

HEALTH CARE ETHICS CONSULTATION: PERSONAL KNOWLEDGE AND APPRENTICESHIP¹



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Keywords: Healthcare Ethics Consultation, objectivism, Michael Polanyi, personal knowledge, Maurice Merleau-Ponty, William H. Poteat, lived experience, complexity and ambiguity in ethics consultation, post-critical thought, teaching ethics consultation, internship, apprenticeship, and virtue

ABSTRACT

The intellectual history of Healthcare Ethics Consultation embraces objectivism and its emphasis on knowledge that has already been achieved. As a result, official descriptions, standards, and guidelines for this practice, while valuable, ordinarily exclude consideration of the ethics consultant in the process of knowing. Narratives of complex cases, including those that have led to perceived errors, are signs that point to Michael Polanyi's notion of personal knowledge. The writings of Polanyi, Maurice Merleau-Ponty, and William H. Poteat support a paradigm shift to "post-critical thinking," opening new avenues for ethics consultation teaching and learning, particularly in the setting of clinical internships.

The Haunting Ambiguity: Autobiographical notes

I first became interested in Bioethics during my PhD studies with William H. Poteat at Duke University (1973-1980). My original plan had been to get a graduate degree in Sociology, my major at Beloit College (1967-1971), where I studied with Donald Summers, the Chair of the Sociology Department. Professor Summers taught Sociology at Beloit from 1959-1993. His charismatic teaching style and eclectic

interests in social theory, phenomenology, and philosophy equipped students with a wide-ranging grasp of sociology, coupled with a philosophical tendency to question and critique sociology's methodology and conclusions. We studied the pioneering ideas of Auguste Comte (1798–1857), Émile Durkheim (1857–1917), and Max Weber (1864–1920); along with Phenomenologists Alfred Schutz (1899–1959), Edmund Husserl (1859–1938), and Maurice Merleau-Ponty (1908–1961).

Introductory Sociology leads the student to entertain the possibility that “social facts” are objective, observable, and governed by laws that generalize across various situations and cultures. Further, students learn to think that social facts wield a causal influence, positioning the individual in a social milieu, sanctioning those who “deviate” from expectations, as well as maintaining and “solidifying” social structures.

Durkheim's foundational study, *Suicide*, compared and contrasted suicide rates between various European social groups. Through careful reasoning and argument, Durkheim concluded

that different rates of suicide (as distinct from individual cases—a problem for psychology) are the consequence of variations in social structure, especially of differences in degree and type of social solidarity. Thus egoistic suicide, a product of relatively weak group integration, is prevalent in those groups where lack of social cohesion is marked, for example, among the unmarried and Protestants; and anomic suicide, induced by a breakdown of social norms, is encouraged by sudden changes characteristic of modern times. Durkheim also made clear that social solidarity can induce suicide, illustrated by his third type, altruistic suicide, revealed, for example, by high rates in certain primitive societies and in some modern armies (Timasheff 1967, 114).

This is the type of sociological reasoning that began to make me feel anomic myself. If even suicide, an ostensibly individual decision and choice, is merely the reflection of social forces, what about other aspects of life in which we believe ourselves to act freely? Sociology appears to create a double vision, in which one discredits ordinary perception and attends to levels of existence that are unseen, yet purportedly more real and determinative. Lounging in a comfortable arm chair in the Beloit College library, striving to follow Durkheim's complex argument set forth in the conspicuous red book with its huge white SUICIDE, I wondered if those around me would consider me strange, deviant or even suicidal. Perhaps exaggerated self-consciousness is an occupational risk for sociologists.

In the classroom, Summers would often pause in the midst of discussion and ask us, “Do you get a sense of the haunting ambiguity?” He did not explain the meaning of this intriguing question, but my interpretation is that he was alluding to the strangeness

of the sociological imagination. He wondered whether we were beginning to discern the “presence” of social norms and expectations that were all around us, but paradoxically hidden, absent a special, reflexive methodology. Social reality had ineffable, unspecifiable elements. I believe that Summers was calling attention to Merleau-Ponty’s insight: we are situated in a taken-for-granted world of beliefs and expectations which form the essential basis of our observations and reckonings.

My plan for graduate school was to continue studies in theoretical sociology and phenomenology at Duke University (1971-1980). But as I gained more experience with Sociology’s emphasis on empirical observation, I became disenchanted with the field. As an example, Erving Goffman (1922-1982), a student of Durkheim, turned his attention to small-scale, face-to-face “interaction.” He regarded interaction as a type of drama, in which actors seek to control the way they appear to others by displaying and adjusting roles they have “internalized” during their upbringing and subsequent group memberships. However, like other sociological facts, the roles that actors play are normally “invisible,” only revealed when social expectations break down (Goffman 1959, 13). At some point, we graduate students were encouraged to test interaction theory ourselves, by conducting social “experiments” such as walking into a shoe store and trying to buy two left shoes, observing and then reporting the reactions of the hapless, and frankly manipulated, employee. The assumption was that research and observation simply required “standing back” from the social setting, “displaying” a mildly deviant act and describing what followed.

