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RETHINKING HEALTH CARE ETHICS

Stephen Scher
Kasia Kozłowska



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Stephen Scher
McLean Hospital
Department of Psychiatry
Harvard Medical School
Boston, MA, USA

Kasia Kozłowska
The Children's Hospital at Westmead
Disciplines of Child & Adolescent
Health, and of Psychiatry
University of Sydney Medical School
Sydney, NSW, Australia



ISBN 978-981-13-0829-1 ISBN 978-981-13-0830-7 (eBook)
<https://doi.org/10.1007/978-981-13-0830-7>

Library of Congress Control Number: 2018942879

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Printed on acid-free paper

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The registered company address is: 152 Beach Road, #21-01/04 Gateway East, Singapore 189721, Singapore

“Rethinking Health Care Ethics is a fine example of the power of interdisciplinary work, particularly the role of the social sciences and their relationship to philosophy. It no less focuses on how to make that helpful to the clinicians who have to make the hard decisions. The book brings a valuable set of insights to important issues.”

—Daniel Callahan, co-founder and President Emeritus, The Hastings Center

“This is a practically useful and important book. It takes on the intricate and confusing problem created by bioethics when applied not in policy but in clinical practice. There, as the authors delineate, bioethical principles and methods are frequently found by clinicians to be irrelevant and unhelpful. The authors effectively review the large social science literature that seeks to explain this failure. What makes the book important is that it sets out in a compelling and nicely illustrated way an alternative clinical framing. That framing enables the authors to develop an entire pedagogy for clinical bioethics. This is hugely ambitious, and readers will agree and disagree about different recommendations. Yet overall the authors must be praised for engaging an extraordinarily difficult subject with original thinking and practical proposals. Best of all this is a very human form of clinical training and intervention that turns on the moral cultivation of the individual and her or his growing acquaintance with clinical experience. The authors seek to empower clinicians, and I believe they succeed.”

—Arthur Kleinman, MD, author of *The Illness Narratives*, *What Really Matters*, and *Patients and Healers in the Context of Culture*

“Health care ethics has typically been taught in the classroom, not the clinic; the actual ethical thinking of clinicians has been less investigated and is less well understood. *Rethinking Health Care Ethics* addresses this deficit by giving educators and clinicians a new way of thinking about ethics—a way that is accessible and relevant and not dependent on applying complex philosophical theories. The book provides a pathway for students and clinicians to integrate ethical thinking into clinical practice from the get-go. I strongly recommend this book to all health care educators and clinicians.”

—Merrilyn Walton, MSW, PhD, Professor of Medical Education, Faculty of Medicine, University of Sydney

“In this superbly written book the authors draw on materials from philosophy and the social sciences to elaborate a model of ethical discourse for clinical health care whose central feature is the recognition and development of each trainee’s and each clinician’s own moral thinking, based in the self and reflecting a person’s entire life experience. From this core insight, and with many vignettes drawn from their own clinical experience, the authors also elaborate an approach both to formal classroom teaching and to less formal teaching in clinical settings that amounts, in effect, to a full program for teaching clinical ethics. I warmly recommend this groundbreaking book as a highly useful resource for teachers, trainees, and health care professionals interested in clinical ethics as an inherent part of compassionate, effective, and safe health care.”

—Per Olav Vandvik, MD, Professor of Evidence-Based Practice and Shared Decision-Making, University of Oslo

“Scher and Kozlowska offer a powerful and deeply reasoned critique of teaching and practice in contemporary bioethics. In its place, they offer a timely, compelling, and humane proposal for rethinking values and ethics in the care of patients.”

—Allan M. Brandt, Harvard University

To all those who helped us learn to trust ourselves

PREFACE

The early history of this book is connected with the first author (SS) alone. As described in detail in Chapter 2, the book has its origins in the 1980s, in my clinical work in hospitals affiliated with Harvard Medical School (HMS). Robert Lawrence, Chief of Medicine at Cambridge Hospital and first Director of the Division of Primary Care at HMS, had the vision and generosity to open his department to what was presented to him as a promising, but untested, approach to teaching medical ethics at the bedside and through various forms of clinical conferences rather than in the classroom. Early on, the work was supported by the late Carl Walter, a retired clinical professor of surgery who was also the leading early researcher in asepsis, the inventor of the plastic blood bag, and at that particular time the director of the medical school's Alumni Fund. The strong support from Bob and Carl helped to establish the clinical ethics program and enabled it to be extended to other HMS hospitals. The Division of Primary Care also sponsored my continuing education course, "The Terminally Ill Patient: Ethical, Legal, Psychological, and Social Issues," which is discussed in Chapter 8. Throughout this period at Harvard, Daniel Federman, initially Dean for Students and Alumni and then Dean for Medical Education, was a regular sounding board and source of encouragement, as was John Stoeckle, a revered clinician and professor who was an inspiration to generations of Harvard medical students and residents.

After that early work at Harvard, and during my years as a Visiting Scholar at Yale Law School and teaching ethics and organizational behavior at Yale School of Management, I acquired many debts, large and small, to many people for many things, but none pertaining directly to this book. Among other reasons, my professional work veered into editing. I joined the editorial staff of the *American Journal of International Law* in 1999 and the *Harvard Review of Psychiatry* in 2003. I stepped down as Senior Editor of the *American Journal* at the end of 2016, and am now in my sixteenth year as Senior Editor of the *Harvard Review*.

The joint history of this book—the collaboration by the two authors—began about a decade ago, with three articles (one by SS, and two by both of us) that laid out what might be seen as the working foundation for what we publish here. We are indebted to the many friends and colleagues who have discussed these issues with us in conferences, over coffee or dinner, in the hallway, or by email or telephone, sometimes in response to drafts or articles of various sorts that we have sent to them. In alphabetical order: Dennis Butler, Megan Chambers, Catherine Chudleigh, Bronya Cruickshank, Catherine Cruz, Bronwen Elliott, Robert and Sue Faron, Sue Foley, Philip Hazell, Sophie Holmes, Melissa Lim, Judy Longworth, Hugh and Maxine Martin, Georgia McClure, John and Loyola McLean, Angela O'Hara, Robert Pullen, Karen Hazell Raine, John Sandeman, Blanche Savage, Richard Schram, Peter Schuntermann, Toni Turano, Danielle Vandenberg, and Merrilyn Walton. Bella Eacott of the Clod Ensemble in London and Paul Dwyer, Louise Nash, and Karen Scott of the University of Sydney were especially helpful as we sorted out the use and availability of drama materials for educating health professionals. Megan Chambers, here in Australia, and Alan Abrams of Harvard Medical School each contributed to the write-up of a clinical vignette.

More recently, we have been blessed with six impressively astute readers who have commented on the entire first draft of this book: the historian Allan Brandt and psychiatrist John Peteet of Harvard, child and adolescent psychiatrist Megan Chambers (now working with the indigenous population in Alice Springs, Australia), social worker and health policy specialist Bronwen Elliott, nurse Natasha Haynes of The Children's Hospital at Westmead, and evidence-based health care researcher and clinician Per Olav Vandvik of the University of Oslo. Allan and Per also were also remarkably generous (and remarkably acute) in commenting on various revised drafts as we responded to readers' first

sets of comments on each chapter. Finally, clinical nurse consultant Karen Hazell Raine (currently Clinical Lead of the New South Wales Statewide Outreach Perinatal Service for Mental Health) was instrumental in identifying numerous articles that helped us bring certain problems into much clearer focus. The book is much, much stronger substantively and clearer stylistically because of what these many readers have contributed. We are deeply grateful to all of them.

Finally, we are grateful to Joshua Pitt, our editor at Palgrave Macmillan, and to Sophie Li, the editorial assistant who ushered us through the production process. Their efforts made for a surprisingly smooth experience as we moved the manuscript from its earliest stages through final production.

Needless to say, the remaining mistakes, problems, points of uncertainty, and intellectual confusions are ours alone. We trust, though, that the reader can see through any such infelicities to recognize the present effort for what it is: an attempt to develop a way of thinking about health care ethics that recognizes and builds upon the baseline ethical competence and understanding that all health professionals, simply as mature and thoughtful human beings, bring to their work.

One of the vignettes in Chapter 2 and portions of Chapters 2–6 are adapted from earlier works published by Australian Academic Press: the first author’s “Ethics Anxiety,” *Australia and New Zealand Journal of Family Therapy* (2010), 31(1), 35–42, and our joint article “The Clinician’s Voice and the Limits of Bioethics,” *Australia and New Zealand Journal of Family Therapy* (2011), 32(1), 15–32. Some material in Chapter 5 has been adapted from our “Thinking, Doing, and the Ethics of Family Therapy,” *American Journal of Family Therapy* (2012), 40(2), 97–114.

Boston, USA
Sydney, Australia

Stephen Scher
Kasia Kozłowska

CONTENTS

1	A Brief Introduction	1
2	The Limitations of Bioethics: A Personal History	13
3	The Rise of Bioethics: A Historical Overview	31
4	Theory and Practice: From the Top Down	45
5	The Elusiveness of Closure	57
6	Ethics and the Self	71
7	The Self in an Interpretive Community	83
8	A Framework for Teaching Clinical Health Care Ethics	95
9	Teaching Clinical Ethics in the Formal Curriculum	113
10	Teaching Ethics in a Clinical Setting	139
11	Empowering Clinicians	157
	Index	165

LIST OF TEXT BOXES

Text Box 5.1	A Model for Ethical Problem Solving in Clinical Medicine	59
Text Box 9.1	TACCT [Tool for Assessing Cultural Competence Training] Content Domains	118



CHAPTER 1

A Brief Introduction

Abstract In this chapter we introduce the themes of the book and present our overall approach to clinical ethics for health professionals. Of special note is our assumption that the social sciences—especially history, sociology, and anthropology/psychology—can do much to enrich how health professionals think about clinical ethics. We also provide an overview of the book as a whole.

Keywords Health care · Clinical ethics · Bioethics · Ethical principles
Health professionals · Patients · Social sciences · Professional education

The audience for this book is anyone who has experienced a discrepancy between their own individual thinking about ethics—whether in medicine, nursing, social work, psychology, or other fields—and what they encounter in the academically oriented, comparatively theoretical discussions of ethics as presented in grand rounds, at conferences, and in professional and academic journals. What these clinicians know is that this difference makes a difference: their ways of thinking and acting are grounded not in academic abstractions but in their own selves, their general life experiences, years of clinical encounters with patients, and myriad discussions with friends and colleagues, both junior and senior. What they also know is that when they need advice concerning ethical problems in their work, the best source of support and feedback is likely

to be their own colleagues, who understand how those problems are embedded in, and inseparable from, the clinical milieu.

That, in a nutshell, is what this book is about. The starting point is that health care trainees and clinicians carry around with them, as part of their very selves, the emotional and intellectual resources required for them to act and think ethically—or, in broader terms, humanely and reflectively—in their encounters with patients. Any effort to develop clinically relevant ethics that fails to build upon these preexisting personal resources will inescapably fall short of achieving its intended result, however good or admirable.

THE DOMINANCE OF BIOETHICS

In this context, health professionals have not been well served, or at least not well enough served, by the academic community of *bioethicists*—the philosophers, theologians, lawyers, and social scientists of various sorts who have come to dominate, worldwide, the diverse fields of health care ethics over the last half century. The theoretical, philosophically oriented approaches of bioethicists generally leave clinicians feeling somewhat at a loss, not knowing exactly how to proceed. Especially noteworthy in this regard is the principle-based approach commonly known as *principlism*, in which autonomy, beneficence, nonmaleficence, and justice, along with rules such as confidentiality, privacy, and truthfulness, are deemed sufficient to generate and understand all of health care ethics. The models of ethical discourse presented by bioethicists, however, regularly fall short of connecting with the clinical milieu and with clinicians' own well-developed, intuitively engaging modes of ethical thinking. And though these latter modes of thinking are the ones with which clinicians are most comfortable, bioethicists have seen these concrete, humanly grounded ways of thinking as too informal and unsystematic to merit serious attention.

Understood in terms of the classic triad of thought, emotion, and action, bioethicists have focused almost exclusively on thought—ethical thinking *per se*—and given inadequate inattention to emotion and action. What has been lost in the process are the concrete human dimensions of caregiver-patient interactions and, more generally, the connection between ethical discourse and the full dimensions of the self. Especially in a domain of activity, such as health care, that is so rich in human interactions, it is

only by respecting and building upon the interconnectedness of thought, emotion, and action (Bruner 1986) that one can expect any success in teaching clinicians or otherwise advancing clinical ethics.

One final but crucially important point. Feelings—understood here as the subjective experience of emotion (Damasio 1994)—play a centrally important role in the process of ethical discovery and, indeed, in ethical discourse generally.¹ Philosophers, because of their probing attention to ethical theory, may learn to access their moral thinking with ease (though as the first author [SS] can well attest, only after years of effort and training), the easiest mode of access for everyone else is often through their gut feelings about right and wrong, about the fittingness or unfittingness of a current or proposed action, or about something being not quite what it should be. These feelings, a deep expression of the self, are a sign that further thought may be required, that something needs to be sorted out. And without these signs, many of us would have no idea where to begin moral exploration.

It is the above elements—the thoughts, emotions (and feelings), and actions of the self, plus a person’s professional and personal experiences and goals—that serve as our point of departure. By taking these elements as the foundation for rethinking health care ethics, we hope to develop an approach that embraces and builds upon the particularity of each individual clinician.

THE LENS OF SOCIAL SCIENCE

Another way of understanding our approach is through the lens of social science. As a relatively new and influential social phenomenon, bioethics has drawn the attention of leading social scientists. A common theme raised by social scientists is the narrow intellectual perspective of bioethics, its overly rationalistic modes of analysis, and its disconnection from flesh and blood human beings.² The sociologist Renée Fox (1999, p. 9) notes that bioethics’

coolly rational mode of analysis focused on autonomy-of-self bends [bioethics] away from detailed attention to the empirical contexts in which ethically relevant events occur, from how they are experienced, and from serious consideration of the play of both rational and nonrational social and cultural factors in moral life.

She adds that bioethics tends not only “to minimize the role of social and cultural factors” but to “regard them as epiphenomena.” In another essay, Fox, along with her coauthor Judith Swazey, presents an excellent summary of criticisms of bioethics—some from outside, some from within bioethics itself—many of which focus on the limits of principlism and its inattention to the broader human dimensions of health care (Fox and Swazey 2005).

The same frustration with the narrow frameworks of bioethicists is reflected in the observation by the historians Gary Belkin and Allan Brandt (2001, p. 8) that “history can shift our attention to how experiences and practice are established in culture rather than focus on abstracted terms, concepts, and formulations.” Indeed, bioethical formulations need to resonate with experience and to capture “how attitudes toward suffering, expectations about medicine, customs of establishing desert and entitlement, get formed, cohere, and change.” In a separate essay Belkin (2004, p. 378) urges that bioethics be supplanted by a *medical humanism* that is

less concerned with generating rules of conduct than with deepening and enriching the self-understanding and perspective brought to bear when people confront choices and each other. And a humanistic ongoing engagement and routine self-reflection can make medicine more deeply ethical than can duels over methodologies of ethics per se. Bioethics has narrowed how reflection in medicine about medicine takes place and has inhibited rather than rescued a medical humanism by an overrated focus on restrictive reduction to “the ethical.”

Belkin and Brandt, like Fox, see the need to move past the goals and standards of present bioethics to a broader framework that incorporates cultural, historical, psychological, and social perspectives and that, as Leon Kass (1990, p. 8) argued so lucidly, is strongly oriented not to the analysis of “extreme examples” but to the “morality of ordinary practice.”

The anthropologist Arthur Kleinman (1999, p. 72) has focused on the gap between the particular and the universal, between “moral experience,” which is local and rich, and the goals and methods of bioethics, with its quest for “objective standards” and its “models of moral reasoning championing the reflection and rational choice of autonomous individuals.” Bioethics, in Kleinman’s view, “risk[s] irrelevance”; it “simply

does not account for social processes of moral life.” What any viable approach to ethics in health care *does* need to take into account is the moral experience of individuals, which

is about the local processes (collective, interpersonal, subjective) that realize (enact) values in ordinary living. These processes cross the boundary of the body-self, connecting affect and cognition with cultural meanings, moral norms and collective identity with sense of self. Thus moral experience and personal experience are interfused, value with emotion. (pp. 71–72)

Though Kleinman elaborates an anthropological/ethnographic approach to bridging moral experience and bioethics into some form of workable harmony, the approach we take into this book is broader and more eclectic. Like Kleinman, we see individual moral experience as fundamental. It is crucial in understanding clinical ethics generally—that is, how health professionals understand and address the ethical dimensions of their work. And it is also crucial to the process of professional training in health care—that is, how we help particular individuals make the transition from preprofessional aspirants to professional trainees in health care to mature professionals. In that context, and building upon Kleinman’s notion of individual moral experience, the present volume represents our own effort to develop an approach to health care ethics that draws upon the insights of sociology, history, and anthropology, and that bridges the gap between local, concrete experience and the quest for universality and objectivity.³

We have been focusing in this section on perspectives from the social sciences, but bioethics has also met with strong criticisms from within. Two of the most articulate such critics have been Daniel Callahan, himself the founder of the Hastings Center (see Chapter 3), and Larry Churchill.⁴ Callahan (2003) is a self-described communitarian, and Churchill’s graduate training was in religious studies rather than philosophy; because of these orientations, both are likely more attuned to the human dimensions of health care. By the same token, their critiques have much in common with those of social scientists. Callahan (2003, p. 288) is especially critical of the “all too common” mistake by philosophers that

good ethics comes down to good arguments. It is as if an anatomist thought that human nature could best be understood by stripping all the flesh off a body to uncover the hidden bones. . . . Rationality at the least needs the help of the imagination. At the clinical level this means,

for instance, an ability to enter into the needs, pain, and suffering of others, to grasp their situation and respond appropriately to it. At the policy level it means understanding—for example, how a proposed health care reform might not only improve health or access to health care, but how it could play out in the larger political and social scene.

Our own view, and we're sure that Callahan would agree, is that the enrichment of ethical discourse with materials from the social sciences is a potentially powerful way to facilitate, on both the clinical and policy levels, the "imagination" to which he refers. Much of what we say in our chapters on teaching ethics (Chapters 8–10) is based on this insight, coupled with the idea that teaching needs to engage the whole person—thought, emotion, and action—and not just the intellect.

LIMITATIONS

The field of health care ethics is, of course, vast, and we obviously will be discussing only part of it. What we will *not* be discussing, except in passing, are questions of public policy, research ethics, legal regulation and professional accountability (including licensure, disciplinary frameworks, and negligence/malpractice), and *patient safety*, the organized effort to reduce preventable injuries within health care.⁵ With regard to this last topic, the safety of patients is obviously of paramount concern in all fields of health care, and the World Health Organization's efforts to promote patient safety have, on a global scale, raised awareness of, and helped to reduce, preventable injuries. What our book can contribute to patient safety is to help health professionals to recognize the legitimacy of their own ethical thinking, to bring that thinking to bear upon their own work, work environment, and culture, to communicate and cooperate more effectively, and to look critically at—and when necessary, act to improve upon—existing practices.

