are co-constituted by the individuals involved therein and the issues derive their fundamental ethical import from this constitution. Fourth, each case is structured by fallible assessments and decisions that have an inherent complexity that may not be readily reducible to simpler elements.[23] Zaner offers a far more nuanced exposition of these points than can be commented upon in this paper, but three observations can provide reliable signposts on our way toward the question of the doing clinical ethics.

The first signpost is that clinical ethics is essentially and inextricably bound up with actual cases. That is, one cannot think about clinical ethics or purport to be a clinical ethicist without active engagement with actual cases of patient care. That means that academic bioethicists, who view themselves as engaged in a clinical enterprise because they think about medicine or review cases on committees are fundamentally mistaken. Clinical ethics requires an extensive and active engagement with patient care. It cannot be done from afar, but involves the clinical ethicist in the actual setting of clinical cases because the specific circumstances of the case provide the structures of ethical meaning.

The second signpost is that the meaning and interpretation of the actions in the clinical case are *co-constituted* by the individuals involved therein. In other words, the case as a clinical ethical reality does not exist apart from the particular individuals involved in the case. The clinical ethicist, as a participant in the case, brings skills of assessment and judgment to bear on the specific circumstances of the case. In this regard it is worth noting that Zaner's discussion of the conception of the clinical ethicist as an expert[24] appears to be grounded in his conviction that the case, with its complex circumstances and structures of meaning, is so integral to the functioning of the clinical ethicist that a knowledge or expertise that is *independent* of the case will be fundamentally insufficient. That is why he sees merit in the view that the clinical ethicist is a facilitator working with others in the case.[25] The element that is essential for Zaner, however, is not the technique of facilitation as such, but the fact that the facilitation essentially involves an interpretive *interaction with others in the case*. This is the essential point that needs emphasis, because he does not sufficiently consider that the skills of interpretation and reflection that are so well-exemplified in his own work constitute a type of expertise – at least in the sense of discipline or skill – that are needed for effective and responsible engagement with the case in

doing clinical ethics. Both elements, the *possession* of the skills and discipline and *exercise* of these capacities are essential for understanding clinical ethics.

The debate over expertise or authority in clinical ethics has unfortunately assumed the independent possession of ethical knowledge and has given little attention to the type of practical knowledge involved in doing clinical ethics. As I stressed in a discussion of the importance of the question of method for ethics consultation, the rules guiding ethics consultative activities have relevance and meaning for the practice of ethics consultation only to the extent that they are actually *enacted* in the particular case.[26] Analysis of the nature of authority in ethics consultation[27] thus leads to a consideration of the conditions under which participants in a case are able, inclined, and willing to even *listen* to an ethics consultant.[28] Zaner's work helpfully makes clear that the question of the nature and scope of clinical ethics is, at bottom, a general problem of the social constitution of the meaning of clinical ethics as a practice.[29] All individuals involved in the case thus constitute the meaning of the case as they interact, agree, and disagree. This observation highlights a corollary point, namely, that the clinical ethics essentially entails the practical function of co-constituting the ethical meanings of the case. Thus, the perspective that provides the best vantage point for accurately reflecting on the doing of clinical ethics is one that is itself engaged in the activity of clinical ethics. It is also a perspective that must accept responsibility for the involvement.

Zaner rightly characterizes this approach as a social phenomenological one, because the doing of clinical ethics is a special problem of the social constitution of the social world of the clinical ethics case. That Zaner's work stresses the *clinical* element in clinical ethics thus is not a conceit or an allusion to an esoteric (medical) knowledge, but as an essential recognition that the meaning of clinical ethics is embedded in the active social construction of meaning in the particular case.

The third signpost on the way toward the question of the meaning of the doing of clinical ethics is that the distinctively *clinical* character of the case is not reducible to or captured by the specific physical setting of the hospital or bedside, the interaction with patients/families or health professionals, or the possession of a specific clinical knowledge or qualification. Rather, the *clinical* nature of clinical ethics is bound up with being actively involved in patient care and is normatively guided by the overriding *therapeutic* nature of patient

care.[30] Clinical ethics is therefore wrongly conceived as the ethics of cases or problems that happen to involve medicine and patient care; rather, it is essentially *about* and *involved with* the delivery of patient care. The therapeutic goal thus imparts a normative structure to the activities comprising clinical ethics. Since it is ultimately about therapy, clinical ethics must, quite remarkably, also incorporate and accommodate this therapeutic orientation.

These observations summarize my understanding of Zaner's complexly articulated reflections on clinical ethics. His writings are remarkably unlike those of other bioethicists, because he confronts the doing of clinical ethics from within the perspective of the activity itself. This is a difficult, even arduous, task. It requires that the one who is engaged as a clinical ethicist also must sustain a reflection on the meaning and the conditions of the activity. This undertaking, odd and difficult though it may be, is critical for the field, and Zaner's work blazes a path toward the question of what it means to do clinical ethics.