Philosophically unsophisticated, we were not aware of the ethical and epistemological issues of this type of inquiry. I was later able to reflect that in the name of objectivity, we were deceiving the shoe store clerk, perhaps even treating him as a Kantian “means to an end.” Colleges have by now established more rigorous standards for the review and approval of research on human subjects; at minimum, this project would now receive expedited review as a student research project.² But since we had not reframed in advance the ordinary taken-for-granted situation of a sales event by placing it in a research context, the store clerk reasonably assumed that the person “who wanted to buy two left shoes” was acting in good faith, telling the truth. There is a related epistemological quandary. The sociologist-observer may adopt the pretense of being interested in two left shoes, but it is a mistake to believe that this “bracketing” of one’s everyday expectation can “remove” him or her from the situation in its entirety. He or she is still fully present with the clerk by virtue of their mutually affirmed, taken-for-granted reality. As I later realized from studies of Polanyi, sociology’s stated methodological ideal rested on a skeptical, “non-fiduciary,” approach to social facts, whether in studies of face-to-face interaction or in statistical research. A “skeptical” stance was the stated norm, even though both the founders of sociology, alarmed by the breakdown of many traditional social institutions in the 1800s; and the more recent activists working for social justice, all held deep moral convictions. Sociology had

adopted a second-order, “objectivist” account which described the sociologist as a mere observer and compiler of social facts. According to Polanyi and Poteat, objectivism is the false picture of human knowing, derived most recently from the Enlightenment that endorses a program of universal doubt, skepticism, and personal detachment as the definitive method of discovery in science and other forms of knowledge.³

In the mid-1970s I heard that William H. Poteat was offering a seminar on Merleau-Ponty, and I began a change of majors to Religion. I participated in Poteat’s seminars on Merleau-Ponty, Michael Polanyi, Walker Percy, Soren Kierkegaard, and Paul Ricoeur. Poteat would skillfully lead us to “go for the jugular” of whatever author we were reading (Breytspraak 2008, 16). He helped us demonstrate that the writer’s stated purpose was riddled with fatal flaws, inconsistencies and the “infelicities” of unexpunged Cartesian dualism. My hope was someday to teach, *like Poteat*, philosophy or religion in a college or university. To be on the safe side, though, my dissertation chapters addressed quasi-practical applications that might allow a wider range of options: sociology of religion, acquisition of language, and the newly developing field of bioethics.

When I moved to Toledo, Ohio, in the early 1980s, I learned that the new Director of the Medical College of Ohio School of Nursing was from Georgetown University and wanted to establish a nursing and humanities program. With others, I created the program, then for several years taught nursing ethics and humanities for classes of R.N. and M.S.N. students. During this period I continued to read extensively in bioethics, attended early conferences of The Society for Bioethics Consultation, and served as a founding board member and officer of the Bioethics Network of Ohio. In 1990, I accepted the position of Hospital Ethicist for what is now Mercy St. Vincent. My charge was to “revitalize the moribund” ethics committee and serve as chair of Human Subjects Research.

History, Intellectual Commitments, and the Practice of Health Care Ethics Consultation

Bioethics is a practice discipline and “convivial order,” a community of like-minded persons who, over time, have jointly accredited a body of knowledge (Polanyi 1962, 203-222). This sedimentation (Merleau-Ponty 1964, 89-92) is rooted in ancient philosophical and religious commitments, but is noteworthy for rapid development in the years following World War II. Consistent with Polanyi’s description of knowing, one can observe individuals and groups in the field of Bioethics as they rely on previous commitments to actively consider key events and deepen general understanding of ethical practice.

The war crimes trial of Nazi doctors (1946-1947) led to vigorous articulation of human rights and insistence upon their integration in medicine and research.⁴

Beginning in the 1950s, the virtual elimination of many infectious diseases brought longer life spans, but ironically, was accompanied by the emergence of “diseases of aging” that posed issues relating to quality of life. Patients and health care professionals began to wonder whether they had an ethical obligation to employ every newly developed technology.

Early questions about ventilator support provide an example. Physicians in the 1950s originally used ventilators as a temporary measure, to sustain the lives of polio victims and to resuscitate patients in the operating room. Doctors then began to extend the technology to a wider range of patients, including those who were seriously ill and might not recover. In 1957, Dr. Bruno Haid, Chief Anesthesiologist at the University of Innsbruck, brought personally troubling questions to Pope Pius XII. Please note Dr. Haid’s perplexity, hesitancy, awkward language, and his reliance on religious tradition; all accord with Polanyi’s descriptions of the person in the act of knowing:

First, does one have the right, or is one even under the obligation, to use modern artificial respiration equipment in all cases, even those which, in the doctor’s judgment, are completely hopeless?

Second, does one have the right, or is one under obligation, to remove the artificial respiration apparatus when, after several days, the state of deep unconsciousness does not improve if, when it is removed, blood circulation will stop within a few minutes? What must be done in this case if the family of the patient, who has already received the last sacraments, urges the doctor to remove the apparatus? Is Extreme Unction still valid at this time?