CHAPTER SUMMARY

Chapter 2. The Limitations of Bioethics: A Personal History. The next chapter looks at the origins of this book in the work of the first author [SS] as a researcher, teacher, and consultant in the 1980s, when he taught ethics, at the bedside, in hospitals affiliated with Harvard Medical School.

Chapter 3. The Rise of Bioethics: A Historical Overview. In this chapter we discuss the rise of bioethics beginning in the late 1960s with the founding of the Hastings Center, followed shortly thereafter by the Kennedy Institute of Ethics at Georgetown University. After looking at its early U.S. history, we turn to the mixed response to the bioethics movement in Europe and the change in direction there following the discovery of Fritz Jahr's work from the first half of the twentieth century. Finally, we look at how the 2005 Universal Declaration on Bioethics and Human Rights fits into this history.

Chapter 4. Theory and Practice: From the Top Down. We turn here to the development of substantive doctrine in bioethics, beginning with the California Supreme Court's 1957 *Salgo* decision introducing the legal doctrine of informed consent, and moving up to and through the formulation, in the late 1970s, of four central ethical principles for understanding health care ethics. We note some discontinuities between bioethics, so conceived, and the clinical thinking and practice of health professionals, and we raise some questions concerning ethical "dilemmas," closure, and ethics expertise.

Chapter 5. The Elusiveness of Closure. When confronting any difficult ethical situation, reaching closure—a single, determinate decision—is typically difficult. Some bioethicists have proposed that health professionals use multistep processes as a means of ensuring thorough consideration of the relevant issues and reaching a conclusion. To evaluate such proposals, we look at a multistep process that *does* work: the judicial appeals process as exemplified by U.S. federal courts (which we use as a convenient model). We suggest that various institutional, educational, social, and substantive/intellectual factors are at work in enabling appeals courts to reach decently informed, well-reasoned decisions, and that these factors are *not* shared by the suggested multistep processes for ethical decision making. We conclude that health professionals need to look elsewhere for a model for making ethical decisions.

Chapter 6. Ethics and the Self. Going back to basics, we see the development of ethical thought, emotion, and action as an inescapable and fundamental part of becoming a person, and as the essential background against which we need to think about clinical ethics for health care trainees and health professionals. We distinguish between *formal* and *informal ethical discourse*, noting that bioethicists engage in the former, whereas health professionals engage in the latter. We also introduce the notion of *fast* and *slow thinking* as a way of understanding informal

ethical thinking and what we describe as *implicit ethical frameworks*, which could be understood as ethics without the language of ethics.

Chapter 7. The Self in an Interpretive Community. We present two vignettes—each of which invokes implicit ethical frameworks—as a means of introducing the notion of *interpretive communities*. This notion, first elaborated by the literary theorist Stanley Fish in his 1980 book *Is There a Text in This Class?*, enables us to understand how clinical ethics can be understood as embedded—invisibly but powerfully—within health care institutions and practices. As a consequence, health professionals typically discuss clinical ethics not in terms of principles or other express ethical standards, but in terms of goals, values, concerns, complications, benefits, risks, problems, uncertainties, and other factors that potentially affect the care of patients.

Chapter 8. A Framework for Teaching Clinical Health Care Ethics. In this first of three chapters on teaching, we frame the general question as how to extend trainees' existing ethical frameworks to their new professional fields (e.g., medicine, nursing, social work). We assume that trainees, when they enter professional school, already have well-developed ethical frameworks of their own. The challenge is to integrate those existing frameworks with trainees' growing knowledge of their own fields—that is, with the process of becoming mature members of their own particular interpretive communities. In this context we discuss what we call *touchstones for learning* (i.e., questions that help one gain access to one's own ethical thinking), the need to create space for reflection and discussion, and the use and potential abuse of senior clinicians' power and authority to maintain the status quo and discourage professional growth.

Chapter 9. Teaching Clinical Ethics in the Formal Curriculum. In this second of three chapters on teaching, we discuss the design of formal courses for teaching clinical ethics, giving particular attention to core lecture courses, discussion classes, and observational and participatory activities of various sorts. As with the other chapters on teaching, the focus is on the self, informal ethical discourse, and interpretive communities. For our examples, we focus on some of the central substantive issues relevant to the education of health trainees and professionals: mental health, cultural competence (extended), patient communication, informed consent, and shared decision making. We also discuss the use of *counterstories* as a means of exploring the positions and perceptions of others.

Chapter 10. Teaching Ethics in a Clinical Setting. In this last of three chapters on teaching, we address the challenges of teaching ethics during the actual clinical portion of professional education. The opportunities for teaching are diverse and even extensive, at least if the institutions make a place for such opportunities by setting aside (and protecting) the time needed for such activities. We discuss the possibility for regularly scheduled case conferences of various kinds, ad hoc case conferences, formal clinical modules, and mentoring. We also briefly discuss the challenges that trainees face in maintaining the self in the face of unrelenting work and the professional and career pressures presented by their interactions with senior clinicians.

Chapter 11. Empowering Clinicians. Weaving together the themes discussed in earlier chapters, this concluding chapter presents a straightforward, relatively informal summary of what we hope clinicians will take away from reading this book. In the process, we attempt to anticipate and clarify some potential questions about what we have tried to communicate. The chapter title, in a way, says it all. Our primary goal is to empower clinicians to respect their own moral thinking and to use it in addressing the problems that they confront in clinical health care.

NOTES

1. Academic writers have spilled large amounts of ink over the proper use of *moral* versus *ethical*. For better or worse, *moral* is more common in philosophical circles, whereas *ethics* is overwhelmingly more common in health care, presumably because of the recurrent attention paid to codes of professional ethics. For simplicity of expression, we will be using *ethical* rather than *moral* except when doing so produces obviously odd results or some form of ambiguity. For example, a *moral philosopher* is a philosopher who focuses on problems in a particular field of philosophy, alternatively known as either *moral philosophy* or *ethics*. An *ethical philosopher* would be a philosopher who acts ethically, independent of the field of his or her specialization.
2. We only scratch the surface here of the criticisms of bioethics from the perspective of the social sciences. See, for example, Leigh Turner's wide-ranging article, "Anthropological and Sociological Critiques of Bioethics" (2009).
3. For a recent, engaging effort to bridge this gap and move past current criticisms of bioethics, specifically in relation to medicine, see Jing-Bao Nie, *Medical Ethics in China: A Transcultural Interpretation* (2011).
4. See, for example, Churchill's "Are We Professionals? A Critical Look at the Social Role of Bioethicists" (1999).

5. The landmark event for the WHO's patient-safety efforts was the 2002 resolution of the World Health Assembly (WHA55.18), in which WHO member states were asked to "pay the closest possible attention to the problem of patient safety and to establish and strengthen science-based systems necessary for improving patients' safety and quality of care." The World Alliance for Patient Safety was launched in 2004; the report *Conceptual Framework for the International Classification of Patient Safety* was published in 2009; and the two editions of the *Patient Safety Curriculum Guide* were published in 2009 (specifically for medical schools) and 2011 (for all health professions). For a helpful overview, see "Educating Future Leaders in Patient Safety" (Leotsakos et al. 2014).

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CHAPTER 2

The Limitations of Bioethics: A Personal History

Abstract This book has its origins in the work of the first author (SS) as a researcher, teacher, and consultant in the 1980s. During that period, the growing interest in bioethics was coupled with a growing distrust of doctors and the medical profession. To capture that particular historical period and how the first author's views about ethics and health care evolved—in particular, through his own, concrete experience with health professionals of various sorts and in various settings—this chapter is presented in the first person.

Keywords Health care • Clinical ethics • Social controls • Codes of ethics • Professional organizations • Ethical confusion • Ethics anxiety
Professional education

SOCIAL CONTROLS AND THE MEDICAL PROFESSION

From 1980 to the end of 1982, I was the associate director of a research project based in Boston and sponsored by the Ethics and Values in Science and Technology (EVIST) program, which was itself funded jointly by the National Endowment for the Humanities and National Science Foundation. That project, “Social Controls and the Medical Profession,” was designed to examine the formal (especially, legal) and informal (interpersonal, educational, and social) means by which health professionals (primarily physicians) are controlled—or channeled into doing what we, the public, want them to do.¹

At the outset of that project, I considered myself a standard-issue philosopher and lawyer, with a PhD in moral and political philosophy, a law degree, a year of law practice with a prominent Wall Street law firm, and a semester teaching ethics to undergraduates at New York University. I had done a good deal of reading in bioethics, including the field's leading journal, the *Hastings Center Report*, and I was well familiar with the newly published, and soon to become leading book in the field, *Principles of Biomedical Ethics*, by Thomas Beauchamp and James Childress (now in its seventh, 2013 edition).

At that point, and before I had begun to work on the EVIST project, I shared a number of views that were dominant among bioethicists—namely, that these writings

- were powerful and persuasive efforts to understand ethics in health care;
- could be used to teach health professionals about professional ethics and how they should behave in dealing with their patients; and
- were a necessary means of overcoming the biases and ethical shortcomings of (in particular) a medical profession whose formal ethical code was self-serving, and whose behavior, individually and collectively, was fundamentally mercenary and self-interested.

Looking back, these views seem harsh, but they were actually part of a larger public discourse about American medicine. The bioethics movement developed during exactly the same period as the consumer rights movement in the United States, and the us-against-them stance and perceptions of the consumer rights movement came to be very much a part of the bioethics movement, too.² Thus, along with my bioethicist colleagues, I believed that without the interventions of bioethicists, including philosophers, theologians, lawyers, courts, and legislatures, there was little hope or expectation that the medical profession would or could reform itself.

In his Pulitzer Prize-winning book, *The Social Transformation of American Medicine*, published in 1982, the sociologist Paul Starr provided a succinct description of the forces at work then. For advocates of patient rights, the

issue was basically professional dominance, and [the advocates'] aim was to increase the power of consumers. This new consciousness about medicine shaped new intellectual developments. In medical ethics, medical

sociology, and medical history, the dominant sympathies began to change. Much of the traditional work in these fields was written from the physicians' viewpoint, if not by doctors themselves. Increasingly, over the past decade, philosophers, lawyers, sociologists, historians, and feminists, newly interested in health care, have portrayed the medical profession as a dominating, monopolizing, self-interested force. Once a hero, the doctor has now become a villain, and the resentment of this new work by the profession and older scholars in these fields has been intense. (p. 392)

It was against this background—as an educated theoretician with no practical experience in medicine or with doctors and other health professionals—that I began my work on the EVIST project. My education was, of course, about to begin.

The project included regular two-day meetings of roughly a dozen researchers and a dozen doctors. At one of those meetings—well into the second year into the project—someone raised a question about the impact of the bioethics movement on medical practice. In particular, how had the bioethics movement and associated legal cases and new statutory schemes affected the medical treatment that any of the doctors present had given to their patients? The surprising, even flabbergasting response was that none of the doctors present could think of a single instance in which that treatment had actually been different. That is, despite an upheaval in the way that outsiders—bioethicists, consumer activists, courts, and legislatures—perceived doctors and a parallel upheaval in the regulation of medicine, these doctors perceived the actual impact on medical treatment as negligible. The process had changed—for example, informed consent had come to be a legal requirement—but the treatment actually provided to patients had remained essentially constant.

This surprising response dovetailed with some ideas that had occurred to me as I was developing background materials to be distributed in advance of that same meeting. In reading (or, in many instances, rereading) articles from the *Hastings Center Report*, and in thinking about the approach to medical ethics presented in *Principles of Biomedical Ethics*, I was struck by the discontinuity between these academic writings and my own perception of how doctors and other health professionals—indeed, anyone except trained philosophers and theologians—actually understood and thought about their ethical responsibilities and about the ethical problems that arose in the course of their work.³

THE BIRTH OF A PILOT PROJECT ON TEACHING MEDICAL ETHICS

As the EVIST project was coming to an end, I approached the Division of Primary Care at Harvard Medical School about running a pilot project for teaching clinical ethics in the hospital (Cambridge Hospital, in particular). The central features of my proposal were that the primary audience would be medical residents⁴ rather than medical students or medical staff, and that the teaching method would be essentially Socratic; that is, rather than acting like an ethics expert whose primary role was to convey authoritative knowledge, I would primarily ask questions in an effort to bring out, clarify, and build upon the doctors' own thinking.

Although a question arose at this planning stage about considering medical students (on clinical rotations) as the primary audience, my view was that medical students—during their first years in the hospital (until they became residents, after graduation)—were simply too preoccupied with learning the technical ABCs of medicine to have much energy for the psychosocial side of things. By contrast, medical residents were in their immediately post-medical school years and were consequently, for the first time, actually responsible for the care of patients (though under the supervision of attending physicians). That is, they were faced day-to-day and hour-to-hour with questions about how to treat patients, how to deal with colleagues, how to address the concerns of families, how to cope with the uncertainties of medical practice, and how to deal with the limits of their capacities, as doctors, to cure patients. For the residents, these questions were incessant, unavoidable, and often difficult, and in addressing the questions, the residents were basically forming the professional selves that would serve as the foundation for all their future work in medicine. In this context the assumption underlying my proposal was that by connecting up ethics concretely with thought, emotion, and action, and by connecting it with the specific concrete problems that the residents wanted and needed to solve, the residents would learn faster and better, and with lasting impact on their work.

As for taking a Socratic approach to teaching—versus a didactic approach that focused on material (in particular, ethical principles) to be learned and then applied—my reasoning was that using the residents' own thinking and feeling (and actions) as the jumping-off point for discussion would make ethics more accessible and tangible for the residents, and more useful to them in their care of individual patients. That is, in pushing residents to analyze their own thinking (about ethics,

in particular, but also about psychosocial issues, in general), they would come to better understand what they were doing and why, and would also acquire, in the process, the foundation for a lifelong process of reflecting on their work as doctors.⁵

Despite all of the above ideas about what and how to teach the residents, at the outset of the pilot project I still carried around the same prejudices that had come to be entrenched in the bioethics literature and in bioethicists themselves:

- Doctors, like other professionals, had an unswerving commitment to protecting their own self-interests. When push came to shove, self-interest would dominate over the interests of patients.
- To address the above problem of self-interest, doctors needed to be constrained by externally imposed ethical and legal standards. Only then would the interests of patients be protected.
- The traditional code of medical ethics, as opposed to the new bioethics developed by ethics experts outside of medicine, was primarily a self-serving exercise in professional self-protection.
- Ethical problems in medicine were difficult, complex, and capable of being analyzed and solved only through the use of ethical theory and ethical principles.
- It was only persons professionally trained in ethics—namely, philosophers and theologians—who had the expertise required to understand, analyze, and solve such problems.

Everything began to change, and these assumptions—discussed individually below—began to crumble, as soon as I started working in the hospital.

PERCEPTIONS AND MISPERCEPTIONS

Self-Interest

What impressed me immediately was the degree of dedication and selflessness, rather than self-interest, that the medical residents brought to their work. From the beginning of the day until the end, their goals were to take care of their patients and to learn medicine. The amount of time (in work hours per week) required to achieve these goals was enormous, of course—hence the current, ongoing efforts to establish limits on how

many hours residents can work a week—but the residents pushed themselves day in and day out to take care of their patients and, in the process, to learn medicine. And if the attending physician, residents, and others had difficulty determining what might be causing particular symptoms, and if the situation was life-threatening or otherwise urgent, the residents might spend long hours in the library trying to sort out the possibilities. It was not that anyone had to ask them to do that; it was simply necessary as the only way of addressing the medical problems of very sick patients.

To “learn medicine” was itself a twofold process. The mass of technical knowledge required to practice medicine is apparent to anyone who has been involved, as either a participant or observer, in the process of medical education. But in addition to the technical aspect of medicine, the medical residents also were developing their sense of themselves as doctors—their professional identities. What was most striking was how difficult it was for the residents to deal with failures of various sorts, with the worst failure being the death of a patient in one’s care. Learning to deal with these failures was, in effect, to learn to deal with the limits of medicine, and the limits of one’s powers as a doctor, to cure disease and help patients. The distress experienced by the residents in such circumstances is revealing: at the baseline, the residents wanted, more than anything, to help their patients, which made coping with failures so painful and difficult. A large part of my work in hospitals, especially early on as I began to work in each new setting, was devoted to these problems of death and dying, and to helping the residents develop a textured understanding of what they could and could not achieve as doctors.

My experience with, and perceptions of, the senior, attending physicians was somewhat different. All had developed their own professional styles, which ranged from the deeply humanistic and patient-centered doctors, at one extreme, to the dedicated technicians, at the other. Those at the former extreme were regularly more involved with patients and assumed that their open, direct communications with patients would serve to satisfy requirements for informed consent, whereas those at the latter extreme tended, for example, to dot every *i* and cross every *t* when it came to informed consent. For them, informed consent was just another technical process that needed to be undertaken, especially to protect them from any potential legal action.

The particular setting that I was working in—hospitals affiliated with Harvard Medical School—was not actually a comfortable environment

for doctors who preferred to “cut corners” or who were more interested in money than in patients. But the variation in professional styles within that setting brought to mind that the broader field of medicine was not subject to those same institutional constraints, and that the absence of those constraints allowed for a much broader, and unfortunate, range of professional styles and professional goals, such as wealth, power, and dominance. For all my idealism at the time, I realized that I was working in a place that was an example of what was best about American medicine but not therefore representative of it.

Need for Externally Imposed Ethical and Legal Constraints

Critics’ demands for additional ethical and legal constraints on doctors was itself, in large part, a product of seeing them as self-interested professionals whose primary allegiance was to themselves, not their patients. This particular form of reasoning—namely, that more aggressive regulation was urgently needed in order to counteract the endemic self-interest of doctors—rested, I soon came to realize, on a slanted perception of doctors. To be sure, some small percentage of doctors (and other health professionals, too, as in any field of human endeavor) acted primarily, even exclusively, out of self-interest. It was also true, however, that the overwhelming majority of health professionals—whether, for example, residents, attending physicians, nurses, social workers, or psychologists—were dedicated to the task of providing good, appropriate care to patients, and that this task carried with it strong, though implicit, ethical constraints. You can’t practice good medicine, for example, without practicing in accordance with the ethical constraints that are embedded—deeply embedded—in the traditions of medicine. That said, ethical and legal constraints are obviously needed to address problems connected with incompetence, malpractice, and abuses and bad faith of various kinds, including charlatans and doctors who see themselves as dispensing machines for psychoactive drugs.