As Alfred Schütz has shown in his fundamental work on the phenomenology of the everyday social world, a social scientist can have no privileged position of observation, but is always intertwined with his subject matter. This involvement is quite unlike the mythical distance that is supposed to exist between the natural scientist and the objects of investigation.[31] Reflecting on clinical ethics is thus a reflection *in the midst* of the things themselves, namely, the active engagement in the clinical ethics enterprise itself. There is simply no substitute. There is also no special position of privilege earned by this unique undertaking. The only grounding that exists for this doing is thus to be located in the particular circumstances of the individual case as well as the assiduous adherence to methodological and evidentiary standards that are lamentably peripheral concerns for the field.[32]

PIVOTAL POSITION OF THE PATIENT CARE

Zaner's work moves our question of the meaning of clinical ethics forward by merging it with a broader discussion of the meaning of patient care and clinical medicine. His work shows that the term *clinical ethics* is ambiguous, because it includes both the activity of the person in the role of the clinical ethicist *and* the ethical meanings and values exhibited in the actions of all – patients, family members, physicians, and other health care professionals – who are involved in

the clinical case. This broad inclusion is necessary, because the ethical meaning of the case is socially constructed, like all meanings in the everyday world of experience.[33] From this perspective, doing clinical ethics becomes less a matter of deploying specific techniques for pre-given ethical problems than an existential and ethical encounter with the sick and their need for care.[34]

The clinical ethicist is never just an observer or spectator,[35] but a participant in the world of patient care that alters the meaning that makes up the real experiences underlying any narrative about the case. The presence of the clinical ethicist in the case and the reflection on the clinical situation that this presence makes possible stand in need of the most careful description. That is why before it can be explained, justified, or legitimated, the doing of the clinical ethics must be accurately described and understood.

For this reason, the clinical cases that Zaner discusses are often presented less as "ethics" cases per se, than as cases narrating the actual lives, feelings, and sufferings of patients, the struggles of families and health care professionals as they struggle to come to terms with illness. Even though ethical or value considerations seem to ooze from these situations and relationships, Zaner's case discussions are remarkably bereft of the typical ethical vocabulary of rights, duties, or virtues. In part this is due to his concentration on the actual clinical and scientific challenges facing physicians and other healthcare professionals as they diagnose and devise treatments for their patients. In an important sense, these case discussions are not presentations of ethics cases as such, but renditions of the practical experiences involved in trying to understand the structures of meaning constituted in and for the case.

The activities associated with patient care all involve a concern for relevance. Patient care is a world of work, not a realm of ideas or speculation. It is a space in which the concern for the patient primarily drives not only the therapeutic, but the analytic and intellectual functions of health professionals as well. This focus on the patient (and the patient's well-being) gives patient care not only an "ethical" orientation as a patient rights approach to medicine would insist, but also a distinctively practical orientation within which clinical ethics has to operate and create meaning. This practical focus sharply differentiates clinical ethics from ethics or bioethics conducted in universities where freedom of inquiry and the pursuit of knowledge for its own sake are in the main unfettered by practical demands. In the clinical setting, the purpose and vector of reflection and action is ultimately practical rather than intellectual. Problems thus emerge

and are identified as ''ethical'' as the result of a specific interpretation of some blockage in the course of patient care. Therefore, the need for a solution is driven by a practical, not intellectual concern. This helps to explain why problems that are brought for ethics consultation are widely recognized as not strictly ethical problems, but communication problems. The accuracy of the characterization of the problem in the request for clinical ethics help is no more essential for the competent handling of the case than is the accuracy of the characterization of shortness of breath, fatigue, and nausea by a patient as ''probably only a cold.'' The competent physician will listen to the patient's complaint and presentation of symptoms, but go further to ascertain a deeper and more relevant history of the symptoms, elicit signs of illness and, perhaps, order tests to reach a diagnosis. Similarly, although a clinical ethics case may start with the request for ''ethics'' help, the first activity of clinical ethics involves a probing of the structures of meaning operating in the request for assistance. Thus, it is wrong to think that clinical ethics should primarily respond with a ready-made technique like mediation or conflict resolution. Instead, the first response must be the interpretive process of uncovering the actual and latent structures of ethical meaning involved in the case. Thus, to the question why one might do clinical ethics as a philosopher, Zaner gives the very reasonable answer that one cannot seriously and competently reflect on medicine and its ethics without fully engaging the concrete clinical situation.[36]

CONCLUSIONS

In this paper, I have raised the question: what is the doing of clinical ethics? I have argued that common approaches to this question fail to account for the fact that clinical ethics is essentially an engagement with and in patient care where the ethical dimensions subsist in the social structures that constitute the therapeutic and ethical meaning of caring for particular patients. I have further claimed that a guide to the full understanding of this question is to be found in the work of Richard M. Zaner, which links the meaning of our question with the normative meaning of patient care.

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