Third, must a patient plunged into unconsciousness through central paralysis, but whose life—that is to say, blood circulation—is maintained through artificial respiration, and in whom there is no improvement after several days, be considered *de facto* or even *de jure* dead? Must one not wait for blood circulation to stop, in spite of the artificial respiration, before considering him dead? (Pius XII 1957).

The Pontiff responded,

Normally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities, are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.⁵

Drawing on centuries of Roman Catholic ethics, the Pope's distinction between ordinary and extraordinary means of treatment continues to inform decision-making in today's Bioethics (Taboada 2008). The consensus in Bioethics is that the benefits and burdens of a potential treatment should always be weighed in the light of the patient's own goals of care (Ross 1993), and the informed patient with reliable decisional capacity has the right to refuse any treatment, whether or not it is life-sustaining.

In the late 1960s, a series of well known "right to die" cases fostered public, academic and legal commentary, and a small number of academics began to offer clinical ethics consultation in hospital settings.⁶ Ethics consultation is currently established in virtually all health care settings in the United States, Canada, and throughout much of Europe; the standards of accrediting organizations such as the Joint Commission require a process to address ethical issues.

Healthcare ethics consultation is a service that clinical ethicists provide, on request, to those directly involved in the care of a patient, including patients themselves, family, and health care professionals (Jonsen, et al 2010). Questions about whether or not ethics consultation is a profession are now, for the most part, answered in the affirmative. The American Society for Bioethics and Humanities (ASBH) has a membership of over 1,800 individuals and institutions. The ASBH has published *Core Competencies for Health Care Ethics Consultation*, 2nd Edition (2011) and *Improving Competencies in Clinical Ethics Consultation: an Education Guide*, 2nd Edition (2015). There are multiple training programs throughout North America and Europe, most requiring a period of in-person mentoring by skilled providers of clinical ethics consultation. The ASBH (2013) is also piloting a quality attestation process for evaluating the practice of clinical ethics consultants (Kodish, et al. 2013, 26-36).

Ethical decisions in the hospital often attempt to balance the benefits and burdens of life-sustaining treatment. Ethics consultants are deeply involved in complex, emotionally fraught and frequently tragic clinical situations, but descriptions of the lived experience of becoming skilled in ethics consultation or of serving as an ethics consultant are almost entirely absent from published guidelines and professional literature. Further, although clinical ethicists are beginning to learn ways to address the "moral distress" of those we serve, there has been little explicit attention to the "moral distress" and emotional reactions of the consultant him/herself. Some noteworthy exceptions that we will discuss later are Frolic's (2011) work on "mindful embodiment" and several first-person accounts of ethics consultants' experiences with errors.⁷

Objectivist Thought in Current Descriptions of Ethics Consultation

Michael Polanyi found that modern, objectivist descriptions of scientific discovery and all other fields of knowledge were at odds with his own experience as a scientist. Polanyi realized that a personal, lived process of *coming to know*, or *knowing*, is

antecedent to and continues in established knowledge, giving it a personal backing within the convivial order of science. As we have remarked earlier in our discussion of the growth of bioethics, Polanyi observed that scientists tacitly rely on previously discovered knowledge and embark on a series of educated guesses towards uncovering new understandings. However, according to Polanyi and Poteat, objectivist thinking

tends to lose track of the *how* of knowing while presuming a relationship of hypercritical suspicion, guarded distance, and objectification to achieve “objective knowledge,” from which personal presence and involvement are withheld or repressed. By presuming personal involvement in the process of knowing to be illegitimate, because it is thought to adulterate the objectivity of what is to be known, features of that knowledge that are the result of personal participation drop out of the resulting conception, including most notably the presence of the subject who is doing the knowing and who is indwelling the context and discerning the facts of that knowing (Cannon 2014).

According to Poteat, this is a captivating imaginative picture, largely unnoticed, that we who are caught up in modernity both have and are in the midst of (Poteat 1985, 13). Precursors of this worldview can be traced to early Western thought, but it is perhaps best articulated in the modern age by Descartes (Poteat 1985, 151).

Cartesianism, as characterized in [Poteat’s] *Polanyian Meditations*, is not a systematic theory rigorously explicated by its exponents. Rather it is a dominant but deeply sublimated metaphysical grammar composed of a vocabulary of paradigmatic images and values, motifs and metaphors that operate at a subterranean level in the imagination; and this grammar informs all our implicit beliefs about the nature of Reality and our relationship to it, determining even the motivation to think or inquire in the first place (Cashell 2008, 54).

Descartes believed that the philosopher could only achieve certainty in knowledge by mentally doubting everything, and building up a collection of impersonal knowledge claims that, if successful, will have overcome our best attempts to doubt them, effectively placing himself or herself outside of nature and relationship. However, Poteat observes that Descartes obviously relied on his French language, a contradiction and inconsistency that renders the project fatally suspect (1985, 275).