Traditional Codes of Medical Ethics as Self-Serving and Self-Protective

Although commentators sometimes dismiss the American Medical Association’s Code of Medical Ethics (and virtually all other codes of professional ethics promulgated by professional groups) as largely self-serving and self-protective, I came to realize that this criticism

doesn't really matter, one way or the other. Even if the claim was correct, it simply wouldn't follow that doctors were *therefore* less reliable, competent, or trustworthy. Yes, the AMA tries to protect the profession's prerogatives (as in lobbying legislatures and drafting new ethics codes for the medical profession). In the process, the association does try to minimize all unnecessary forms of external intrusions. That's exactly the task of a professional association (for medicine or any other profession) or trade group, and that's why some proportion of the practitioners in any field support such associations. The relevant question, though, is the following: what difference does that make in terms of understanding the work of individual doctors (or other health professionals)? The task at hand is the task at hand, and my own view, which developed through my work with doctors, was that the nominally self-protective activities of groups such as the AMA did not significantly influence how health professionals thought about or approached their work, or the services that they provided to patients. In particular, with important exceptions (such as the need to obtain patients' informed consent), the details of the Code of Medical Ethics are secondary to what, one might say, really counts. During their professional training—medical school and the years immediately thereafter—doctors spend countless hours caring for patients, working in teams, and interacting with, and learning from, senior colleagues. The medical profession's Code of Medical Ethics *does* express important values and give formal recognition to patient autonomy and informed consent. The point, however, is that the impact of such codes is small in comparison to the years of professional training that all doctors—and all health professionals—undergo. And for better or worse, the source of ethical action is in the person, not a formal code.

*Ethical Problems in Clinical Medicine Are So Difficult and Complex
That Their Resolution Requires Application of Ethical Theory
and Ethical Principles*

This claim about the difficulty and complexity of ethical problems in medicine will be discussed, in various forms, throughout the book. What is important to note now is that virtually everything I learned through my experience teaching clinical ethics ran strongly against any such claim. Even in the area of death and dying, with its growing range of unprecedented ethical issues, the questions arising clinically—at the

bedside—were not about ethical theory but about, say, Mrs. Smith, what her condition was, what she understood about it, and what she wanted (and why). And what about her family? What did they know, and what did they want? Were they prepared, say, for her death, and what did one have to do to help them through what was typically perceived as a family crisis? It would be possible to address such problems in the language of ethical theory (as in determining what rights were at stake), but this type of situation was inescapably, fundamentally human. The language of ethical theory had the effect of distorting and rendering more abstract, rather than clarifying, the problems at hand.

Need for the Ethics Expertise of Philosophers and Theologians

As might be inferred from the preceding paragraph, there are two ways of approaching and understanding ethical problems in medicine. One way is through theory, and another through practice. After I started to work clinically, I soon realized that doctors, as well as other health professionals, had the capacity to use their own, existing thinking—not just about ethics, but about the personal and social milieu in which medical care is provided—to understand and analyze ethical problems in medicine. By the same token, if I or anyone wanted to help doctors develop their ethical thinking, especially in relation to emerging problems within modern medicine, one would need to build upon that same foundation. Based on my own growing experience in clinical medicine, the need to adopt new or different models of ethical thinking, such as those involving abstract philosophical principles, had yet to be demonstrated.

TWO VIGNETTES

Separate from the question of how my views about doctors and the medical profession (as described above) came to diverge from those common among bioethicists, however, is the question of whether these different views actually made a difference. Were they merely inconsequential differences in perception between me and other bioethicists, or did the standard assumptions of bioethicists have a tangible, real-world impact on doctors? I soon came to realize that they did. Two examples will illustrate one of the main problems I recognized early on in my clinical work in hospitals.

Ethical Confusion

Two years or so after starting to my work in hospitals, I was asked to join an ad hoc conference about the possible use of electroconvulsive therapy (ECT) to treat a chronically depressed patient in his fifties with a life-threatening medical condition. This particular patient had refused ECT many times before, as he was doing again now. During his extensive medical history of problems other than depression, the patient had also refused many of the treatments offered. The patient's physician and psychiatrist—both of whom knew the patient well—believed that he possessed the mental acuity required to make such decisions. A key difference was that, in the past, the patient's medical problems (other than his depression) had been comparatively minor, and he had always, though sometimes only slowly, recovered his health.

The patient had recently been diagnosed with a blocked duct connecting the kidney to the bladder; he had already lost one kidney; and he was refusing the surgery that would correct his present, life-threatening condition. Some of the doctors, nurses, and social workers involved in his care had, at an earlier point, vehemently urged the use of ECT despite the patient's refusal. Since these clinicians had taken the patient's depression to be clouding his judgment, their hope had been that the use of ECT might lift the patient's depression and lead him to accept treatment. And because of the stakes—life or death—even the patient's own doctor and psychiatrist were beginning to second-guess their long-stable judgments about his capacity to make treatment decisions.

Such was the information I had as I prepared for the conference on this emotionally charged case. When the conference began, I asked one of the doctors to discuss how the group of 25 or so caregivers currently perceived the situation. The doctor, only a few years out of medical school, immediately noted that the staff had finally reached a consensus not to use ECT. Speaking with clarity and insight, this young doctor spent about ten minutes explaining the staff's thinking. He described the arduous process of give and take that had ultimately led to a consensus, analyzed the central ethical issues raised by the patient's situation, addressed the psychological issues raised by the case and the staff's conflicting feelings about it, and then drew the implications for the care of the patient.

At the center of the analysis was the view that this particular patient was not simply experiencing a temporary depression that was interfering

with his thoughts and feelings. Instead, this patient had suffered from depression his entire adult life, and the depression was fully integrated into his adult personality and way of thinking about himself and his life.⁶ Whether the patient was competent or not within the doctrine of informed consent was a matter of continuing disagreement among the staff, but this disagreement, the staff nonetheless agreed, did not matter. What did matter was that administering ECT to this patient would have violated his long-standing preferences, his integrity as a person, his conception of himself, and his long-term efforts to maintain, in the face of chronic and sometimes severe depression, his independence and his control of his life. The staff were therefore prepared to respect the patient's refusal of ECT and to provide whatever supportive care he needed as his kidney function deteriorated and, within a relatively short compass, took his life.

As the doctor was speaking, I realized that his analysis largely overlapped with my own, which left me wondering exactly what I was going to say. But then something astonishing happened. After noting, in summary, that the staff were in agreement on how to proceed and why, the doctor stated that they remained quite at sea concerning the proper ethical analysis of the situation. He closed with the statement, "We don't know what to do." My jaw must have dropped in amazement when I realized that he was not just disparaging, but dismissing, the most impressively acute, lucid analysis of a problem in clinical ethics that I had ever heard given by a doctor (or anyone, for that matter).

That is, at the end of what I considered a remarkable presentation, the doctors and other health professionals present at the conference continued to feel deeply confused and uncertain—despite their having used their own collective wisdom and resources to reach a nuanced, carefully elaborated consensus. What was odd about this continuing uneasiness was that the process of ethical reflection, especially when it reaches a conclusion supported by consensus, typically leads to cognitive and emotional closure. The process itself may be agonizing, but after it is over, people are typically capable of recognizing that they have explored the relevant ethical and emotional issues, given each issue its due weight, and reached a conclusion that reflects a satisfactory integration of all the considerations involved. It is this sense of integration that produces closure, and with it the capacity to cope with and defuse the previous intellectual and emotional turmoil. It is just this sense of integration, of recognizing that they had successfully engaged in a process of ethical reflection, that

the doctor and his colleagues had not been able to achieve. As I perceived the situation, this continuing state of ethical confusion reflected a baseline lack of confidence in their own ethical capacities.

I understood this state of confusion to be a legacy of the bioethics movement itself. Bioethicists had assumed a public posture as ethics experts and as arbiters of the medical ethic; they had taken on the same role in medical schools and hospitals; they insisted that ethical problems in medicine need to be discussed and resolved in terms of abstract ethical concepts and principles, specifically with the tools of modern moral philosophy; and they unequivocally conveyed the impression to doctors that they were mere neophytes in ethics. Could anyone be surprised that doctors had come to question—and distrust—their own ethical judgment?

Ethics Anxiety

In the preceding case the ethical confusion arose at the end of a process of ethical analysis and reflection. That is, even after reaching a consensus based on an established relationship with the patient, their long familiarity with him and his problems, and an exhaustive analysis of the clinical situation, the clinicians still could not trust their own ethical judgment. The same type of confusion can also arise, as we shall see, at the very beginning of the process of ethical reflection, and where the ethical issues themselves are actually straightforward.

Late on a Friday afternoon, a 62-year-old man was waiting to be discharged from the hospital after a negative evaluation for myocardial infarction. While seated on his bed and discussing his follow-up care with a second-year medical resident, the patient mentioned, without any elaboration, that he was afraid to go home. After the resident asked for an explanation, the patient stated that he was afraid that he would sexually abuse his granddaughter again. He expected that he would have the opportunity to do so within the next two days.

Given the above, it was obvious what had to be done. The medical staff needed to keep the patient in the hospital to protect the granddaughter from another round of sexual abuse. All actions by the resident and other staff needed to be organized, in the short term, toward that end (with the remaining problems to be sorted out later). There was no reason, moreover, to suspect any opposition from the patient, who had, in effect, already asked the hospital for help.

But that's not what happened.

The resident's immediate response was to ask the patient to wait in his room. The resident then left to consult with the Associate Director of Medicine, who was also Director of Housestaff Education. After the resident notified him of the patient's disclosure, the Associate Director of Medicine decided, as he should have, that the hospital's overriding concern was to protect the granddaughter. He then became intellectually mired, however, in a variety of ethical and legal problems. Did the patient have an ethical or legal right to go home? Did the hospital have an ethical or legal right to force him to stay? Did the hospital have an ethical or legal obligation to inform the victim's parents? Did the hospital have a legal obligation to inform social services or the police?

With no hope or expectation that he could instantly think through this entire set of ethical and legal questions, and with the discharge of the patient imminent, the Associate Director of Medicine proceeded to focus on a single question: did the hospital have a legal right to force the patient to remain in the hospital? The Associate Director then began what proved be a frantic, frustrating, and unsuccessful search for authoritative legal advice. He was unable to reach the hospital's outside legal counsel, in part because it was already late on a Friday afternoon. He was able to reach but unable to obtain any useful assistance, legal or otherwise, from the hospital's social service department or from that of the city in which the hospital was located. The hospital's social service department promised to begin an investigation on Monday (presumably because the social worker in charge had simply assumed that the patient would remain in the hospital over the weekend). After two hours of telephone calls, discussions with several attending physicians and medical residents, and repeated but brief conversations with the nurses responsible for the patient, the Associate Director was left in precisely the same position he had been in when the medical resident originally reported the situation to him.

The Associate Director of Medicine and the rest of the professional staff drawn into the situation were at this point experiencing extreme stress. In the absence of any medical justification for keeping the patient in the hospital, the Associate Director believed that he and the staff were powerless to prevent the patient from being discharged. And if they allowed the patient to go home, they felt that they would be knowingly accomplices to another episode of sexual abuse. During this entire

two-hour period, the patient remained in his room alone and with no knowledge of the medical staff's response to his disclosure.

Forced to act unilaterally, the Associate Director decided that protecting the granddaughter from further abuse was his paramount goal, no matter what the specific ethical or legal rights of the hospital or the patient were. He therefore informed the patient that the medical staff wanted to keep him in the hospital until they could formulate an adequate plan for his return home. The patient accepted this recommendation without any hesitation or objection. On the following Monday, the hospital's department of social services initiated its standard intervention in cases of sexual abuse. The victim's family was notified, and the patient agreed to embark on long-term psychotherapy.

What is ultimately so striking about this case is the contrast between the patient's (predictably) docile acceptance of the Associate Director of Medicine's recommendation, and the medical staff's deepening distress and sense of panic as they attempted to decide upon a course of action. Given the difficulty of admitting to another person that one has engaged in conduct such as sexual abuse, it was apparent from the outset that the patient was himself in extreme distress and wanted to be helped. By contrast, the medical staff seemingly lost their flexibility, perspective, and capacity for problem solving. We see this in the resident's hurried and premature departure from the patient's room, in the continuing inattention to the patient and his almost certain state of growing distress, in the Associate Director of Medicine's exclusive focus on the need for authoritative legal advice, and in the failure of the medical staff to step back and reexamine the clinical situation itself: their own perceptions and reactions to it, the patient's obvious willingness to be helped, and the full range of options open to them. In the end, the situation was resolved effectively only because of the Associate Chief of Medicine, in desperation, decided to disregard the potential or perceived legal risks and to rely on his own, individual ethical judgment concerning what needed to be done. Ironically, the situation would have been resolved quickly and with minimal stress had the Associate Chief of Medicine simply relied on his own clinical skills and his own clinical and ethical judgment in the first place.

Instead, the Associate Chief of Medicine and the other doctors perceived the situation as one requiring ethical and legal expertise—with the former supposedly belonging only to bioethicists, and the latter belonging to lawyers. The result was a deteriorating situation characterized

by cognitive paralysis, clinical delay, and the potential loss of a patient's good will, without which the situation would have become even more difficult to resolve. In cases like this one, doctors' ethical confusion—their ethical disorientation—may express itself in a phenomenon that I would later describe as “ethics anxiety” (an intentional parallel to mathematics anxiety)⁷: when physicians or other health professional are distressed by a situation that they have identified as involving potentially difficult ethical issues, especially a situation that may also involve legal issues, they may become intellectually paralyzed and lose track of their own abilities to analyze the problems, ethical or otherwise, raised by the clinical situation at hand.

BIOETHICS AND ETHICAL SELF-DOUBT

Underlying both the ethical confusion in our first vignette and the phenomenon of ethics anxiety in our second is the radical discontinuity between the ethical and legal standards of bioethics and the concrete, clinically oriented ethical thinking of doctors and other health professionals. And in both cases, this discontinuity created enormous stress and left the physicians unable to act in accordance with their own clinical training and ethical and professional judgment. Indeed, the physicians and other health professionals did not trust themselves, thereby compromising their efforts to proceed with direct, timely, and effective responses to the clinical situations they encountered.

More broadly, what these two cases suggest is that the bioethics movement, rather than assisting doctors and other health professionals to address ethical issues as they arise clinically, has actually undercut, in some respects, their capacities to make such judgments. This realization dovetailed with my growing skepticism, as discussed earlier, concerning the standard assumptions then current in bioethics—about doctors, the need to control their behavior (and misbehavior) through new ethical and legal standards, the role of the organized medical profession, the nature of ethical problems in medicine, and the need for ethics expertise. All my experience suggested that the way to improve and maintain ethical thought and conduct in medicine and other fields of health care was by building on health professionals' existing resources—how they think, feel, and act—rather than by trying to achieve those same goals by imposing a way of thinking that simply doesn't come naturally.

THE MORE THINGS CHANGE, THE MORE THEY REMAIN THE SAME

Now, let's fast-forward two decades, when I happened to come across a prestigious medical journal's special issue on clinical ethics. Much to my distress and surprise, I found that little had changed from when I had taught clinical medical ethics in Harvard Medical School hospitals twenty years before. The articles were almost exclusively oriented toward theoretical, principle-based analyses of clinical situations, mostly extremely difficult ones; if read by practicing physicians, some of the articles might have been admired as intellectually impressive even though they might nevertheless have fallen short, even far short, of clinical relevance. My own response to the articles was that they failed to connect up with the clinical milieu or with the actual concerns of doctors and other health professionals. What I immediately realized was that the bioethical assumptions and the abstract mode of argumentation that I had put behind myself so many years before were continuing to dominate the field of bioethics, to the disadvantage of the field itself, practicing physicians, other health professionals, and, most importantly, their patients. And it was then that I decided that it was time for me to do some more writing and to do what I could to free the clinician's voice, which had been silenced far too long. I published several articles on bioethics shortly thereafter (Scher 2010; Scher and Kozłowska 2011, 2012), and not long after that decided to write this book—and in tandem with a clinician, to ensure that the book never loses its clinical focus and relevance.

That said, the approach presented here is not specifically based on the assumption that the bioethics movement has helped or not helped doctors and other health professionals address ethical issues that arise in their clinical work. The fundamental claim, instead—both for me and my coauthor—is that, from the perspective of learning to think and act ethically within health care settings, there's simply a better, more useful way of understanding health care ethics and the demands it places on clinicians. In particular, the beginning of wisdom is to see clinical ethics, like all ethics, as embedded within the self and as deeply interconnected with each person's thinking, feeling, and acting. To ignore this concrete human foundation is to undercut, at the outset, the possibility of understanding and advancing clinical ethics.

NOTES

1. Formal social controls are externally imposed and coercive, often involve the law, and include such things as licensing (e.g., to practice medicine), official recognition of expertise (as in board certification in a specialty), mandated legal requirements (e.g., informed consent), and legal actions (e.g., to obtain recovery for injuries from malpractice). Informal social controls are the interpersonal processes intended to bring persons noncoercively to adopt certain values and to behave, preferably from within, in particular ways. For our purposes in this book, the most common forms of informal social control are (other than professional ethics as such) professional education and socialization, the process by which health professionals learn what they need to know and to do in order to become professionally competent.
2. This theme is taken up again in Chapter 3.
3. Over the years, as I worked with doctors and other health professionals, I became more and more convinced that, if you wanted to help health professionals develop their own ethical thinking—to become “more ethical”—you needed to start at the baseline of their own present ethical thinking rather than expecting them to engage in the unnatural, cumbersome process of applying abstract ethical principles to the concrete world of clinical health care. But at the particular time that I’m writing about in this paragraph, these ideas had yet to coalesce.
4. The terminology for referring to doctors who have just finished medical school but who are, as is generally required, undergoing further, post-graduate training differs from country to country. For ease of exposition, we will be using the standard U.S. term *resident* to refer to doctors during that training period, which itself precedes a possible further period of specialist training as *fellows*. As an example of the latter, a doctor who has completed a residency in medicine (three years) might further specialize by doing a fellowship in oncology or cardiology.
5. Of note, the broader audience for this pilot project included the full range of health professionals working in the hospital: attending physicians, medical students, nurses, psychologists, social workers, and even (to the extent that I encountered them) hospital administrators. Moreover, I soon came to see that these disparate groups all encountered, and analyzed, ethical problems as thoughtful human beings who only happened to be doctors or nurses or social workers. To make any fundamental distinction among these groups of caregivers was to miss their fundamental sameness.
6. This sort of integration is the focus of David Shapiro’s classic study, *Neurotic Styles* (1965).
7. For a fuller discussion of this case, see Stephen Scher, “Ethics Anxiety” (2010).

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CHAPTER 3

The Rise of Bioethics: A Historical Overview

Abstract The bioethics movement did not arise and expand in a vacuum. As discussed in this chapter, advances within medicine were creating a need for ethical issues to be identified and addressed. Major new work in philosophy suggested that philosophically trained “bioethicists” could uniquely contribute to ethics in medicine. The growing momentum of the consumer rights movement lent its particular, rights-oriented contours to bioethics and the demands it placed on physicians. Likewise, courts were giving legal force to the rights of patients against doctors. These diverse forces coalesced into a worldwide movement—despite the mixed response in Europe and elsewhere—that came to dominate the scholarly literature in health care ethics (not just in medicine) and that set itself as a model for how health professionals were supposed to think about clinical ethics.