Of course, ordinary descriptions of healthcare ethics consultation do not explicitly raise objectivist thought as a standard. Nevertheless, the widespread cultural reliance on the ideal of purely objective thought, uncovered by Polanyi and Poteat, may well influence the tendency to avoid descriptions of personal knowing in clinical ethics consultation. The ASBH Core Competencies are valuable, even necessary guidelines

for practice, but if taken as a complete description, without considering the ethics consultant in the context of practice, they may give the impression that ethics consultation is simply the application of explicitly known standards. This diverts attention from the *consultant who is struggling through* the steps of gathering information, speaking with all involved, identifying and describing the ethical issues, and attempting to reach an acceptable course of action. Frolic, an anthropologist with expertise in Bioethics, conducted ethnographic research with ethics consultants, asking them what they do when they are consulting. Their typical answers were rote role descriptions: writing policy, doing consults, and teaching. When pressed, they would occasionally remember the faces of patients or responses of doctors in difficult cases, “but [the consultants] were absent from these narratives, as if they were not agents in the drama but rather a Greek chorus standing in the wings, narrating the unfolding of fate” (Frolic 2011, 371-372).

In a positive development, the second edition of the *Core Competencies* has a more extensive discussion of the “attributes, attitudes and behaviors” of ethics consultants. Actually, these appear to be a set of core virtues: tolerance, compassion, honesty, honesty, self-knowledge, courage, prudence, humility, leadership, and integrity. The persistent controversy about whether these characteristics should be defined as “observable behaviors,” an “internalized inclination to behave in a certain way,” or a more “fundamental constituent of persons” may signal an objectivist, modern critical influence on Bioethics conversation. At the same time, the report does encourage nurturing and modeling these behaviors in educational programs (ASBH 2011, 32-33).

Another source of the tendency towards objectivist thought in clinical ethics may be the discipline’s early grounding in Enlightenment philosophical concepts. The eclectic group of academics, administrators, clergy and health care professionals who put together the field needed a common language for ethics discourse. Some leaders turned to the philosophical styles of Immanuel Kant and John Stuart Mill. Other scholars proposed the use of four ethical principles (respect for autonomy, beneficence, non-maleficence and justice; fondly known as the “Georgetown Mantra”) to identify an ethical dilemma, which was conceived as a conflict between two of these principles, either of which might be reasonably justified (Beauchamp and Childress 2001). While Bioethics continues to rely on principles for conceptual analysis, other methods have been suggested, including descriptive phenomenology (Zaner 2006), feminism (Tong 1997), narrative ethics (Charon 2006), and casuistry (Jonsen 1986). However, in even these approaches, the primary focus is not on the *consultant’s own self-reflection*, but rather on how the consultant may better understand *patients, families and health care professionals* in their milieux. Frolic notes that many of these

approaches to [ethics consultation]...helpfully draw attention to how context and power shape the analysis of cases and the agency of involved actors...However, they fall short in applying this insight.

First, they highlight the situatedness of *others* involved in [ethics consultation], but tend not to look in the mirror at their own situatedness. Using metaphors like “witnessing” and “hearing” to describe the work of [ethics consultation] characterizes the consultant as a passive vessel or conduit of communication, without acknowledging their own contextual filters. Even as other parties become more fully “fleshed out,” the [ethics consultant] remains a wraith-like character, a disembodied “voice of reason,”...providing unbiased facilitation and principled advice (2011, 374).

Churchill’s account of a “fairly routine” ethics consultation also draws attention to the situatedness of the consultant in his or her own “story” (2014 S36).

Personal Accounts of Error as Signs that Point to Post-Critical Thinking

As an alternative to objectivist accounts of knowledge, Polanyi and Poteat seek to establish a *Post-Critical* description of knowing, an exceedingly rich and complex endeavor. Both Polanyi and Poteat described the embodied person (for Poteat, the mindbody) as the radix of all acts of knowing. Polanyi demonstrated that our powers of discovery are continuous with those of all living things. Poteat’s especially difficult task was to encourage his students and readers to begin to take notice of, and bring to the surface, the tacitly held commitments that underlie all knowing.

In the context of the present discussion of ethics consultation, the most telling features of this project are: (1) restoration of confidence in the embodied, situated person as the source of all new and previously received knowledge; (2) accreditation of discovery as the person’s skillful integration of subsidiarily known clues into a comprehensive whole; (3) acknowledgment that knowing is to some extent unspecifiable, that is, not amenable to clear and distinct description; (4) recognition that apprenticeship is key to taking up a practice; and (5) reclamation of a “fiduciary” aspect to language, morality, and the social world. This essay will attend to those aspects of post-critical philosophy most connected to my discussion: the personal appraisal that is most easily discerned in complex, unresolved ethics consultations and that is nonetheless present even in routine consultations.

Errors in judgment cause regret, intense rehearsal of missed clues and actions that might have been taken differently, renewed inquiry with colleagues, and search of published literature for alternative approaches. The personal feelings, reconsideration of missed opportunities and actions, and consultation with one’s own convivial order echo Polanyi and Poteat in their contention that knowing is a skilled performance of integrating tacitly known clues into a comprehensive whole within a convivial community of like-minded knowers.