Keywords Health care • Clinical ethics • Hastings Center • Kennedy Institute of Ethics • Consumer rights • Patient rights • American bioethics • European bioethics • Fritz Jahr • Universal Declaration on Bioethics and Human Rights

MODEST BEGINNINGS

The modern era of health care ethics is often traced to Henry Beecher’s influential, 1966 article on ethical problems in clinical research, with particular attention (through a series of actual examples) to the

failure to inform patients of the risks involved in experimental treatments (Beecher 1966). Beecher, a professor of anesthesiology at Harvard Medical School, soon followed that article with another, also published in the *New England Journal of Medicine*, on the ethical problems in caring for “hopelessly unconscious patients” (Beecher 1968). In this second article Beecher gave particular attention to the problem of determining when medical treatment could be discontinued. He well recognized that the issues addressed in both of these articles were the product of the explosive, postwar growth of medical research and the resulting, unprecedented advances in understanding and treating disease. That is, these unprecedented advances carried with them equally unprecedented ethical problems in the care of patients.

Beecher’s approach to addressing these ethical problems was simple. He had published these articles in the United States’ leading medical journal, whose primary audience was his fellow physicians and clinical researchers; he had identified the problems concretely and with precision; and he expected the medical profession—and even individual researchers and health care providers—to take appropriate action. For example, in the case of the problems that he had identified in clinical research, he reasoned that the most “reliable safeguard” of the patient’s interests—and against unethical behavior—was “the presence of an intelligent, informed, conscientious, compassionate, responsible investigator” (Beecher 1966, p. 1360).¹

THE HASTINGS CENTER AND KENNEDY INSTITUTE OF ETHICS

The world of health care ethics did not remain that simple for long. New problems were emerging faster than the medical profession, without an immediate, large-scale, and immediate effort, could itself address. The result was a developing, and growing, gap between the profession’s established practices, ethical and otherwise, and the public’s need to address the problems that emerged as modern medicine extended its scientific and clinical powers. The gap was soon filled by the founding in 1969 of the Hastings Center/Institute of Society, Ethics and the Life Sciences, a signal event in the development of modern health care ethics. The new field that took shape was called *bioethics*—a term explicitly chosen to encompass not only medicine and the rest of health care, but the entire field of the (human) life sciences (Callahan 1971, 1973). The Hastings Center—located in the village of Hastings-on-Hudson,

just north of New York City—took the lead in setting the direction, methods, and intellectual standards of bioethics through its own journal, the *Hastings Center Report* (Callahan 1971, 1973). The Kennedy Institute of Ethics at Georgetown University, another bastion of bioethics, was founded two years later, in 1971.²

In order to understand the direction, both short and long term, taken by the Hastings Center and Kennedy Institute of Ethics, by their growing number of advocates (especially from outside the medical profession), and by the bioethics literature itself, it is helpful to understand the social, legal, political, and intellectual environment in which the Center and Institute developed.

THE RISE OF SCIENTIFIC MEDICINE

Until penicillin and sulfa drugs were developed and introduced in the late 1930s, the scientific revolution of the late nineteenth and early twentieth centuries had yet to generate major advances in the treatment of disease.³ The practice of medicine remained largely “empiric”—that is, based directly on physicians’ collective, historical observations of what helped patients, rather than on the scientific understanding of disease processes and how to affect them. Much of the physician’s work remained, by default, supportive and palliative. In comparison to our present health care system, public expenditures for medical care were minimal. Almost all physicians were private practitioners paid directly by their patients. The medical profession was essentially self-regulating, with legal regulation of medicine verging on the nonexistent. Hospitals were simple institutions compared to the complex behemoths we are all too familiar with today. And the traditional medical ethic, centered on the Hippocratic Oath and basically unchanged for twenty-five hundred years, continued to serve patients and physicians well.

Following World War II, the rate of scientific and therapeutic progress rapidly accelerated. Sulfa drugs and penicillin had saved countless lives during the war, which had also seen impressive advances in surgery and in the treatment of traumatic injuries. In the United States (and also in Europe), public and private funding of scientific research increased dramatically, fueled by expectations that further advances were just over the horizon. The highly visible and successful introduction of the polio vaccine in the early 1950s served to legitimize these expectations, which soared yet again. The era of modern medicine had begun in earnest.

Over the next two decades, unprecedented advances in the understanding and treatment of disease created an environment of almost unqualified optimism within the medical profession. Radiation therapy, chemotherapy, treatments for advanced heart disease, and hundreds of new and powerful drugs came into common use. With access to the diagnostic tools, medical treatments, surgical procedures, and technology of modern medicine, physicians considered themselves to be worthy opponents of the most devastating illnesses: pneumonia, heart disease, even cancer. Military metaphors came to pervade the language of medicine. Physicians “fight” or “combat” disease, which is the “enemy.” Bacteria “invade” the body, which has its own “defenses.” Radiation therapy “destroys” or “kills” tissues. The drugs available for use against cancer are referred to individually as “weapons,” collectively as an “armamentarium.” The research effort to discover cures for cancer came to be known as the “war on cancer.”⁴ The battle against disease was being waged and—so it seemed—won.

In the exhilarating days of mid-twentieth-century medicine, physicians saw themselves as applied scientists who marshalled the diverse technical resources of modern medicine against the onslaught of disease. The physician’s exclusive tasks were to identify pathological processes and to determine which surgical and pharmacological interventions were necessary to eradicate disease and its symptoms. Physicians were trained to provide aggressive, unrelenting treatment for all diseases; only a patient’s death would signal defeat.⁵

Within this framework, physicians perceived the patient as little more than the locus of disease:

The human body belongs to the animal world. It is put together of tissues and organs, in their structure, origin, and development not essentially unlike what the biologist is otherwise familiar with; it grows, reproduces itself, decays, according to general laws. It is liable to attack by hostile physical and biological agencies; now struck with a weapon, again ravaged by parasites. (Flexner 1910, p. 53)⁶

Patients’ needs were thus defined medically, exclusively in terms of their diseases. The role of patients remained the same as it had been throughout the history of medicine: to trust their physicians and to submit passively to whatever treatments their physicians deemed appropriate. Except for the need to administer pain medications, physicians

dismissed pain and suffering as merely subjective phenomena that were no more than the unfortunate and unavoidable consequences of disease. And since physicians' overriding obligations remained—as they always had been—to diagnose and treat disease, the personal preferences of patients had no impact on, or relevance to, physicians' medical decisions. Physicians' authority over their patients was complete and absolute.

PATIENT RIGHTS AND CONSUMER RIGHTS

Physicians' inattention to patients' subjective experiences and preferences proved to be one of the central shortcomings of scientific medicine. As early as the 1957 *Salgo* case, courts recognized that physicians' unilateral decisions could lead to results at variance with patients' own interests and goals. The plaintiff in *Salgo* had sued to recover damages for what he claimed was the negligent performance of a diagnostic procedure, an aortography, in which dye was injected into the aorta to determine whether it was blocked. On awakening the day after the procedure, his legs were paralyzed. In addition to the original complaint for negligence, the plaintiff later appended a further claim that his physicians had been negligent in failing to warn him of the risks associated with the procedure. In a decision that awarded damages to the plaintiff, the court announced a new legal doctrine—*informed consent*—that required physicians to provide patients with all relevant information about available treatment alternatives. It was the patient, not the physician, who should decide how to balance the risks and benefits associated with any particular procedure or treatment. In so restricting physicians' traditional authority to control the course of medical treatment, the doctrine was specifically designed to ensure that patients' preferences were incorporated into the process of making medical decisions.

Notwithstanding the *Salgo* case, events within the broader American society would prove to be the driving force behind, give a sense of mission to, and even substantially shape the bioethics movement. These developments would soon outpace Beecher and his efforts to mobilize the medical profession as the vanguard of a new medical ethic.

In 1962, President John F. Kennedy presented a landmark address to the U.S. Congress about the rights of consumers (Kennedy 1962), which he described as follows:

1. The right to safety—to be protected against the marketing of goods which are hazardous to health or life.
2. The right to be informed—to be protected against fraudulent, deceitful, or grossly misleading information, advertising, labeling, or other practices, and to be given the facts he needs to make an informed choice.
3. The right to choose—to be assured, wherever possible, access to a variety of products and services at competitive prices; and in those industries in which competition is not workable and Government regulation is substituted, an assurance of satisfactory quality and service at fair prices.
4. The right to be heard—to be assured that consumer interests will receive full and sympathetic consideration in the formulation of Government policy, and fair and expeditious treatment in its administrative tribunals.

In addition to defining the above rights, Kennedy (1962) also noted the following:

Consumers, by definition, include us all. They are the largest economic group in the economy, affecting and affected by almost every public and private economic decision. Two-thirds of all spending in the economy is by consumers. But they are the only important group in the economy who are not effectively organized, whose views are often not heard.

Kennedy's solution to consumers' lack of organization and lack of voice was to define a new role for the federal government:

Additional legislative and administrative action is required . . . if the federal Government is to meet its responsibility to consumers in the exercise of their rights. . . . To promote the fuller realization of these consumer rights, it is necessary that existing Government programs be strengthened, that Government organization be improved, and, in certain areas, that new legislation be enacted.

But asserting a new role for the federal government was not the same thing as organizing consumers or giving them the voice that they lacked. That process was set in motion, however, by the 1965 publication of Ralph Nader's *Unsafe at Any Speed*—the seminal event in the emergence

of the consumer rights movement in the United States. Of special note was the ideology that the book brought to the marketplace of ideas—namely, that consumers should assert their ethical and legal rights against large and powerful corporations as a means of controlling them and protecting consumers from outright corporate misconduct and from poorly designed or unsafe products; such powerful organizations had shown themselves unworthy of the public's trust. Suddenly, the skeletal framework of consumer rights described by President Kennedy took form in a movement that would change the power relationships between consumers and corporations—and, in time, between consumers and anyone providing them with goods or services, including professional services of any kind.

APPLIED ETHICS AND THE CONSOLIDATION OF BIOETHICS

During this same time period, American academics were becoming actively involved in issues of ethics and public policy, primarily but not exclusively as a result of widespread opposition within the academic community to the war in Vietnam. And the publication in 1971 of John Rawls's *A Theory of Justice*—considered by many philosophers the most important book of moral and political philosophy of the twentieth century—instilled in the philosophical community a sense of confidence that genuine progress was being made, and that more was to come. Rawls's book was important in two ways, both of which fed this new sense of confidence. First, the book integrated a vast range of problems within the history of Western moral and political philosophy—problems that had often been discussed separately, without a broader sense of how they were related to other problems. Suddenly, as it were, the history of ethics and political philosophy could be understood as an integrated whole. Second, the book set forth a new way of thinking about ethical reasoning and of how to move from theoretical assumptions to actual ethical conclusions. That is, the book bridged ethical theory and normative ethics—theory and practice—in a way that brought dynamic new life to this area of philosophy.

But this philosophical honeymoon did not last long. *A Theory of Justice* generated a spectacular burst of philosophical activity, much supportive of Rawls's theory and his arguments, but also much that was critical. More broadly, and despite its initial optimism, the philosophical community came to appreciate how difficult it was to make progress either in ethical theory or in normative ethics—that is, in using the tools

of moral philosophy to analyze, solve, and reach consensus on problems encountered in the real world. The challenge of applying philosophical theory to normative problems was far more difficult than they had hoped.

It was during this same period of the 1970s, however, that the small but rapidly growing group of bioethicists—many of whom were associated, in one way or another, with the Hastings Center or Kennedy Institute—effectively separated themselves from the mainstream of moral philosophy and established what was to become the new discipline of bioethics. And, whereas academic moral philosophy had taken on a new modesty concerning what was coming to be called *applied ethics*, the new field of bioethics witnessed a burst of theory construction, concept formation, problem identification, and conceptual clarification of the kind associated with the formative period of any new field of study (Callahan 1973).

With surprising rapidity, this new academic discipline came to have its own training programs, research centers, journals, tenure-track positions, funding sources, professional organizations, and national and international conferences. Philosophers, sociologists, theologians, lawyers, commissions, courts, and legislatures were the new, and authoritative, voice for ethics in medicine. By the early 1980s, little over a decade after the founding of this new field, bioethics and bioethicists had come to dominate not only public discussions of health care ethics in the United States but also, increasingly, the teaching of ethics in medicine, public health, nursing, and all of the allied health professions. A decade later, in 1991, the International Association of Bioethics was founded. Signaling the worldwide reach of the bioethics movement, the inaugural World Congress of Bioethics took place the following year in the Netherlands. The thirteenth such conference, with 700 delegates from 44 countries, was held in Edinburgh in 2016.

As might be expected, given the society-wide ferment associated with the American consumer rights movement beginning in the late 1960s, the emerging bioethical paradigm placed the rights of patients—the consumers in medicine—at the center of its theorizing. In *Unsafe at Any Speed*, Nader had drawn attention to the challenge of “defining values relevant to . . . new technolog[ies] laden with risks,” and he noted that a “great problem of contemporary life is how to control the power of economic interests which ignore the harmful effects of their applied science and technology” (Nader 1965, p. vii).

The public, moreover, did not have the expertise and information required to identify those harmful effects or the attendant risks. The question was whether the relevant actors—corporations in the case of the automobile, and doctors and the organized medical profession in the case of medicine—could or would identify and in some way address the “inherent but latent dangers” (p. vii). And just as Nader had identified the lack of public trust in automobile manufacturers and in their capacity to address safety issues on their own (pp. 248–249), so would the public perceive the entrenched interests of doctors, individually and also collectively as an organized profession, as a pervasive obstacle to be overcome in protecting the rights and interests of patients (Starr 1982).

In this context, Beecher’s two articles in the *New England Journal of Medicine* (Beecher 1966, 1968) represented a fleeting instant in which the medical profession recognized, and came close to seizing, what might be called the *ethical moment*. Instead, the bioethics movement seized that moment for itself, and the medical profession and subsequently the other health care professions—ranging from nursing to social work to clinical psychology to public health—found that bioethicists had staked their own claim to knowing the path forward.

AMERICAN BIOETHICS AND ITS (EUROPEAN) DISCONTENTS

It is perhaps not surprising that a movement with such distinctive American social and intellectual roots might run into some sort of resistance elsewhere.⁷ As Amir Muzur notes in “European Bioethics: A New History Guaranteeing a New Future” (2017), through nearly the end of the twentieth century, the principlism at the core of American bioethics—the “Georgetown mantra” (p. 63) of autonomy, beneficence, nonmaleficence, and justice—was a “globally predominant doctrine” (p. 61) that, even so, had been adopted only slowly and with ambivalence in Europe. There, as in America, ongoing advances in medicine presented a pressing need for substantive ethical discussion and for decisions on matters of public policy, but efforts to “Europeanise” bioethics by “revising the set of [four] principles” (p. 61) had yet to generate a new model to replace it.⁸

Rolf Löther’s 1998 rediscovery of the work of Fritz Jahr,⁹ a German theologian whose writings span the full second quarter of the twentieth century, set things on a new course (Jahr 1927). Jahr had used the

term *Bio-Ethik* in establishing a bioethical imperative that was parallel to Kant's *categorical imperative*; it was a moral principle defining an ethical stance to the whole of nature, not just to one's fellow humans. And Jahr himself saw this principle as the product of a long, ongoing European intellectual tradition. For the Europeans looking to find a new way forward, Jahr's work was foundational, preceded the emergence of American bioethics, and set the stage for a distinctively European approach to the field. As Muzur notes (2017), Jahr's work has generated a whole series of distinctive and separate *national* approaches—in Europe and beyond—that leave open whether some future consolidation, toward some shared or universal set of principles, will prove possible.

As a footnote to these ongoing developments (with uncertain outcome) in Europe, we think it worth noting that the discontinuity between Jahr's work and American bioethics is deeper and more long-standing than the above summary suggests. Continental and Anglo-American philosophy broke off in separate directions after Kant (1724–1804). Fichte, Hegel, Schleiermacher, Husserl, and Heidegger are some of the leading figures on the Continental side, whereas Bentham, Mill, Russell, Ayer, and Wittgenstein are some on the Anglo-American side. The most tangible difference between these two lines of philosophy is that the latter is oriented toward language, science, and intellectual precision, whereas the former sees knowledge more broadly and would generally consider the ways of science as only one way—and at that, a very constrained or limited way—of understanding ourselves and the world. In that context, Jahr's work has been, at least for Europeans, truly liberating, for it points to foundations in their own intellectual history that are unconnected with the Anglo-American roots of American bioethics.

THE UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS

For all the above activity in Europe—which is, to be sure, still playing itself out—the globally dominant conception of bioethics remains closely connected with principlism, the “Georgetown mantra.” The first nine of the fifteen articles of the Universal Declaration on Bioethics and Human Rights, adopted by the United Nations Educational, Scientific and Cultural Organization in 2005, include all of the original four principles from that principlist framework and draw out their consequences.

The remaining six articles address broader social dimensions of bioethics not covered by the original four principles: respect for cultural diversity and pluralism (Article 12), solidarity and cooperation (Article 13), social responsibility and health (Article 14), sharing of benefits (Article 15), protecting future generations (Article 16), and protection of the environment, the biosphere, and biodiversity (Article 17). Few bioethicists would find reason to dispute any of these additions, and any bioethicist committed to the four principles would likely see these additional principles (except, perhaps, for the not-so-Anglo-American Article 13 on solidarity, which comes directly out of the French, not American, Revolution) as simple extensions or even consequences of the original four.

Ten years after the adoption of the Universal Declaration, UNESCO published *Global Bioethics: What For?* (2015), a publication marking the twentieth anniversary of the organization's Bioethics Programme. Although one does see in the essays some effort to move beyond principlism, its presence remains strong and confining. As noted in the volume's introduction, the ongoing challenge for UNESCO's Bioethics Programme is to implement the principles of the Universal Declaration and "to make the ethical principles a reality" (p. 8). In this context, one contributor—Jean Martin, a general-practice physician/clinician, not a bioethicist—notes that the principles of the Universal Declaration remain the "fundamental points of reference" for bioethical teaching and discussion; bioethics itself, so conceived, with principles as the core, "must be a strong component in syllabuses—at schools, universities and professional or general training courses" (Martin 2015, p. 30).

Whether one thinks in terms of the original four principles or the expanded set of principles in the Universal Declaration on Bioethics and Human Rights, our concern remains the same. What happens when these sorts of ethical principles meet the very concrete world of clinical practice and the day-to-day clinical challenges of health professionals? That is the question we explore in the next two chapters.