In the medical literature, Bosk recounts a “forgive and remember” response to mistakes that he observed as a sociologist “embedded” in a surgical residency program (2003, 39). Hilfiker courageously relates his own experience in an incident involving his patient, “Barb.” The clinical picture was ambiguous; after four negative pregnancy tests and an ultrasound, Hilfiker concludes that while Barb had been pregnant, the fetus had died and that a dilation and curettage was necessary to prevent infection. During the procedure, Hilfiker is alarmed to realize that he is removing recently living body parts; the pathologist confirms that at the time of the operation, the fetus had been alive. Hilfiker’s personal account was a confession that greatly influenced subsequent discussion of how to prevent and address medical error (1984,118-122).

Ethics consultants’ mistakes also occasion personal regret, reaching out to colleagues, and new learning. Paul Ford and Denise Dudzinski (2008) arrived at the idea for *Complex Ethics Consultations: Cases that Haunt Us* during a conversation with their mentor, Richard Zaner, whose own philosophical commitments include phenomenology and ethics. They agreed that the personal, affective components of ethics consultation should receive more attention, so they invited experienced ethics consultants to contribute first person accounts of cases that they remember with regret, consternation, and at times a feeling of failure. These are the perplexing cases that continue to “haunt” ethics consultants months, or even years after the fact; in a sense they are unresolved. They are occasions for reconsideration, mental experiments with alternative courses of action, and attempts to construct the fact patterns differently. If ethics consultation were merely the application of impersonal, quasi-logical rules to the facts of a particular case, as in the objectivist account, such persistent revisiting would be superfluous; but this “timeless,” unsituated approach does not fit with lived experience. As Al Jonsen wrote in the book’s introduction,

In my immature days as a scholar of ethics, ethical problems appeared in my books as timeless moments: whether or not to tell a lie, whether or not to save a threatened life. Also, these ethical problems existed in the conscience of the one who must choose, or between several persons debating right and wrong. When I entered the world of clinical medicine, ethical problems were suddenly swept into a temporal sea, moving, changing, sweeping to an ever-receding horizon. Cases concerned persons with a developing illness, an imminent crisis, a constantly shifting physiological picture, and deepening emotional responses. I was surprised by the clinicians’ oft-uttered phrase, “We should give this some time.” For me, ethics was [supposed to be] timeless true (2008, xvi).

Authentic descriptions and teaching of clinical ethics consultation should attend to the personal experience of practitioners and learners. Here is the account I contributed to Ford and Dudzinski's book.

Listening to the Husband

In September, two months after I began my position at a Catholic hospital, Fr. Kelly, a Catholic priest on staff requested what turned out to be my first ethics consult. He related that Ms. Barnes, a middle-aged woman on a ventilator with advanced chronic obstructive pulmonary disease (COPD) was asking to be taken off ventilator support. "How should we respond to requests like this in a Catholic hospital?" (USCCB 2009, 29-33). Logistical problems interfered with my attempts to schedule a full ethics committee meeting in a timely fashion, so with the endorsement of the ethics committee chair and hospital attorney, I used an individual consultant model.⁸ I kept in touch with these officials and with other ethics colleagues as I worked through the case. The basic steps of ethics consultation are gathering facts, speaking to all involved, identifying and analyzing the ethical issues, often participating in a family care conference, and writing an extensive chart note with a range of acceptable options supported by ethical theory/readings.

I proceeded to the hospital unit on a Friday. I spoke with Ms. Hernandez, the Nurse Manager. She said nursing staff were very frustrated by the case. Ms. Barnes repeatedly expressed a desire to be taken off the ventilator and was refusing food and most medications. Ms. Barnes was married, and her husband was strongly opposed to removal of life support. It seemed to the nurses that Ms. Barnes was being treated against her will simply because Dr. Evans, the attending physician, feared a lawsuit. Also, nurses had suspicions that Mr. Barnes was having an undue influence in the situation; Ms. Barnes seemed to "act differently" when her husband was in the room. I saw Mr. Barnes as an unusual, possibly dangerous, shadowy figure. Why did he sometimes come to the hospital in camouflage clothing—was he a survivalist or in a paramilitary organization? One of the nurses heard that someone saw him carrying a knife. How should these observations affect medical decision making?

I interviewed Dr. Evans, who described Ms. Barnes as a "pulmonary cripple" who had required frequent hospital admissions and ventilator support over the past months. At first, the patient and family had agreed that discontinuing life support was appropriate, but now the husband was "adamantly opposed." On the other hand, inconsistently, the husband was not in favor of a "full code," i.e., all measures to attempt resuscitation if Ms. Barnes' heart should stop beating. Perhaps he felt that this event would take the life support decision "out of his hands."

Dr. Evans explained that he often withdrew ventilator support in patients with end-stage chronic obstructive pulmonary disease, but not when other family members

disagreed. Another problem was that the patient's out of state medical insurance made it difficult to find a nearby ventilator support extended care facility (ECF). Attempts to "wean" Ms. Barnes from ventilator support were continuing. No, Dr. Evans did not see a need for an ethics consult or ethics committee meeting, but he had no strong objection to proceeding.

I made a short chart note about the ethical question, and left for the weekend, hoping that "weaning" efforts would be successful, but on Monday the nurses reported that whenever ventilator support was decreased, Ms. Barnes became very anxious and indicated she wanted support increased once again. It was time, actually past the time, to talk to the patient.

A nurse accompanied me as we entered Ms. Barnes' room. Ms. Barnes could speak "a little" by blocking the tracheostomy tube for short periods. I felt awkward and concerned about the seriousness of the decision. I had never tried to communicate with someone on a ventilator and worried about misunderstanding or misinterpreting what she said. I asked yes or no questions:

"Do you want to stop the ventilator machine?"

"Yes.

"Do you understand that you will die when the ventilator is stopped?"

"Yes"

"Do you know your husband is against this wish?"

"Yes"

"Should we listen to him?"

"No."

"Do you want him included in this decision?"

"No."

I explained to Ms. Barnes that in my role, I could not promise a particular outcome, but that I would speak to Dr. Evans and her husband. The case seemed to be a clear conflict between patient autonomy and unjustifiable paternalism. However, I also had concerns about inconsistency in Ms. Barnes' wishes and the quality of her informed consent.

After this conversation, while I sat at the nurse's station writing a lengthy, carefully considered, almost "textbook" chart note, Mr. Barnes called into the unit to speak to the social worker. Should I now take the opportunity to speak with Mr. Barnes, and/or involve the social worker as an interested party? She informed me that she had been working with Mr. Barnes for his "ongoing emotional problems" and "it might not be a good idea for an additional person" (me) to speak with him. I pondered this, as well.

In the chart I indicated that Ms. Barnes was the primary decision maker and recommended that the medical team continue, as well as document, conversations with her to be sure she understood the consequences and process of ventilator withdrawal.

This recommendation, I hoped, would address the inconsistency in Ms. Barnes' views and support her autonomy, defined as free action, the ability to reason and deliberate about choices and authenticity.⁹

After several days I returned to the unit. Unfortunately, the program I had so carefully set out in the chart was not happening. There was no evidence of any ongoing conversation between the health care professionals and Ms. Barnes. No one had followed my recommendations.

The pattern continued at length: weaning attempts were unsuccessful, Mr. Barnes wanted treatment to continue and his wife to be transferred to a nursing home, Ms. Barnes refused to be transferred and at certain times voiced a desire to stop ventilator support, but would inevitably become anxious when "weaning" was attempted. I continued to "follow at a distance."

In October, the nurses put up Halloween decorations. The cardboard pumpkins, spiders and witches reminded me of the passage of time, the triviality of death in public awareness, and the real suffering experienced by Ms. Barnes and those around her, a suffering that it seemed I was powerless to change. Ms. Barnes eventually agreed to, or gave into, transfer to an ECF, but was this her authentic decision, or just a form of surrender? All too often, we assume that the ethical question has been resolved when a patient agrees to what "we" think she should do. Ms. Barnes' death after several weeks in the extended care facility seemed to vindicate the nurses and their moral dis-ease with the situation.

As I look back at this case, I recognize that it was complex, difficult, and could not be resolved by simply identifying and analyzing the dilemma of autonomy vs. paternalism (seemingly based on the wishes of the husband and doctor instead of Ms. Barnes' best interests). Ambiguities included multiple perspectives among those involved, issues of family dysfunction and emotional instability, perceived threats of violence, worries about lawsuits, uncertainty about the ethics consultation process, and logistical problems (Bernal 2008, 108).

In addition, the power structure in the hospital was difficult to navigate: ethics consultation is supposed to serve the patient, but it seemed she was at the bottom level of a complex hierarchy: hospital administration, medical staff, nursing administration, social work, pastoral care, and finally, it seemed, the patient herself. The suffering of the patient, time pressures, contingencies, risk, and ambiguity of this process obviously stand in sharp contrast to the received accounts of ethical deliberation represented by utilitarianism and Kantian idealism and principlism. Over the years, I have continued to feel regret about this case.¹⁰ As I stated in the article, "I felt new, inexperienced and overwhelmed. I doubted my own skills and authority... By proceeding so cautiously, I might have overlooked opportunities to facilitate an earlier and more ethically sound resolution" (Diekema, D., 2013). More diplomacy with each of the involved parties might have helped, for example:

Dr. Evans, please tell me more about why you are reluctant to withdraw ventilator support when the family disagrees. What is your concern? Under what circumstances might you agree? What would be the medications used to help Ms. Barnes' air hunger if and when the ventilator is withdrawn? I recommend a family conference; would you agree to attend?

Ms. Barnes, sometimes you say that you would like to be removed from the ventilator, but at other times you seem to want continued support. Please help me understand. Would you be willing to participate in a family conference, here in your room?

Mr. Barnes, are you aware that your wife has expressed the wish to stop ventilator support? Are you against letting her decide? Why? At the hospital, we like to see the patient herself make her own decisions. Do you see a way to come to an agreement?