NOTES

1. This same sentiment is reflected, a decade later, in the following remark by a surgeon commenting on the potential use of review boards to determine suitable candidates for psychosurgery:

- “What I resent, and resent very deeply, is the idea that has been prevalent for the past seven years that patients have to be protected from physicians. This is a terrible, terrible thought to me. The best guardian that you can have of your welfare when you are ill with anything is your physicians.” From Sue Sprecher, “Psychosurgery Policy Soon to Be Set,” *Real Paper*, January 21, 1978. (as quoted in Paul Starr, *The Social Transformation of American Medicine*, p. 390)
2. See David J. Rothman’s *Strangers at the Bedside* (1991) for a full history of the bioethics movement’s first two decades.
 3. One noteworthy exception concerned surgical interventions for the treatment of acute disease, an advance made possible by Lister’s work on antisepsis and the subsequent development of sterile surgical technique. Another was the development of a vaccine for smallpox.
 4. There may be something of the American character in this. The United States also had a war on poverty and a war on drugs.
 5. The medical profession’s difficulty in accepting that a patient is dying continues into the present day (Ivory 2016).
 6. This quotation is taken from Abraham Flexner’s visionary, early-twentieth-century study of medical education, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*.
 7. Here we have intentionally played on the title of Freud’s *Civilization and Its Discontents*.
 8. As Muzur notes (2017, p. 64), efforts to export the four principles revealed discontinuities between those principles and the values of the rest of the world.
 For instance, while autonomy has been crucial for the Anglo-American culture ever since Independence, in Europe the principle of solidarity is more important. In Eastern-Asian bioethics, autonomy again happens to be interpreted in the Confucian sense, i.e. stressing the sovereignty of family instead of the individual which is similar to what we can observe in some African cultures as well.
 9. Jahr’s most widely read essay is “Bio-Ethik. Eine Umschau über die ethischen Beziehungen des Menschen zu Tier und Pflanze” (1927), translated under the title “Bio-Ethics. Reviewing the Ethical Relations of Humans Towards Animals and Plants” by Hans-Martin Sass in the Croatian journal *JÄHR* (2010). The journal changed its subtitle from *Annual of the Department of Social Sciences and Medical Humanities* to *European Journal of Bioethics* in 2014 (volume 5), and may be, in library catalogs (including Harvard University’s Harvard Online Library Information System [HOLLIS]), located only under that title (not *JÄHR*). Jahr’s essays are available in English translation in *Essays in Bioethics, 1924–1948*.

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CHAPTER 4

Theory and Practice: From the Top Down

Abstract The bioethics movement, originating in the United States but then expanding to become a worldwide phenomenon, generated a conception of ethical reasoning that is oriented toward ethical (and legal) rights—and also, more abstractly, toward ethical principles. These modes of reasoning, though useful and even powerful tools for trained philosophers and bioethicists, do not mesh well with how clinicians think and work. The discontinuities arise in various contexts, and will often be discussed here and in subsequent chapters. In this chapter we focus on the development of the bioethical model of *principled decision making* and the notion of ethics expertise to which it gave rise.

Keywords Health care • Clinical ethics • *Salgo* • Informed consent
Patients' rights • Autonomy • Principled decision making • Ethical dilemmas • Ethics expertise

FROM RIGHTS TO PRINCIPLES

In what sociologists refer to as a process of *normative entrepreneurship*, the Hastings Center, Kennedy Institute of Ethics, and a small but growing cohort of bioethicists, as well as state courts and even the U.S. government, moved rapidly in the 1970s and early 1980s to articulate and consolidate a particular conception of ethical problems in health care and how to analyze and address them.

The conceptual center of the new bioethics movement was generally seen as involving informed consent (from the original 1957 *Salgo* decision by the California Supreme Court), patients' rights (invoking the language of President Kennedy (1962), Ralph Nader (1965), and, indeed, the larger civil rights movement of the 1960s [see Chapter 3]), or, in what would become the distinctive vocabulary of the bioethics movement, individual autonomy.

We can understand this progression as occurring in four stages.

First was the *Salgo* case, in which the California Supreme Court chose to enforce a policy that it described as "informed consent"—the need for physicians to provide patients with the information required to give their informed consent to treatment. The Supreme Court's opinion refers only once to the rights of patients, and even then, it does so only in quoting the earlier, lower court opinion in the same case.

Second was the assertion of patients' rights as such—most centrally, the right of patients to give informed consent to treatment. It was, indeed, a short step for courts to move from *Salgo*'s assertion about what doctors are required, or have a duty or obligation, to do (i.e., to *provide information* to patients so that they can make informed decisions), to the correlative assertion that patients have a *right to be given* that same information. And throughout the 1970s, as state courts were using the doctrine of informed consent as the central tool in analyzing that decade's landmark cases about death and dying, the bioethics literature was generating its own wide-ranging, but parallel, literature on informed consent. Though the legal cases nominally based their decisions on patients' legal rights, and the bioethics literature was nominally based on ethical rights, the two frameworks interacted and ran together. Court decisions were interpreted as extending the ethical understanding of patients' rights, while the ethical understanding of patients' rights, as advanced by bioethicists through their contributions to the bioethics literature, was used by courts and legislatures in articulating further legal advances. The doctrine of informed consent came to be the centerpiece of the bioethical paradigm, used to analyze and decide problems as wide-ranging as the care of the dying, at one extreme, to the ethically permissible conditions for selling genetically engineered tomatoes, at the other.

A third step, conceptually at least, was the expansion of the rights framework to include the rights not just of patients but of myriad other persons (parents, spouses, health professionals) and institutions (hospitals, insurance companies, the government, even society itself),¹ with the consequence that virtually any ethical situation could be construed in terms of conflicting rights.

A fourth, final step in the progression of bioethical thought was the move toward a more general plane, the level of philosophical discourse—that is, the level of principles. In this context, the emergence of a fully elaborated, mature bioethical model of health care ethics was marked, as noted in Chapter 2, by the 1979 publication of *Principles of Biomedical Ethics*, by Tom Beauchamp and James Childress, with its four principles of autonomy, beneficence, nonmaleficence, and justice. That book consolidated, and articulated in theoretical terms, the decade of bioethical discourse since the founding of the Hastings Center. The success of this approach can be measured by its longevity. The seventh edition of the Beauchamp–Childress volume was published in 2013. A parallel volume, with more emphasis on the law, is *Ethics and Law for the Health Professions* by Ian Kerridge and colleagues, originally published in 1998, with its fourth edition published in 2013. As noted in Chapter 3, the original set of four principles was expanded through the 2005 Universal Declaration on Bioethics and Human Rights, but the same emphasis on principles remains central, even exclusive.

Seen from the perspective of bioethics, as described above, the informal, intuitive ethical reasoning that had served health professionals (and patients) for two millennia was unacceptable, among other reasons because it incorporated built-in prejudices and biases about who decides what, and why. Health professionals needed to be guided, instead, by self-conscious ethical reasoning based on abstract ethical principles. That is, according to this bioethical model, health professionals were supposed to apply abstract ethical principles (including the principle of autonomy underlying informed consent) to concrete clinical situations, ultimately reaching particular ethical judgments. This process came to be enshrined as *principled decision making*; any other form of reasoning was deficient.² Principled decision making is a prime example of applying an abstract or theoretical framework to specific cases or problems—that is, of reasoning from the top down.

A further step in the emergence and consolidation of the bioethics movement was the involvement of the U.S. government through the work and publications of the initial President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The Commission's many publications—twelve books published from 1981 to 1983 and coming with the authority and visibility of any presidential commission—covered such a wide range of issues, and in such depth, that they effectively consolidated the ethical framework that U.S. bioethicists and courts had been articulating over the course of the 1970s.

DISCONTINUITIES WITH CLINICAL THINKING AND PRACTICE

The product of the above developments was a body of theoretical work that reflected the intellectual frameworks and linguistic conventions of philosophers and lawyers but that paid little attention to the long-established ways in which doctors and other health professionals actually thought and acted. Nowhere is the discontinuity between clinical medicine and the bioethical model of principled decision making more apparent than in Beauchamp and Childress's treatment, in *Principles of Biomedical Ethics* (1979, 2013), of the maxim *primum non nocere*, "First, do no harm"—a principle that is well familiar to all health professionals. This principle, especially when used within concrete factual situations presenting relatively concrete, well-defined ethical problems, is generally perceived as both easy to understand and easy to apply. By contrast, in *Principles of Biomedical Ethics*, the principle morphs into something that physicians, nurses, and other health professionals—part of the intended audience for the book—would likely not recognize and would surely be unable to apply.

To be more specific, as set out in the first, 1979 edition of *Principles of Biomedical Ethics*, the familiar principle of "do no harm" is better understood as the principle of "nonmaleficence, [which] refers to the noninfliction of harm on others." The principle of nonmaleficence is then distinguished from the "principle of beneficence," which requires that one take "positive steps to help others." The principle of beneficence is distinguished, in turn, from the "principle of benevolence," which requires that one act with the *intention* to benefit others. Beauchamp and Childress (1979) continue (pp. 135–136):

Sometimes in moral philosophy nonmaleficence is used to refer more broadly to the *prevention* of harm and also to the *removal* of harmful conditions. However, since prevention and removal generally require positive acts that assist others, we shall use the term "beneficence" to refer to acts involving prevention of harm, removal of harmful conditions, and positive benefiting, while "nonmaleficence" will be restricted to the noninfliction of harm.

. . . The duty to *confer* benefits and actively prevent and remove harms is important in biomedical and behavioral contexts, and of equal importance is the duty to *balance* the good it is possible to produce against the harms that might result from doing or not doing the good. It is thus appropriate to distinguish two principles under the general heading of beneficence: the

first principle requires the *provision* of benefits, and the second requires a *balancing* of benefits and harms. The first may be called the principle of positive beneficence, while the second is already familiar to us as the principle of utility.

Finally, Beauchamp and Childress (1979, p. 101) encourage the reader to keep in mind is that the principle of nonmaleficence can be properly applied only if one also takes into account, among other things, “due care, . . . risk-benefit assessments, and . . . detriment-benefit assessments.”

Even for someone trained in moral philosophy (as is the first author [SS]), this sort of language and analysis is difficult and burdensome to sift through, made only worse by the substitution of the conceptually opaque term *nonmaleficence* for “do no harm”—a precedent set firmly in motion by Beauchamp and Childress and followed almost uniformly in the bioethics literature, in the United States and elsewhere (see, e.g., the volumes by Kerridge et al. 1998, 2005, 2009, 2013).³ Indeed, as a measure of how the principle of nonmaleficence has permeated writing and discussion on bioethics, the word *nonmaleficence* surpassed a quarter of a *million* hits on Google toward the middle of 2017 (before Google changed the manner in which it counts hits). This number of hits is, in effect, a measure of the distance that the bioethics literature has moved away from the language and concerns of clinicians. And the term itself—*nonmaleficence*—signals, in a word, that the bioethicists are the experts and that clinicians are not.

If one assumes that the intellectual contributions of bioethics should help health care clinicians to stand on their own two ethical feet by themselves, it is fair to say that the language and methods of bioethics have fallen short.

VIGNETTE: DILEMMAS AND THE QUEST FOR CLOSURE

The disconnection between theoretical and clinical contexts finds direct expression in the following example (drawn from the all-too-recent experience of the first author), where there is a parallel disconnection between the therapist’s bioethics-framed thinking and her incapacity to tap into her own clinical thinking and experience.

A therapist asked me if I could give her my opinion about an ethical problem. Without waiting for an answer, she immediately proceeded to tell me

about “an ethical dilemma” that she was trying to resolve. A patient of hers had recently lost his job and was therefore unable to pay anything for further treatment. So the question was whether (1) the therapist should continue treating the patient despite his inability to pay, or (2) whether the therapist should tell the patient that treatment must be stopped because of that same inability to pay. In favor of the first option, the therapist felt that she had a *right* to be paid for her services and should not be expected to work for free, and in favor of the second, the therapist felt that the patient had a separate *right* to receive the treatment that he needed, independent of whether he had the current means to pay for it. In the process of presenting the situation to me, it became clear that the therapist saw no other options as being available. When she had finished, I asked her if she would consider other possible solutions to her “ethical dilemma,” which she had framed as exactly the sort of irresolvable dilemma of conflicting rights that are so commonly used in teaching bioethics. Since the therapist was, I found, immediately receptive to the suggestion that there might be alternative courses of action, and not just two (the “*dilemma*”), I mentioned that her patient, with no income whatsoever at that point and no immediate prospect of employment, would qualify for free care (under the United States’ federally mandated free-care program) at one of the local teaching hospitals. Rather than being abandoned, the patient would be able to obtain continuing psychiatric care of high quality, despite his lack of economic resources, until his professional situation improved. The therapist immediately recognized that this third option would enable her to escape the no-win situation of conflicting rights that she had constructed for herself using the bioethical paradigm.

In the above situation, the solution proposed by the first author was effective and readily available, but as various people mentioned when I subsequently discussed the situation with them, the solution was certainly not unique. Various sorts of other arrangements could also have been worked out with the patient (e.g., less frequent appointments, or a promise from the patient, or even a contract, to pay when his financial circumstances improved). But the availability of multiple options serves only to emphasize the point of the example. From the perspective of how the therapist had been taught about ethics (from a bioethicist) at a leading American medical school, she was doing exactly as she should have. She construed the situation as involving an ethical dilemma—literally an ethical choice between two mutually exclusive options—and as involving a conflict between various rights and abstract principles (e.g., the therapist’s obligation to provide treatment; the therapist’s right

to be paid for services; the patient's right to obtain needed health care; the possible relevance of altruism, self-sacrifice, and the obligation to help someone in distress).

In both the academic literature and in the classroom (note: the *classroom*, not the *bedside*), “dilemmas” and conflicts involving rights or principles have always been a mainstay of bioethical discussions: witness the publication of various “case studies in” books by Robert Veatch and colleagues: medical ethics (1977), nursing ethics (1987), allied health ethics (1996), pharmacy ethics (1999), and, most recently, biomedical ethics (2010, with a second edition in 2015). But these “dilemmas” are basically unresolvable in their own terms: Should individuals with severe developmental delays be sterilized? What happens when prospective parents disagree about whether to abort a genetically defective or otherwise malformed fetus? Should patients with one chance in 25 (or 50, or 100, or 500, or 1000) of recovering be maintained on life support indefinitely? Should families with a history of abuse but a strong recent record of safety have their children removed when conflict at home creates the potential for harm? Reasonable, well-intentioned people—whether ethicists, health professionals, or laymen—will come to different conclusions. The more difficult the dilemma, the less likely that anything resembling a consensus will emerge. And *if* a consensus does emerge, it will likely be only after a long process of debate and analysis. Even then, some people are likely to have some perfectly good reasons for rejecting what has, by hypothesis, come to be the consensual view.

The basic problem here is that rights and principles, though legitimate dimensions of ethical discourse, are actually difficult to sort out when they conflict. Rights, for example, define interests that can be asserted against other persons and that typically demand a particular outcome—whatever that right requires—unless others can, in response, assert their own rights. That is, if a person legitimately asserts a right against others, the only way that the others can effectively oppose it is by asserting back their own rights or other compelling interests (e.g., public safety) that undercut or oppose the initial assertion of rights. The immediate unanswerability of an assertion of rights is what accounts for the lively classroom discussion of the ethical dilemmas that have become so common in teaching health care ethics. Veatch and colleagues, for example, self-consciously design their cases to generate conflicts among rights. Different students end up taking different “sides” and seeing different rights (e.g., those of the patient, those of the family, or those of society)

as more fundamental than others. The discussion may be lively and even combative, but within the confines of a single classroom session, reaching a reasoned consensus is unrealistic. The advantage of this approach to teaching ethics is that it does offer an opportunity to explore the complexities of the cases presented, but the disadvantage is that it provides no obvious way of moving beyond those complexities. Students are simply left at loggerheads with one another.

ETHICS EXPERTISE: WHAT IT IS AND ISN'T

The extent and depth of disagreements in such discussions is, in a small way, a reflection of what typically occurs in philosophical discourse. The philosophical literature abounds in discussions of normative ethical problems of the sorts that are also discussed in the parallel literature of the bioethics movement. As any observer realizes, however, the field of normative ethics (within the field of moral philosophy, not bioethics), for all its erudition and rigor, is characterized by virtually unending intellectual cacophony, conflict, and disagreement; closure and consensus are rare commodities. That is, the expertise of “professional” philosophers—those who teach in philosophy departments throughout the United States and the rest of the world—does not enable them to provide authoritative solutions and closure to thorny ethical problems. It is not an expertise of substantive ethical knowledge that would enable them to draw authoritative ethical conclusions from abstract ethical principles. Their expertise, instead, is fundamentally about *how* to think, not *what* to think: in the process of becoming a professional “expert” in ethics (a process that consumes nearly a *decade* in the life of a PhD philosopher), what one acquires is the capacity to ask questions and to analyze and criticize ethical reasoning.⁴

This particular, process-oriented conception of expertise is radically at odds with the notion of professional expertise current within health care. Whereas the former is oriented almost exclusively toward *how* to think, the latter is oriented almost exclusively toward *what* to think. Put in another way, the expertise possessed by health professionals in their own fields enables them to make specific clinical decisions and to exercise clinical judgment. And the more expert a person is, the more authoritative—and presumably, accurate and reliable—his or her expert opinion will be. By the same token, the reason for consulting someone with more expertise than one has oneself is to obtain reliable guidance, and

closure, in situations where one's own knowledge and expertise are perceived as inadequate. Within health care, the more difficult the problem, the more helpful, authoritative, and reliable expert consultation is apt to be, at least with regard to achieving closure, a way of going forward. Within normative ethics, however—and within bioethics, too—the more difficult the problem, the less likely that expert (philosophical/bioethical) consultation will lead directly to closure. It may well lead to a better understanding of the problem and of the various factors that render it so difficult to resolve. But it will generally not lead to closure; for all their knowledge of ethical principles and how to analyze complicated situations, philosophers with expertise in ethics—including bioethicists—cannot actually provide single, reliable, authoritative answers to difficult ethical questions.

Unfortunately, the differences between the two types of expertise—substantive expertise in *what* to think versus procedural expertise in *how* to think—is not typically recognized within clinical settings. Health professionals are apt to see bioethicists as having the same sort of substantive, authoritative expertise as those professionals have come to expect from senior colleagues in their own fields, and our own impression is that bioethicists are typically content to be perceived as having exactly the same sort of substantive expertise as experts within health care: that is, health professionals can and should rely on the opinions of bioethicists as providing the single, correct answers to whatever question has been asked.⁵ Also worth noting is that hospital administrators and department heads welcome seeing bioethicists in exactly that way: what better way could there be to escape from a messy situation than by relying on the authoritative ethical judgment of a bioethicist?

This mistaken way of perceiving bioethicists has real, and unfortunate, consequences. When clinicians perceive bioethicists as providing authoritative answers, clinicians become mere consumers of information. Their position is one of relative passivity. Clinicians are not generating knowledge or conclusions through their own intellectual activity. Instead, they are receiving information that will not be integrated, assessed, or retained in the same way as information or conclusions that they generate through our own thinking, their own ethical engagement/reflection.

The shortfall is exactly the same as what happens when someone else is driving a car and telling us how to get somewhere. It's simply not the same as what happens, and what we learn, when we are driving the car ourselves. It's only when we are in the driver's seat—when we are active

rather than passive—that we actually learn the route in a manner that will be retained. Likewise, passively consuming some information from a so-called ethics expert will possibly provide a workable way of going forward in a particular situation, but it is unlikely to result in the kind of learning that will help anyone to analyze and address ethical problems in the future. That is, a one-off encounter regarding a particular situation can be expected to produce no more than a single bit of information, useful for the situation encountered but of no further educational value.

Bioethicists have attempted to address this problem of reaching closure in various ways, including multistep processes—the subject of the next chapter. As we will argue, however, such processes promise more than they can achieve.

NOTES

1. And even to animals. In “Should We Stop Keeping Pets? Why More and More Ethicists Say Yes” (2017), Linda Rodriguez McRobbie suggests that keeping animals as pets arguably violates their “right of self-determination.”
2. This preference for reasoning from ethical principles is often taken up not just by those trained to work with such principles—such as those in philosophy, theology, and, to a certain degree, lawyers—but by scholars and practitioners intellectually grounded in other, more concrete fields. For example, when the first author was a Visiting Scholar at Yale Law School in 1994–95, he had what proved to be a remarkable conversation with Professor Jay Katz, a psychiatrist who wrote *The Silent World of Doctor and Patient* (1984) and was one of most revered and humanly sensitive bioethicists in the history of that bioethics movement. When I mentioned that I thought most doctors could and should make ethical decisions without explicitly consulting and applying ethical principles (which is, in fact, the subject of the present book), he stared at me in utter disbelief and said that he was astonished that I could hold such a view.
3. The 2005 Universal Declaration on Bioethics and Human Rights reverted to nontechnical language in its Article 4 (“Benefit and Harm”): “any possible harm to . . . individuals should be avoided.” The declaration also provided for various sorts of protections—to avoid harm—in several other articles. Despite this helpful linguistic change in such a prominent document, bioethicists have, as far as we can tell, continued to use *nonmaleficence* in their publications and on the websites to which they contribute. See, among many examples, “Ethical Frameworks: The Four Principles” (2018) on the UKCEN Clinical Ethics Network, and “Principles of Bioethics” (2013) on the University of Washington School of Medicine’s

generally informative website, Ethics in Medicine, <http://depts.washington.edu/bioethx/>.

4. In this context the first author is reminded of a conversation, long ago, with the head of a graduate training program in medicine (i.e., for residents) at a hospital affiliated with Harvard Medical School. The latter mentioned that the hospital was already being well served by a “trained” bioethicist. The person in question, a recent medical school graduate with no philosophical background, had attended a three-month summer program in bioethics at Oxford University in England. A rough estimate is that he had gained, in terms of analytical and critical skills, the equivalent of less than one year of undergraduate education in a philosophy department. Although he was consequently a mere neophyte in the field, the hospital perceived him as having gone off to Oxford to acquire substantive knowledge, and apparently three months there was deemed sufficient for him to be considered an intellectually authoritative bioethicist.
5. The use of ethical principles that were perceived as leading to determinate conclusions was also a methodology that was agreeable to doctors accustomed in thinking within the traditional biomedical model. The model of principlism stressed clarity, precision, and expertise, rather than feelings, context, and social determinants, the factors that are crucial in understanding the vignettes presented throughout the present book. We are grateful to Allan Brandt for bringing this point to our attention.

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CHAPTER 5

The Elusiveness of Closure

Abstract Unlike what happens in the classroom, where discussions can end in conflict, with agreement nowhere in sight, ethical problems in clinical health care require that decisions be made. Some form of closure is required in order to move forward. And closure can be elusive indeed. In this chapter we look at efforts to achieve closure through the use of multistep processes, as proposed by some bioethicists.

Keywords Health care · Clinical ethics · Closure · Multistep processes
Judicial decision making · Legal process · Institutional constraints
Professional education · Socialization · Expertise

In clinical practice, ethical problems do not arise out of nowhere. They develop, over time, from preexisting, but evolving, clinical situations. We start this chapter with a vignette adapted from the clinical experience of the second author (KK).

VIGNETTE: A MORBIDLY OBESE, DEVELOPMENTALLY DELAYED 14-YEAR-OLD

A family presents with a 150-kilogram (330-pound), epileptic, developmentally delayed, violent 14-year-old boy with a genetically related dementing illness. He had recently started refusing to leave home, with the consequence that he has not been attending school. At the observational

admission, the clinical situation is assessed by the full range of health professionals at the hospital. Particular problems are identified as amenable to intervention, and both staff and family members are given various follow-up tasks to complete, including the following: a trial of different medications; provision of respite services for the parents; organization of services to assist in transporting the child to school on a regular basis; further review of the boy's behavior-management program; and an assessment of the mother's and possibly father's mental and physical health.

In most such clinical situations, even the most difficult ones, health professionals are able to work out viable solutions without consciously addressing even a single issue perceived as ethical. But situations sometimes do not develop in the way one hoped, and serious conflicts may arise—conflicts that bioethicists would immediately identify as raising complex ethical questions. Consider the following sequel to the above clinical situation.

Over the course of the next year, the father's increasing stress about the situation at home led him to withdraw from the family, to spend more time at work, and to opt for more work-related travel assignments. The mother became increasingly depressed, could not, on her own, summon up the energy required to maintain the son's educational and health status, and lost her capacity to resist his demands for food. As a consequence, the son's weight continued to increase; he stopped attending school again; he was rarely leaving his bed; and a medical assessment concluded that without a return to the previous routine, the son's hypertension would become uncontrollable, and he would develop further, potentially life-threatening complications of both obesity and immobility. Though neither the mother nor father was capable of providing proper care for their son, they were also both adamant that the child's care was their business alone and that health professionals and others should stay away. The health professionals noted that without adequate care, the boy would likely either die very prematurely or end up creating an indeterminate (and presumably vast) stream of medical costs that would come out of the public treasury and decrease the funds available to care for other patients.

In a standard textbook on health care ethics, the case would likely here with the question "What should be done?"—or perhaps with a series of questions about, for example, the various stakeholders, their rights and interests, which have priority, how one decides such matters, whether a 14-year-old is potentially competent to make decisions in his own behalf, and whether family privacy overrides the public interest.

What is certain is that such a case would provide the basis for a class discussion that would be interesting, engaging, or even exuberant. But engaging students in a classroom discussion is one thing. Reaching a single, sound clinical decision in a situation permeated with suffering and distress is quite another.

MULTISTEP PROCESSES FOR ACHIEVING CLOSURE

For the purpose of reaching decisions in difficult clinical situations, bioethicists have proposed various sorts of multistep processes for health professionals to follow, enabling them to address all the relevant issues. For example, in *Ethics and Law for the Health Professions* (2013, pp. 138–139), Ian Kerridge and colleagues present a seven-step process: (1) identify the ethical problem; (2) get the facts; (3) consider core ethical principles; (4) consider how the problem would look from another perspective or using another theory; (5) identify ethical conflicts; (6) consider the law; and (7) identify a way forward. The full scope of what is required becomes manifest only in the complete description of the seven steps (see Text Box 5.1).

Text Box 5.1: A Model for Ethical Problem Solving in Clinical Medicine

[Step 1] Identify the ethical problem:

Consider the problem within its context and attempt to distinguish between ethical problems and other medical, social, cultural, linguistic and legal issues.

Explore the meaning of value-laden terms, e.g. futility, quality of life.

[Step 2] Get the facts:

Find out as much as you can about the problem through history, examination and relevant investigations.

Take the time to listen to the patient's narrative and understand their personal and cultural biography.

Identify whether there are necessary facts that you do not have? If so, search for them.

Use the principles of Evidence-Based Medicine (EBM) where possible when assessing or epidemiological evidence.

[Step 3] **Consider core ethical principles:**

Autonomy: what is the patient's (or surrogate's) preferences, goals and values; what is the patient's approach to the problem?

Beneficence: what benefits can be obtained for the patient?

Non-maleficence: what are the risks and how can they be minimized or avoided?

Justice: how are the interests of different parties to be balanced? How can equity or fairness be maximized?

Confidentiality/privacy: what information is private and does confidentiality need to be limited or breached?

Veracity: has the patient and their family been honestly informed and is there any reason why the patient cannot know the truth?

[Step 4] **Consider how the problem would look from another perspective or using another theory:**

Who are the relevant stakeholders? What is their interest? What do they have to lose? How salient are their interests? How powerful are they? How legitimate are they? How urgent are they?

How would the problem look like from an alternative ethical position? For example, consequentialist, rights-based, virtue-based, feminist, communitarian, or care-based.

Has someone else solved a similar problem in the past? How did they do it?

[Step 5] **Identify ethical conflicts** (e.g. between principles, values or perspectives):

Explain why the conflicts occur and how they may be resolved.

[Step 6] Consider the law:

Identify relevant legal concepts and laws and how they might guide management.
 Examine relationship between clinical-ethical decision and the law.

[Step 7] Identify a way forward:

Identify ethically viable options;
 Identify the option chose, for example, by specifying how guiding principles were balanced or by clarifying what issues or processes were considered most significant, and why;
 Be clear about who was responsible for the decision;
 Communicate the choice and assist relevant stakeholders determine an action plan;
 Document the process;
 Assist/mediate resolution of any conflict;
 Evaluate the outcome.

From Kerridge I., Lowe M., and Stewart C., *Ethics and Law for the Health Professions*, 4th ed. (Sydney: Federation Press, 2013). Reprinted with permission.

More concretely, in presenting multistep processes as a means of addressing ethical “dilemmas”—presumably, situations in which a straightforward application of ethical principles yields no unequivocal answer—bioethicists implicitly assert that such processes actually will lead, in some way, to the desired closure. But such processes, if brought to closure via a full consideration of all the relevant issues, are even more complex than Kerridge’s seven steps would suggest. Just how complex can be seen if we look not at bioethics but at what’s involved when law courts consider cases that have been appealed. In such situations, a lower court would have made a decision based on its consideration of both the law and the facts, as in a jury trial. On appeal—in a process that closely parallels the multistep consideration of difficult ethical questions in bioethics—the appeals court considers only matters of law, against the background facts as determined by the lower court. That process of

appealing a decision by a lower court can be considered, for our purposes, as an elaborated version of Kerridge's multistep process for addressing ethical issues in health care.

In considering the work of appeals courts, our goals are twofold: first, to understand the complexity of such multistep processes, and second, to understand why, in law, they actually work as a means of reaching decisions. In the section after that, we return to consider the use of multistep processes in bioethics.

THE MULTISTEP PROCESS OF APPEALS COURTS

Framing and the Diversity of Perspectives

The work of appeals courts is to make decisions about the law in relation to cases that have previously been decided by lower courts. In particular, a case comes to an appeals court when one side of a case argues that the lower court, in making its decision, was mistaken in how it interpreted or applied the law. The task of the appeals court is to determine whether that interpretation or application was mistaken or not, given the facts as determined by the lower court.

For an appeals court judge (we will be taking U.S. appeals courts as a model here),¹ an initial step is to request each side to prepare a written legal *brief* presenting arguments to support their own interpretation of the law (or laws) in question—which is parallel to what happens in bioethics courses as students set out to defend their own views against those of their classmates. In these briefs, each side constructs, as it were, a view of the world that seeks to persuade the court to see the case in that way, too. For this purpose, the attorneys involved may well end up invoking the full range of factors used in ethicists' multistep processes. Historical, cultural, and social factors might be part of framing—and arguing—a case. Linguistic factors are always important in law and may prove central, even decisive. No argument can be made without direct reference to established legal rules and to what that particular court and other courts have done in the past (i.e., relevant *precedents*). Policies underlying a particular area of law are regularly invoked. And references to ethical principles are made, too, if they help to support one's argument (e.g., by referring to factors such as "fundamental fairness"). Another crucial factor in preparing any legal brief, as in a bioethicist's multistep process, is the need to anticipate and address the arguments of the other

side; one test of this comes with oral argument, which enables the judge to probe the positions of the attorneys for each side.

In the case of our morbidly obese, bedbound teenage boy, let's suppose that (1) a child-protection agency had attempted to remove the boy from his family, (2) the family, possibly with the assistance of some sort of pro bono or public organization (and therefore free or low cost), decided to oppose the removal, and (3) in a court proceeding, it was decided that the agency was legally justified in removing the child. If that decision was then appealed, both sides would be asked to prepare legal briefs presenting their positions. And if one assumes that the situation received attention in the local papers, one would also expect that there might be some, or even many, additional briefs submitted by amici curiae—friends of the court. A family-oriented, pro-parent group might insist that the rights of the parents be protected and that they be allowed to retain their child at home, no matter what the consequences. Likewise for any group writing from either the far right or far left, who would presumably be opposed to the intrusion of the state into what they considered a fundamentally private matter. Some groups representing health professionals or institutions would support the child-protection agency, arguing that protecting the health and well-being of the child is the community's fundamental concern, whereas other groups might oppose removal, either to protect the psychological health of a disabled, dependent child or to prevent the child's exposure to physical or sexual abuse in various sorts of foster-care settings. Law professors might write carefully researched, persuasive briefs on both sides of the dispute, often by citing not just the law but the sociological, historical, or anthropological factors relevant to the case.

It is difficult to overstate the potential degree of complexity in such situations. Each brief submitted not only argues in favor of a certain result but provides a distinct set of arguments that typically frame the case in a way that reflects the broader interests of whoever prepared or commissioned that particular brief. Based on such framing, the central issue in the case might be seen as one involving, among others, statutory interpretation, parental rights, children's rights, state interests, abuse of power, domains of interest (public versus private), or the limits of the judicial authority. And each of these arguments might actually have some real merit.

The Complexities of Closure

In many legal cases, one might think that the availability of an established (and relevant) legal rule would carry the day and move directly to closure. If the case were so simple, however, it would never have been appealed

(or accepted for appeal). For example, even when a judge agrees that, *other things equal*, “the established rule in such situations is that . . . ,” it is still an open question whether other things actually are equal. Deciding that question—and how narrowly or broadly to apply or interpret an established rule—is often a key element in the case, and a key element for judges to determine. In this context, courts need to consider all of the elements discussed in the preceding subsection and also a potentially wide range of subsidiary factors, including the following: How quickly is a decision required? Does the court have the time and resources to assess particular factors? Is there a simpler way of deciding a case without getting into complicated, controversial, or time-consuming issues? Is the issue “ripe”; that is, is enough known, often through previous litigation, about the factors relevant to a particular type of legal situation, enabling the court to make a reasoned, informed decision that is likely not to seem, in time, ill-founded or premature? Likewise, will deciding a case in a particular way end up upsetting established law, with the consequence that the decision would be considered unjustified or would create uncertainty in an area of law (e.g., contracts) where clarity and predictability are especially valued?

Against this background of conflicting legal arguments and, one might say, conflicting views of the world, the judge has to decide not only on a result—that is, which side “wins”—but also on the reasoning that led to that result and on what particular remedy, or course of action, to order. In the example we’re considering—the morbidly obese 14-year-old—the judge might decide in favor of the child-protection agency, set forth (or not) a set of reasons why the arguments presented by the opposing briefs were ultimately not persuasive, and then authorize the agency to remove the child but only pursuant to certain conditions. Such conditions might include (1) the availability of a public institution or even another family to take proper care of the child, (2) provision (or not) for the family to visit the child, and (3) conditions, if any, under which the child’s parents might petition the court to have the child returned home. Alternatively, and as often happens, the judge might decide in favor of the parents, provide a justification for that decision, and leave it to the child-protection agency to determine how best to protect the child at home.

What should be clear, no matter what, is that choosing exactly which arguments are “correct” (or stronger or more persuasive than the others) is no simple, determinate process. And it’s not as if there are only two potential results. A judge might find some middle or different ground for a decision—one not presented by any of the parties or *amici curiae*.

The judge needs to take all the diverse factors into account, as best as he or she can, and with the knowledge that except in unusual cases, there will no single, correct answer, and no single correct legal analysis. Different judges and different courts may reach different results, and even when the actual outcome is the same, they may have reached that position through a different line of reasoning. Judicial decisions are as different as the judges themselves, each with their own sensitivities, political views, attitudes toward risk, need for control, and personal and intellectual histories, among many other differences.

What Makes a Judicial Decision a “Good” One?

That said, what makes a judicial decision a good one, and not merely a legally authoritative one because issued by a judge? The main criterion here is the judge’s capacity to credibly apply existing law and potentially to advance it (if only by a smidgen) while holding true to the constraints within which all judges are expected to act. These constraints include the facts as known, the diverse dimensions of existing law—statutory law (made by the legislative branch of government), case law (judicial branch), and regulatory law (executive branch)—and the wide-ranging histories, social forces, and public policies that have shaped these separate areas of law.

The broader institutional character of law comes into play here. Informed assessments of judicial decisions emerge, over time, though the work of other judges, lawyers, and potentially also commentators and critics from the academic community—which can be understood, in effect, as expressing the collective wisdom of the profession. This institutional feedback will influence, in the short term, whether the decision is appealed to (and changed or overruled by) a higher court and, in the long term, the actual “meaning” of the decision. A decision deemed good will generally be interpreted more broadly and therefore have more legal impact in both the short and long term than a decision deemed poor.

Over time, the overall impact of these assessments is to define relatively stable, fixed points in the legal system that enable lawyers and judges to determine what can and cannot be argued effectively, what can or cannot be reasonably interpreted as a point in contention. Likewise, by virtue of their legal training and professional experience, lawyers and judges come to understand which points are relatively fixed and which not, as well as how hard, and by what sorts of arguments, such fixed

points can be questioned. Some points of law and some policies are more fixed than others; some points can be budged fairly easily (albeit only with very good reasons for doing so), whereas others require something much more than that. In the United States, for example, the confidentiality of the psychiatrist-patient relationship can be overridden only when the safety of another person is at risk—as in the case of a patient who tells his therapist that he is planning to murder someone.² Various constitutional doctrines have a similar, high threshold for arguing exceptions. Judge-made law actually does evolve, and sometimes change radically, over time. But in general, judges or lawyers who ignore or move too far away from established fixed points of the law are apt to find their own work ignored, disregarded, or disparaged.

Why Does the Judicial Process “Work”?

This multistep process of judicial decision making is well accepted, used in some form or other worldwide, and, if the judges themselves are competent, considered to generate good results. In short, the model works, and as we see it, there are four main reasons for that.

1. The persons implementing the model—judges and lawyers—are themselves *experts in the relevant field*: law. And they bring this expertise to bear throughout the process, from (at the very outset) deciding which cases to litigate, to every stage of the litigation, to the ultimate decision by, and reasoning of, the judge.
2. The *law itself*—substantively and procedurally—operates as a constraint. Substantive legal rules permeate and shape the process of judicial decision making, from outset to conclusion. These rules, though not inflexible, are relatively fixed signposts for such decision making. Procedural rules, such as those concerning documentary evidence or the examination of witnesses—keep the legal proceedings moving ahead on a defined path, and without having to recreate the process at every step and for every case.
3. More concretely, the *history of each case* serves to frame the relevant issues, and this history helps to determine, in effect, what points of fact and law are in contention, and which are not. It is not that the case, if it arose afresh, might not be seen as raising different issues. The point, instead, is that the history of a case serves to limit the range of issues and focus the attention of the court and the parties involved in the case.

4. The *institutional framework* of the law operates as a strong constraint on lawyers and judges, and serves to channel their attention and legal work. Beginning with the professional socialization that occurs in law school and continuing with the bar examination, professional organizations, continuing legal (and even judicial) education, and myriad other activities, life in the law is lived within educational, social, and legal institutions that define what it is to live and work as a lawyer.