After these conversations, and with a sense of what each party would endorse, a family conference at Ms. Barnes' bedside should have taken place; perhaps with more direct assistance from others on the ethics team, and regular follow-up visits to the nursing unit. Another alternative would be simply to end ethics involvement in the case, as do other consulting services when they have given a final opinion that is, in some situations, making no appreciable difference in patient care. The ethics service could make a note in the patient's chart: "Nothing further to add. Signing off." But would this be a form of patient abandonment? At what point should an ethics consultant draw back from a case that shows no sign of resolution?

I approached the case with the virtues of caution, good faith, integrity and humility; more courage and persistence might have been helpful. On the other hand, not even the highly experienced and virtuous ethics consultant can easily and simply resolve every case. The patient's illness, family dysfunction, the choices available to modern medicine, and the persistent expectation of cure all contribute to ambiguous ethical problems; as well, the responsibility of the ethics consultant is circumscribed by his or her role. The best approach is to strengthen and enhance ethics consultation skills and resources, for example, by more readily asserting the authority of the Ethics service, convening the full ethics committee and seeking colleagues' advice in the most complex cases.

The personal participation of the ethics consultant is clearly apparent in this, and in other accounts in Ford and Dudzinski; the consultants are deeply involved in the situations they relate. Relying on their knowledge and acquired skills, they strive to reach satisfactory conclusions. However, ambiguities, complexities, the demands of the situation and messy contingencies can prove to be intractable. Perhaps the ethicists' tacitly held knowledge and skills were inadequate, or were insufficient to handle the

complexity of the case; despite their best efforts at the time, the haunting cases persisted as unresolved memories.

But it would be wrong to conclude that when the ethicist gains more experience, or the field itself achieves an even clearer consensus about ethics consultation competencies, that the personal elements so evident in “haunting” cases will no longer be required. It is a Cartesian myth to believe that eventually, all will be made clear and distinct. All too often, we forget that the now commonplace knowledge and skills of the experienced ethicist, as well as those of bioethics as a whole, have been sedimented over time, through the concerted efforts of like-minded professionals who have sought to reach meaningful agreement. The searchlight focus on specifiable competencies to the exclusion of more tentative, unspecifiable forms of knowing may paradoxically diminish the effectiveness of teaching and learning (See Merleau-Ponty 1962, 392).

Implications for Teaching and Learning

Thus far, we have considered ways in which the field of ethics consultation may have absorbed the ideal of clear and distinct knowledge from modernity as a whole; then reviewed evidence for the personal coefficient of knowing, revealed in errors, complex cases, and the gradual sedimentation of knowledge in a convivial order. We now need to acknowledge a reasonable question, “Isn’t it obvious and trivial that actual persons conduct ethics consultations, sometimes making errors, but often reaching satisfactory conclusions? What does a description of personal knowing contribute to the field?” (Poteat 1976).

I believe that many opportunities can be found in the context of ethics consultation teaching and learning. While the ethics consultation knowledge base is extensive, focusing on essential core information, process skills, and guidelines for analysis (Jonsen, et al 2010), there is a tendency to view ethics consultation as an application of clear and distinct knowledge. There has been little attention to personal practice elements, such as *how it is that we come to recognize an ethics problem, consider courses of action, and strive to reach an acceptable outcome*. This is the case despite the nearly universal insistence on ethics consultation internships, fellowships and other forms of guided clinical practice: a tacit acknowledgement that these personal skills are essential and must be acquired through interaction in clinical settings with skilled ethics consultants. Polanyi and Poteat’s descriptions of personal knowledge are precisely the tools needed to more adequately account for and foster personal skills in ethics consultation. A more true-to-life, honest description of how we go about serving as ethics consultants, and a humbler approach to our interactions with patients and families, with whom we are co-adventurers, should enhance learning and practice (Ramsey 2002, xii-xiii). To this end, I would recommend that educational programs:

(A) Attend to the exercise and development of virtue in ethics consultation. The ASBH Core Competencies Report discussion (2011, 32-33) views “attitudes,” “attributes” and “behaviors” as rather static entities, but I believe that considering these “traits” as *virtues* is more fruitful. Virtues in philosophical literature, particularly in the natural law tradition, are active forms of personal practice with the intent of promoting human flourishing.¹¹ They are not timeless characteristics, but actions of a person within an ongoing practice (Muller). First person accounts of errors in ethics consultation, particularly the discussions of “haunting aspects,” are excellent material for discernment, via positive and negative examples of aspects of virtuous practice. Ford and Dudzinski provide extensive questions and educational exercises keyed to the cases in their book. Further reflection on the nature of virtue is available from resources such as McIntyre (2007).

(B) Acknowledge and discuss “moral wounds” and “moral “distress.” With few exceptions, the bioethics literature overlooks the possibility that ethics consultants themselves may experience moral distress. It would be good openly to discuss such experiences, using Ford and Dudzinski and mentors’ own reflections on their cases. An exploration of learners’ perceptions as they and their mentors approach a new case would be useful. Do learners experience excitement, anxiety, confusion, trepidation or something else? Are their experiences *walking to* the nursing unit different from *returning* to the ethics office? (Spielberg 1972). Compare and contrast their perceptions to those of their teacher.

(C) Explore the multiple convivial relationships in the hospital, and especially those with the persons who bring us ethical problems. How do the learners’ feelings (for example, anxiety or fatigue) align with those of the patient, family, or health care professionals? (Ulrich, et al 2010, 20-22). How might the similarities/differences affect the relationships? Do learners perceive themselves as unsituated analysts, or as “co-adventurers” with the patients we serve? These reflections are an opportunity to consider the virtues of respect, humility and compassion.

(D) Consider the personal values, commitments and beliefs of the learners. How does their decision to pursue this field relate to their own experiences and background? Are there specific events in their lives, or the lives of persons close to them, that have fostered their

interest? How might these experiences influence their learning and perceptions?

(E) “Think out loud” about the clues, key findings and patterns uncovered by the mentor. Compare and contrast them to Polanyi’s description of medical students learning to read X-rays of the lungs:

At first the student is completely puzzled. For he can see in the X-ray picture of a chest only the shadows of the heart and the ribs, with a few spidery blotches between them. The experts seem to be romancing about figments of their imagination; he can see nothing that they are talking about. Then as he goes on listening for a few weeks, looking carefully at ever new pictures of different cases, a tentative understanding will dawn on him; he will gradually forget about the ribs and begin to see the lungs... He has entered a new world. He still sees on a fraction of what the experts can see, but the pictures are definitely making sense now and so do most of the comments made on them. He is about to grasp what he is being taught; it has clicked (Polanyi 1962, 101).

Student ethics consultants acquire their skills in a similar fashion; gradually recognizing the issues, problems, and appropriate next steps in a clinical case under the guidance of their mentors.

(F) Incorporate conversations with professionals in other, related disciplines. Perhaps conduct patient rounds along with Clinical Pastoral Education (CPE) students, and/or adopt some of their learning practices: “In CPE training, a significant amount of time is spent, through individual supervision and in peer group meetings, helping trainees process their emotional, personal, spiritual experiences and feelings resulting from their patient/family encounters” (Smith 2015). Clinical programs for psychiatrists and clinical psychologists also attend to the professional-patient relationship, asking questions such as, “Who is this patient to you? What memories and/or perceptions are you having? How do these affect your practice?” (Argueta-Bernal 2015).

(G) Frolic describes the ways her clinical ethics program has built “reflexivity” into the clinical experience (2011, 372-374). Small ethics consultation teams allow frequent discussion and peer commentary. When discussing a case, ethics consultation students comment on four questions: “What was the issue? What can I celebrate? What

challenges did I encounter? What did the team learn from this case?” This allows self-awareness, accountability, and attention to moral distress. Role play and reflective practice journals are complementary strategies.

Conclusion

Objectivism focuses on already achieved, explicit knowledge. It thereby fails to describe adequately the person in the process of knowing and omits from consideration all the more or less unspecifiable, ambiguous elements that are involved when, for example, the person begins to perceive a problem, strives to resolve the facts into a meaningful pattern, and then applies the findings. While the physical sciences can generally proceed without incident under this false description, the human sciences and the professions, including ethics consultation, may unfortunately downplay those features that may appear to be “trivial,” yet are in fact essential to the practice, such as one’s good faith commitment to others, one’s tacitly held skills, and one’s setting within a rich convivial order. I hope that the insights of Polanyi and Poterat will open a deeper understanding of these, and other non-explicit features of knowing, so as to enrich practice and teaching in ethics consultation.

ENDNOTES

¹An earlier version of this paper was presented at the 2014 Primacy of Persons Conference, Yale University.

²For extensive discussion, see Bankert and Amdur (2006).

³See Polanyi, M., 1962. *Personal Knowledge: Towards a Post-Critical Philosophy*. New York: Harper Torchbooks.

⁴United States Holocaust Memorial Museum, “The Doctors’ Trial: The Medical Case of the Subsequent Nuremberg Proceedings.” *Holocaust Encyclopedia*. Washington, D.C. See also Pellegrino (1997, 307-308).

⁵See the United States Conference of Catholic Bishops (2009).

⁶President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983).

⁷See Rubin and Zoloth (2000) as well as Ford and Dudzinski (2008).

⁸There are three “models” of ethics consultation in general use: full ethics committee, small consulting team, or individual ethicist; all three relying on conviviality. The full ethics committee model is best suited to newly created Ethics Services or to complex, unusual cases.

⁹For representative definition of these terms, see, for example, Beauchamp and Childress (2001, 1-23) and Jonsen, et al (2010, 1-8).

¹⁰Many thanks to Diane Yeager for drawing attention to “moral wounds” occasioned by involvement in ambiguous, tragic ethics cases. The Primacy of Persons Conference, Yale University, June 6-8, 2014.

¹¹Many thanks to Ronald Hall (2014) for his observation regarding Natural Law Ethics. The Primacy of Persons Conference, Yale University, June 6-8, 2014.

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