REVISITING BIOETHICS

The judicial process, as described above, can be understood for our purposes as a formalized, detailed version of the multistep process that Kerridge and colleagues (2013) recommend for addressing ethical issues in health care. As with the judicial process, the multistep process of ethical decision making should not be expected to produce unique, determinate, “correct” answers. It may be that, in the end, the various dimensions of the ethical problem at hand will be well, even deeply understood. But just how to integrate and balance the various factors remains indeterminate. As in the case of judges and the judicial process, different people will reach different results and for different reasons. More importantly, however, the multistep process in bioethics is not subject to the same constraints that channel the judicial process and that lead to what legal commentators see as generally good results.

The proposed multistep process for making ethical decisions incorporates *none* of the four constraints that channel the judicial process and that lead toward good, generally respected decisions. The most obvious and important difference is that health professionals are not experts in bioethics or in reasoning from ethical principles—the form of reasoning required by Kerridge and colleagues’ multistep process (or, indeed, by other multistep processes). Although bioethicists and philosophers undoubtedly feel comfortable with, and are adept at, analyzing ethical problems through the use of abstract ethical principles, they have reached that point only through explicit, lengthy training in academic programs designed just for that purpose. Needless to say, health professionals have not had that sort of training, and there is no reason to expect them to think and act as though they had.

A second shortcoming of bioethics’ multistep process is that ethical principles do not have the same, relatively stable and knowable structure as the law. As noted above, the judicial process operates within substantive and

procedural constraints that channel the work of lawyers and judges—and it is just this rule-defined structure that law students learn in law school and that is, in large part, tested for in state bar examinations (without which no one can legally practice law). Put quite simply, these substantive and procedural constraints—the fixed points that serve to define an entire field of human activity—have no parallel in bioethics or in ethics generally. The problem here is easy to explain. Suppose that two ethical principles conflict. How does one proceed to address the conflict? Bioethicists and philosophers might have some relevant expertise. Health professional simply do not.

A third shortcoming of bioethics' multistep process is that clinical situations raising ethical problems are not well defined in the way that they are in judicial decision making. Cases are not accepted for appeal because they have been, in some generic way, improperly decided by a lower court. Appeals are made, and accepted by higher courts, because some particular point or points of law—the *grounds for appeal*—may have been decided incorrectly by a lower court. This focus enables the process to move toward closure. By contrast, the bioethical process actually moves in the direction of increased complexity. The closer one looks, and the more exhaustively one attempts to address the full range of issues presented by an ethical situation, the more there is to see (with more and more issues to be explored and decided), the more complex the emotions experienced by the participants, and the more one moves away from a single, potentially determinate result. Judges expect such complexity and, indeed, are expected to make decisions that take into account such complexity. That's their job! But it isn't what health professionals are trained to do, and there's no reason to think that they can do it, especially within the time constraints of clinical health care.

A fourth shortcoming of bioethics' multistep process is that the institutional framework that constrains and channels the work of health professionals is oriented toward the provision of health care—understanding and treating disease and health-related problems. Analyzing difficult ethical problems by using abstract ethical principles is not part of that institutional framework. Health professionals are not trained, and not socialized, to deal with difficult ethical problems in that way. Health professionals do, indeed, deal with such problems whenever they arise. But they do so only after careful discussions, insofar as possible, with colleagues as well as with patients and their families and carers. Each clinician brings to these discussions his or her own clinical experience and established, clinically informed ethical views. But using abstract ethical

principles to address ethical problems is not an integral part of this process, and of what it is to live and work as a health professional.

THE WAY FORWARD

Confronted with the suggestion that they engage in a multistep process for making ethical decisions, one can easily imagine the following—but hypothetical—response by health professionals:

Lawyers are trained in the complexities of such models, and they work with such models, in such systems, their entire professional lives. Likewise, judges learn to make decisions in situations involving innumerable complexities of law, ethics, and public policy, all with underlying human dimensions. Much the same might be said of bioethicists, who are specifically trained to deal with ethical principles and all their complexities. But we have not been trained in any of those ways, and we aren't comfortable dealing with ethical theory and matters of public policy. Our world is concrete and clinical, and our goals are tied in with the welfare of our particular patients. In lieu of a multistep process requiring abstract analysis and the application of ethical principles, give us something that we can work with.

That's exactly what the rest of the book is about.

NOTES

1. Although we are, for the sake of simplicity, discussing the appeals process as if a single judge were deciding the case, federal appellate cases are typically decided by a panel of three judges. One judge writes the majority opinion, and the other two either *join* that opinion or write separate opinions of their own, either in concurrence or dissent.
2. By contrast, if the patient tells the psychiatrist about someone whom the patient has already murdered, confidentiality remains intact (*Tarasoff v. Regents of the University of California*, 1976).

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CHAPTER 6

Ethics and the Self

Abstract In this chapter we begin the process of rebuilding clinical ethics in health care—from the ground up. Clinical ethics, like all ethics, has its foundation in the self—in a full conception of the person whose thoughts, emotions, and actions must be understood as an integrated whole. It is from that foundation that one can then start building, for all health professionals as individuals, a mature professional ethic that incorporates each person’s own history and experience and that integrates those with each person’s growing knowledge of a particular field of health care. And because this conception of ethics is so thoroughly grounded in the self, it is a conception that inescapably connects with all health professionals as individuals and that enables them to understand, appreciate, and elaborate their own ethical thinking.

Keywords Health care • Clinical ethics • Implicit ethical framework
Strategic flexibility • Formal and informal ethical discourse • The self
Daniel Kahneman • Fast and slow thinking • Expertise

BECOMING A PERSON

Implicit Ethical Frameworks

Persons training to be health professionals are not blank slates waiting for input. They have at least a couple of decades of interpersonal

experience behind them—with parents, siblings, other relatives, friends, teachers, classmates, teammates, health professionals, policemen, shopkeepers, workmen, and service personnel of various sorts, among others, not to mention countless brief encounters with strangers in schools, stores, busses, trains, planes, and on the street. They have read novels, watched television, listened to the news, read newspaper stories and magazine articles about current events, and had extended discussions with friends and family about all and any of these. This range of pre-professional human experience is diverse and rich, and provides all of us with wide-ranging exposure to the challenges and conflicts presented in everyday life. Over time, prospective trainees in health care develop, through that experience, their own distinct patterns of thought, emotion, and action—their own relatively stable, though still evolving, personality styles and ways of adult functioning. Embedded in these stable patterns of functioning is each person's mode of relating to other people and of thinking about himself or herself, others, and society—in effect, an *implicit ethical framework*.

Considered as an aspect of the mature or maturing self, this implicit ethical framework is part of what makes each of us a unique person. It influences, if not determines, how each trainee, like any mature adult, thinks, feels, and acts in relation to the world, hour by hour, day by day. As examples, one might be joyful in response to a friend's success in helping out another individual or group; one might be disappointed in oneself for failing to help another person when the opportunity presented itself; one might be pleased at one's courage in standing up against a bully; one might reflect that another person's behavior was mean or selfish or abusive; one might feel distress at something one reads in the paper about some public figure or government official or public policy; one might be appalled to see that a new federal health care program retains barriers to access for the poor; or one might be proud of having published an article that exposed a lie and that presented a needed, and truthful, corrective to a simmering controversy. The examples are endless. We all make judgments about our ethical successes and failures—and about others' ethical successes and failures—day to day, about matters large and small, and typically without even being conscious that we are making ethical judgments.

Interwoven, too, with this fabric of mostly implicit ethical judgments are beliefs and attitudes that scholars in the relevant fields would consider to be sociological, historical, and anthropological/psychological.

That is, we all have views, integrated into our ethical and also non-ethical thinking, feeling, and acting, on such matters as social and economic class, social and political history, and anthropology/psychology, with the last focused on how our own views and those of others are tied in with our social, historical, and cultural milieu. These views may range from the naive to the sophisticated, and they often may have little or no connection with our formal education. Nevertheless, such views are inescapably interwoven with the rest of our thought, emotion, and action, ethical and otherwise.

For the most part, we experience this full range of states and judgments, along with the accompanying feelings, moment by moment, and without moving to a higher or more abstract level of awareness or judgment. We simply *experience*, for example, disappointment or guilt or shame or satisfaction at what we or others have done or failed to do, and we make judgments, ethical and otherwise, moment to moment about the passing scene. We do not reason explicitly or consciously that we are disappointed in a colleague *because* he has failed to do something; we are simply disappointed. Likewise, we typically engage in no formal reasoning process when we make judgments about whether some bit of treatment or an allocation of goods is, say, fair or unfair. We can usually generate the relevant reasoning process if asked, but the reasoning remains, for the most part, unconscious as an integrated, but not explicitly considered, constellation of thought, emotion, and action.

Strategic Flexibility

We are more likely to be conscious of our reasoning, ethical or otherwise, when we encounter some sort of conflict, either within ourselves or with other persons. Conflicts within ourselves are ones that we can work out on our own or through discussions with others, but conflicts with other persons are different. They typically demand that we make explicit our reasons or feelings in an effort to work through any differences. Possible outcomes range from the non-negotiable (because of the law or one person's authority over the other, as with a boss or parent), to agreeing to disagree, to mutually agreeable solutions falling anywhere from one person's original view to that of the other. These conflicts are part and parcel of our social lives, our encounters with others. Over time, we become increasingly adept at addressing such conflicts, at recognizing which conflicts merit more work than others, and at judging how to proceed based on our perceptions of the other persons involved.

We can let things go, or not; we can push hard for our own original views, or not; and we can attempt to find some middle ground, or not. In effect, as we mature we develop a capacity for *strategic flexibility*—that is, for determining just how far we are willing to extend ourselves, or not, in relation to the expectations or demands of others. But rather than being something that we consciously think through in every particular instance, this capacity becomes, as it were, part of us—an aspect of character, a stable way, for each of us, of dealing with other individuals, with work and family, and with the larger social and political environment.

Not everyone's capacity for strategic flexibility has the same contours. Far from it. In this respect we are all individuals and unique. We range from the confrontational and aggressive to passive and compliant, and everywhere in between. And just where we fall on this continuum will vary across different areas of activity. We care about certain activities and choices, and about certain people and relationships and organizations, more than others. We have our own belief systems—religious, cultural, social, political, and even scientific. And we belong to various forms of organization, ranging from the family to the community to the larger, overarching society, all with their own expectations, demands, and commitments, and all integrated into how we perceive, and act in, the world.

FORMAL AND INFORMAL ETHICAL DISCOURSE

As we encounter situations that engage our capacity for strategic flexibility, we inescapably make subtle, often in-the-moment decisions and adjustments. The cumulative impact of these decisions and adjustments is that, as we grow and develop, our relatively stable modes of thought, emotion, and action likewise mature and become increasingly nuanced, as do the implicit ethical frameworks embedded within them. To better understand just what's in play here, it's helpful to introduce the long-standing, but often neglected, distinction in moral philosophy (the subfield of philosophy, rather than of bioethics per se) between *formal* and *informal* ethical discourse. *Formal ethical discourse* is the world of philosophical ethics—and of bioethics—with all its abstractions, principles, methods of analysis, and everything else that philosophers learn about when doing moral philosophy within an academic setting or that bioethicists use when invoking the intellectual armamentarium of bioethics to address problems in clinical ethics. *Informal ethical discourse* is basically everything else—all that passes for ethical discussion, analysis, reasoning, and debate outside an academic,

philosophical setting or apart from bioethics-driven discussions in health care. It is what the man or woman on the street, rather than the philosopher or bioethicist, engages in.

The relationship between formal and informal ethics is that formal ethical discourse is, in effect, an effort to describe, abstract from, and capture informal ethical discourse. In *A Theory of Justice* (1971), the landmark twentieth-century work on moral and political philosophy, John Rawls notes that formal ethical discourse, or “moral philosophy,” is best understood as “an attempt to describe our moral capacity” (p. 46). Thus, in relation to the particular focus of his book, Rawls states that a “conception of justice characterizes our moral sensibility when the everyday judgments we make [and the supporting reasons for those judgments] are in accordance with its principles.” Put more concretely, the task of *formal* ethical discourse is to understand, and to develop what is, in effect, a descriptive theory of, *informal* ethical discourse. And as happens with all theories, if it misdescribes the primary, or first-order, data, it is simply not a good or acceptable theory. In terms of the present chapter, the goal of formal ethical discourse is to expand upon and to systematize what we’ve referred to earlier as our implicit ethical frameworks—that is, when left to our own devices, how we think, feel, and act ethically.

It is not a question of which is “better”; formal and informal ethical discourses are simply different conceptually, reflecting different levels of generality and different purposes. Considered from a systems perspective, the two types of discourse operate on different levels of complexity (Bateson 2000; Capra 1997; Checkland 1981). Put into the language of the present book, formal ethical discourse may be appropriate for more complicated situations that resist consensus or that raise significant, complex issues of ethics or public policy. The six-stage process discussed in Chapter 5 for addressing ethical problems in health care—if led by a professional philosopher or bioethicist¹—would potentially come within that description, as would the judicial process discussed at length in that chapter. By contrast, informal ethical discourse provides a flexible, workable approach to the ethics of day-to-day clinical practice, and it is the type of discourse that all of us use every day in confronting ethical challenges, large and small (Scher and Kozłowska 2011).

It is important to emphasize that the distinction between formal and informal ethical discourse is not one about conscious versus unconscious thought. It is not that a philosopher or bioethicist engaging in formal ethical discourse is somehow conscious of what he is doing, whereas the

man on the street (or the health professional) proceeds without conscious reflection. Informal ethical discourse includes the same complement of processes—conscious, unconscious, intuitive, reflective, analytical, critical, concrete, or general—that engage philosophers, bioethicists, and even judges as they partake in ethical or legal thought, discussion, or action. Depending upon the person and the setting, informal ethical discourse ranges from simplistic and straightforward to sophisticated, rich, complex, enlightening, controversial, and even transformational (one thinks at this extreme of such moral leaders, in recent history, as Martin Luther King and Nelson Mandela). And group discussions involving informal ethical discourse can be just as probing and revelatory as any formal analysis.² What these myriad instances of informal ethical discourse have in common is that they are all the product not of formal academic discourse but of the particular individuals' efforts, alone or together, to understand and reflect upon their own concrete experience and the challenges that they confront day to day.

FAST AND SLOW THINKING

Another way of understanding informal ethical discourse and the notion of an implicit ethical framework is through Daniel Kahneman's work in cognitive psychology and behavioral economics, as recognized by the 2002 Nobel Prize in Economic Sciences. In *Thinking, Fast and Slow*, Kahneman (2011, p. 13) notes that *fast thinking*—"variants of intuitive thought . . . as well as the entirely automatic mental activities of perception and memory"—accounts for many of the judgments and decisions we make in our daily lives. But sometimes such processes are inadequate, in which case we "find ourselves switching to a slower, more deliberate and effortful form of thinking. This is the *slow thinking* of the [book's] title."

As a way of illustrating just what he means by fast thinking, Kahneman discusses an example originally presented by the psychologist Gary Klein, in which a team of firefighters was routinely hosing down a kitchen fire. But then,

the commander heard himself shout, "Let's get out of here!" without realizing why. The floor collapsed almost immediately after the firefighters escaped. Only after the fact did the commander realize that the fire had been unusually quiet and that his ears had been unusually hot. Together, these impressions prompted what he called a "sixth sense of danger."

He had no idea what was wrong, but he knew something was wrong. It turned out that the heart of the fire had not been in the kitchen but in the basement beneath where the men stood. (p. 11)

As Kahneman emphasizes, fast thinking is not therefore (because it is “fast”) naive or uninformed. Indeed, in the example above, as in much of what we consider the exercise of expertise, the thinking was fast and unconscious, yet deeply informed by experience.

In discussing the expert firefighter’s “sixth sense of danger,” Kahneman notes (p. 11): “We have all heard such stories of expert intuition: the chess master who walks past a street game and announces ‘White mates in three’ without stopping, or the physician who makes a complex diagnosis after a single glance at a patient.” In this context Kahneman quotes Herbert Simon, another Nobel laureate in economics, for his “impatience with the mythologizing of expert intuition”:

The situation has provided a cue; this cue has given the expert access to information stored in memory, and the information provides the answer. Intuition is nothing more and nothing less than recognition. (p. 11, quoting from Simon 1992)

And in describing what Kahneman refers to as fast thinking, Simon remarks:

In everyday speech, we use the word *intuition* to describe a problem-solving or question-answering performance that is speedy and for which the expert is unable to describe in detail the reasoning or other process that produced the answer. (Simon 1992, p. 155)

Kahneman notes, however, that it would be a mistake to consider fast thinking as limited to experts or even as characteristic specifically of experts. Kahneman writes:

Expert intuition strikes us as magical, but it is not. Indeed, each of us performs feats of intuitive expertise many times each day. Most of us are pitch-perfect in detecting anger in the first word of a telephone call, recognize as we enter a room that we were the subject of the conversation, and quickly react to subtle signs that the driver of the car in the next lane is dangerous. Our everyday intuitive abilities are no less marvelous than the striking insights of an experienced firefighter or physician—only more common. (p. 11)

In short, what is true of the expert also goes for all of us, every day. We solve problems and answer questions quickly and without engaging in a slow, deliberate thinking process to produce those solutions and answers. The patterns of analysis and thinking are already present in our minds, the product of past experience (including how we have subsequently thought and felt in relation to that experience). When problems and questions arise that fall into patterns that we have previously encountered and that we have analyzed, understood, or otherwise addressed, our response may be immediately forthcoming, needing little or no conscious thought.

In the context of the present chapter, we can understand this fast thinking as, in effect, an integral part of the people we are—part of the way that we respond to the world, and part of our long-term, stable character. Such thinking will range from the trivial ($2 + 2 = 4$, which we learned through slow thinking, after which it became fast thinking) to centrally defining elements of our character, as in expressly refusing to fall into the role of a weak, passive female even though one's male companions expect it—a refusal that might well be a product of long thought (=slow thinking) and repeated encounters with the macho “other.” What these matters of fast thinking have in common is that no further thought is required. One knows more or less immediately what one knows, and insofar as the situation allows, one acts accordingly.³

This analysis of fast and slow thinking applies just as well to our thinking about ethical issues and other interpersonal matters as it does to any other dimension of our lives. That is, as noted above, we increasingly come to develop, as we mature, our own settled ways of interpreting and judging the social and political world. We make judgments every day, and usually with no conscious reflection, about what is, for example, good or bad, fair and unfair, deserved or undeserved, generous or selfish, admirable or shameful, well-intended or mean-spirited. And it's not merely a matter of our making categorical judgments such as “x is unfair.” We usually are able, again without much thought, to assess differences in degree, as when we judge something as extremely or very unfair (at one end of the scale of unfairness) to somewhat or slightly at the other, and anywhere in between.

In making such judgments, we are often ably assisted, as it were, by our feelings. That is, it is not as if we make judgments about ethical and other interpersonal, social, or political matters exclusively as abstract

intellectual reflections upon the passing scene. Indeed, as we encounter and make judgments about particular situations, it is often our feelings that provide us with the most reliable—and an instant—measure or indicator of just where we consider those situations to fall on the continuum of fair/unfair, generous/selfish, and so on. For example, if our gut feeling is one of revulsion, we know immediately, and others know immediately, that we judge the situation to be at the extreme end of the ethical continuum. Likewise, we might feel mildly uncomfortable about a situation that, in our fast thinking, we judge to be somewhat, though not extremely, unfair.

Also as mentioned above, others can ask us why we feel that way about such a situation or about any other that has engaged our fast thinking, and we can almost always provide some sort of rationale (which would be considered, of course, instances of informal, rather than formal, ethical reasoning). But sometimes a question from others would lead us to question our own fast thinking, in which case we would then likely fall into a process of slow—that is, more reflective and deliberate—thinking about the situation at hand. And this slow thinking would likely, in turn, eventually become incorporated into, or at least come to influence, our fast thinking.

Some situations will, for one reason or another, demand that we engage in slow thinking. Situations may be too complex, raising various sorts of questions that need to be sorted out. We might be quite confident, for example, that children need to be protected in certain sorts of situations and that adults do not. But, as very simple examples, what about borderline cases such as a mature late teenager or an immature very early adult? Or what about newly encountered situations whose potential risks need to be determined? Other sorts of situations might present conflicts of various sorts. For example, we might have a settled policy (reflected in our fast thinking) of not intruding into the privacy of our good friends, but if one of them is continuing along a path that is clearly self-destructive, we might well start wondering (via slow thinking) whether—and, if so, when—we should say something. Yet another type of situation is one in which our feelings, especially our gut feelings, suggest that something isn't quite right or quite what it appears, though without our understanding why. As with the senior firefighter whose "sixth sense" told him something was seriously wrong, only after the fact is one in a position to figure out, via slow thinking, the source of one's gut feeling.

DIMENSIONS OF INTERCONNECTEDNESS

What we can infer from the preceding sections—becoming a person, formal and informal ethical discourse, and fast and slow thinking—is that the ethical thinking of persons, including those preparing for careers in health care, is richly interconnected with the myriad dimensions of the self. Thought, emotion, and action can, of course, be separately out and discussed separately, but they each inform, and each are affected by, the others. These various dimensions of self come together in the notion of strategic flexibility, the process by which people come to determine their commitments and their points of comfort in relation to the world. That is, it is through our capacities for strategic flexibility that we draw the line between action and inaction; in this deep expression of the self, each person’s thought, emotion, and action come together to say, “This far and no more.” It is a reflection of what things we care about, and how much.

On the eve of becoming trainees, future health professionals have already long engaged in informal ethical discourse that is literally embodied in the thought, emotion, and action of a lifetime. They have already developed their own fast and slow thinking in ethics. And they have also each developed their own unique, nuanced capacities for strategic flexibility. It is against this background that one needs to elaborate a workable approach to clinical ethics.

NOTES

1. The reason for this condition is that the four factors that make for the success of judicial processes are not operative for health professionals engaging, by themselves, in the multistep process described by Kerridge et al. (2013) or by others. See Chapter 5.
2. As evidence of just how good such discussions can be—even at a remarkably young age—see subsection “Clinical Ethics Module” in Chapter 10 and Strauss (2018).
3. There is no guarantee that fast thinking is *correct*. Persons can, in their fast thinking, be wrong about particular facts and wrong in making particular judgments. In the domain of ethics, prejudices and stigmas, for example, clearly fall into the category of incorrect fast thinking—though it is fast thinking that can be corrected through slow thinking, potentially replaced by new, fast thinking.

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CHAPTER 7

The Self in an Interpretive Community

Abstract In this chapter we continue the exploration of ethics as embedded in thought, emotion, and action. We begin by discussing two cases, one of which presents a sharp conflict, one of which does not, and both of which use the goal-directed, concrete language of clinical medicine as the health professionals work out their differences, the challenges presented by the cases, and ultimately what to do. We then introduce the notion of *interpretive community* as a way of understanding how ethics is embedded in the very framework of health care.

Keywords Health care • Clinical ethics • Implicit ethical framework
Informal ethical discourse • The self • Interpretive community
Morality of ordinary practice • Strategic flexibility • Collaborative
problem solving • Hidden curriculum

TWO VIGNETTES

Strategic Flexibility

In a case conference centered on a deteriorating, 77-year-old, terminally ill woman with colon cancer, the medical residents were in sharp conflict with the patient's gastroenterologist, who wanted to conduct further tests to determine exactly how far the cancer had progressed. The residents

believed that the tests were unnecessarily invasive, however, and pressed the GI specialist to explain why the tests were necessary. That is, given that the tests were invasive and would cause serious discomfort to the patient, what would they achieve? How could they be justified? The GI specialist admitted that the test results would not change the course of treatment, but he was also adamant about the importance—to him—of determining the patient's exact medical condition before he provided any further treatment. It was a complete standoff. Toward the end of the hour scheduled for the case conference, however, the GI specialist used the phrase “not while I’m her doctor.” This phrase suggested a way out of this sharp, unyielding confrontation: would the doctor consider transferring the patient to one of the hospital’s other gastroenterologists? He had no difficulty agreeing—an outcome that respected both his concerns and professional values and those of the residents. The transfer of care to another specialist, when explained to the family, was also one that they found acceptable.

Perhaps the most striking thing about this case is the openness and directness of the confrontation and discussion. The residents assertively express their views, and the GI specialist pushes back just as hard. Neither side is prepared to give an inch. It is fair to say that what we have here is a collision of professional selves—and of what we described in the previous chapter as their patterns of strategic flexibility. As deep expressions of their professional selves, both sides resist what the other is demanding.

Also noteworthy about this case is the complete absence of ethical terminology. The entire discussion took place without any mention of rights, principles, obligations, or any such concepts. The residents spoke of unnecessary, intrusive care, and the GI specialist spoke only of what he was prepared to do, or not, as the woman’s physician. And as a senior physician with established patterns of practice, he did not and would not proceed with any treatment decision without having an evidence-based understanding of the patient’s medical condition. This position was an expression of his capacity for strategic flexibility—that is, his willingness to extend himself, or not, in relation to the expectations or demands of others—that had long been established as part of his fast thinking (“I don’t work that way”) (see Chapter 6). It was part of the framework within which he thought about patient care. But it was not experienced, by him, as an “ethical” dimension of medical care. It was, for him, simply good medicine. Likewise, what the residents were demanding was,

for them, simply good medicine. And it was only by thinking “outside the box” that the two sides were able to reach a mutually agreeable accommodation.

Finally, if one interprets this situation as involving each side’s conception of their ethical obligations, one is missing the two central implications of the case: first, ethics is *embedded*, rather than explicit, in the case (and, more generally, in the practice of health care); and second, ethics, as here, is largely experienced in terms of the concrete, goal-oriented clinical decisions that health professionals make, often in collaboration with patients and families.

Collaborative Problem Solving

Oscar, a 16-year-old boy who lived with his parents in a country town, was referred to a tertiary care hospital for assessment of narcolepsy after a year and a half of sleeping seventeen hours a day following a flu-like illness. After confirming the diagnosis (via a sleep study), the intervention in the adolescent medicine ward included scheduled naps for the narcolepsy, school attendance at the hospital school, physiotherapy (to address a deconditioned physical state), and a trial of medication (modafinil) for narcolepsy. Oscar’s presentation symptoms largely improved, but while awake he began to experience foggy thinking, vagueness, and memory problems (e.g., not recognizing where he was or remembering what had occurred that day), punctuated by what appeared to be dissociative episodes, in which he spoke in a baby voice and acted like an out-of-control toddler. Because the etiology of these new symptoms was unknown, a neurologist and a consultation-liaison psychiatrist were brought in. Potential explanations included a neuro-inflammatory process, a functional stress-related disorder (Oscar had a long history of anxiety), or an unusual feature of the narcolepsy.

The pattern of Oscar’s dissociative episodes was unknown, as were the possible triggers. It was also unknown whether the mother’s constant attention to Oscar’s symptoms was itself triggering or exacerbating his problems. A complicating factor was that much the observational data about Oscar was coming from the mother herself because of the comparatively light nursing staff on the medical ward. The psychiatrist suggested that all of these concerns could be addressed through a two-week admission to the mental health ward, a small ward with ongoing, 24-hour nursing observation and further opportunities for psychometric assessment. This suggestion met with various reasoned objections:

1. The nurses on the mental health ward perceived his current problems as primarily medical and neurological, with the consequence that they saw the transfer as inappropriate and also as creating unnecessary work.
2. Oscar himself had lost his patience with being hospitalized, and wanted to go home. He also had no recollection of his dissociative episodes, so one of the main reasons for his hospitalization was not even within his conscious memory.
3. In contrast to the arrangement on the medical ward, Oscar's mother would not be able to sleep by Oscar's bed. The mother was worried that he would, upon awaking, not know where he was (because of his memory problems) and also that the nursing staff would be unable to administer his narcolepsy medication (of necessity, before he was fully awake, using a technique that the mother herself had developed).
4. Hospital administration was pushing for discharge since the admission, from their perspective, was already overly long.

The treating team (sleep physician, adolescent medicine physician, neurologist, and psychiatrist, plus adolescent medicine, neurology, and psychological medicine residents) understood the situation as involving a set of interrelated problems, each of which needed to be addressed in its own terms.

1. After the team explained to the mental health nurses that the memory problems and dissociative episodes were likely stress related and that the nurses' observations and psychometric assessment were critical in understanding Oscar's problems, the nurses understood why the transfer was needed.
2. The mother, at the team's suggestion, explained to Oscar that, at home, she would be unable to manage his dissociative episodes.
3. The treating team, nurses, and mother reached an agreement that for the first three days of the transfer, she would arrive at Oscar's bedside prior to his waking, administer his medication, and train the nurses how to do the same.
4. The team explained to administration that unless Oscar's problems were brought under control now, he would simply return later, and in worse condition than at present.

During the resulting admission, nursing observations revealed that Oscar's memory problems and dissociative events typically occurred when Oscar's nighttime sleep had been unsettled (typically involving a range of violent movements). A presumptive disorder of REM sleep was identified

and medicated. With improved sleep, the daytime symptoms improved dramatically, allowing for Oscar's discharge and return to school.

This case is noteworthy for what might have gone wrong but did not. Early on, the treatment team's relationship with the mother could well have deteriorated and, on the spot, ended the intervention. She might, in particular, have resented the treatment team's suggestions that independent reports of Oscar's functioning were important to obtain and that she, because of her high level of concern for her son and her attention to his symptoms,¹ may by her very presence have been exacerbating or even triggering Oscar's symptoms. She may also have refused her son's transfer to the mental health ward, given that she would no longer be able to stay overnight in his room. But the staff handled the delicate matter of her reports gently and directly, and they were able to work out a compromise concerning her overnight stays, one that addressed her main concerns but that also enabled the team to assess (beginning three days after the transfer) the mother's potential contribution to her son's medical situation. The initial opposition of the mental health ward nurses and the hospital administration was also handled directly and with aplomb. Oscar could himself have simply refused to continue with the hospitalization, but the mother, fully informed of the medical situation, was able to explain why a return home was not possible from her perspective without a further stay in the hospital. Finally, almost invisible in the case is the seamless cooperation of an increasing number of specialists as the case developed. Absent is any suggestion of turf or professional prerogatives; throughout the case, the treatment team, ever expanding, operates as a unified whole. Likewise, since the case was so well managed and the communication so effective, none of the care providers felt that their own goals or standards had been compromised in any way; their professional selves were fully expressed.

Also noteworthy about this case, as with the first (concerning strategic flexibility), is that it is completely lacking in ethical terminology. The entire case occurs within the goal-directed framework of providing good medical care to this particular patient.² The mother asserts no rights; the patient asserts no rights; the mental health nurses assert no rights; and the various members of the treatment team assert no rights. No ethical principles are invoked. Good, respectful, effective care is

provided, with the potential conflicts addressed only by reference to what needed to be done to help the patient.

A final element of this case is the implicit teaching—whether one calls it the *informal* or *hidden curriculum* of medical training—of the adolescent medicine, neurology, and psychological medicine residents. What they witness and, indeed, participate in is the direct, effective, humanly responsive management of a medically difficult situation, again without any mention of ethical concepts as such. The treating team aimed to provide good medical care, and they did.

To take a step back, it is important to note that these cases are not unlike many of those that come before hospital ethics committees, and that some bioethicists conceive of their work along the above lines—as aiding health professionals, patients, and families to reach mutually agreeable outcomes. What we are adding, in this book, is an overall framework within which to understand such efforts.

INTERPRETIVE COMMUNITIES

The two cases above bring to mind what the anthropologist Arthur Kleinman observed about the moral experience of health professionals. As mentioned in our introductory chapter, Kleinman (1999, pp. 71–72) sees their experience, like that of all other persons, as embedded in “the local processes (collective, interpersonal, subjective) that realize (enact) values in ordinary living” and that connect “affect and cognition with cultural meanings, moral norms and collective identity with sense of self,” with the consequence that “moral experience and personal experience are interfused, value with emotion.” That’s just what we see in our two cases. The ethics—what we have called *informal ethical discourse*—is embedded in the social environment as what people do, what people feel, and what people think.

In this context it is helpful to borrow a notion at the interface of sociology and literary criticism. In his 1980 book *Is There a Text in This Class?* and as subsequently elaborated (1989) in *Doing What Comes Naturally*, the literary theorist Stanley Fish uses the expression *interpretive community* to describe “not so much a group of individuals who shared a point of view, but a point of view or way of organizing experience” that itself defines and includes the practices and standards that enable individuals to act together, or to be “constituted,” as members of a particular community (1989, p. 141). Though each member of a community thinks and acts

individually, the “interpretive acts” are not themselves individual but communal. They take place within the “understood practices and assumptions” of an institution (1980, p. 306). In that respect each member of a particular interpretive community is what Fish calls an “embedded practitioner whose standards of judgment, canons of evidence, or normative measures are extensions” of the community itself (1989, p. 144).

The role of practices and standards, along with their interconnections, is crucial in understanding what interpretative communities are and how they function over time. Interpretive communities, for Fish, can be understood as sets of institutional practices with “assumed distinctions, categories of understanding, and stipulations of relevance and irrelevance” (1989, p. 141). With this orientation toward shared *processes and standards* rather than toward *substantive agreement and closure*, interpretive communities are not monolithic but allow both for a diversity of viewpoints and, *within the bounds* of a community’s practices, for robust individual expression. Indeed, it is this robust (and diverse) individual expression, coupled with the ever-evolving social context in which community activity (= interpretation) occurs, that enables an interpretive community to change and adapt over time.

Examples of interpretive communities are everywhere, and we are all familiar with them. Fish’s immediate interest was literary theory and the interpretive community of literary critics. What he said about literary criticism would apply just as well, and in the same terms, to any academic field such as economics or history or philosophy or any of the sciences. Fish himself also gave some careful, probing attention to the law, especially the judiciary, and other writers have applied the notion of interpretive community to journalism and to international law, among other fields. What distinguishes these different interpretive communities are their distinctive, interconnected sets of practices—their shared goals, standards, processes, positions, and social roles, all within an evolving social context. Disagreement *within* interpretive communities is common but is managed (and built upon, generating change and progress) through the shared understandings that constitute each separate community. Disagreement *between* different interpretive communities is also common, but how it is managed is an open question; there are not necessarily any shared understandings and processes to manage conflict or even discussion. Disagreements can be gentle or sharp, settled or not. By the same token, social, political, or legal forces can impinge, intentionally or not, on any particular interpretive community. But the actual

impact of that impingement will depend upon the way in which the community incorporates it, or not, into its existing practices. External forces will, that is, inevitably be reinterpreted as they meet the existing practices of an ongoing interpretive community.

HEALTH CARE AS OVERLAPPING INTERPRETIVE COMMUNITIES

Given the above characterization of interpretive communities, our suggestion is that each field of health care—for example, medicine, nursing, social work, or clinical psychology—can be understood as an interpretive community, and that the overarching field of health care can be understood as comprising overlapping interpretive communities. We suspect, in particular, that health professionals will see themselves in the following quote from Fish’s *Doing What Comes Naturally*, which concisely describes what it is to be a member of an interpretive community and which also, in effect, summarizes the entire analysis set forth in the preceding section:

To think *within* a practice is to have one’s very perception and sense of possible and appropriate action issue “naturally”—without further reflection—from one’s position as a deeply situated agent. Someone who looks with practice-informed eyes sees a field already organized in terms of perspicuous obligations, self-evidently authorized procedures, and obviously relevant pieces of evidence. (pp. 386–387)

It is this naturalness of perception, action, and reasoning that is so apparent in the two cases that opened this chapter. It is a naturalness, too, that describes the experience of professionals working within particular fields of health care, where one simply is, and works as, a doctor or nurse or social worker or clinical psychologist. A health professional doesn’t step back and say, for example (except perhaps in very unusual circumstances), “Since I am a nurse, this is how I am supposed to think.” Instead, a trained nurse simply (or “naturally”) has come to perceive, think, and act as a nurse or, perhaps even better, as the *particular* nurse that, through training and experience, he or she *has become*.

It is helpful to note that this naturalness of self-expression—“without further reflection”—directly parallels our discussion of fast thinking in Chapter 6. Much of the thinking that occurs naturally and without reflection would be characterized as fast thinking and as elements of a

person's expertise, or *working knowledge*, in a particular field of health care. Drawing on Fish's quotation above, these elements include perception, range of options, actions, obligations, procedures, and rules of evidence/relevance. Depending upon the situation, however, fast thinking can give way to slow thinking, as when the standard way of thinking about a problem doesn't quite fit a particular case, or when disagreement or conflict arises and the situation needs to be sorted out through explicit discussion, or when a person is pushed to extend the limits of his or her strategic flexibility. And even when disagreement is sharp, it typically takes place against a rich background of shared working knowledge (characterized broadly, as above).

In the care of any particular patient or group of patients, or in formulating policies of one kind or another, professionals from different fields of health care regularly interact, bringing with them each field's distinctive interpretive framework. Much of what is in these different frameworks actually overlaps since central to all of them is the quest to provide health care to patients with some form of science- or evidence-based interventions. Nevertheless, nurses might see a particular case or policy one way, social workers another, clinical psychologists another, and doctors another. For any sort of consensus to be reached, these differences need to be worked out. A baseline for reaching consensus is each field's pattern of strategic flexibility, which defines the range of solutions tolerable to the professionals in each field. Negotiation and discussion can then take place within those boundaries, though with the understanding that those boundaries might themselves shift as a result of this exchange of ideas.

In the following case we see both the separate interpretive communities that exist within health care and how they interact and come together to reach new understandings.

Mrs. T, an 89-year-old widow in deteriorating health and with a history of recurrent strokes secondary to chronic hypertension, was hospitalized in the wake of her three children's concerns. She was progressively more disoriented, lacking in energy, and not eating well, and appeared to have recently suffered another stroke. In the hospital she was medically stabilized, but her baseline symptoms—disorientation, lethargy, and lack of appetite—continued to worsen, to the point that she only occasionally recognized her children. Over the course of the hospitalization, she also became less and less able to take nutrition by mouth. As it became clear to the medical staff (an attending physician and his team of residents) that Mrs. T would starve or die of dehydration without medical intervention

(IV fluid and some form of artificial nutrition), they made plans to intervene as required. The nursing staff, however, expressed some concern that the patient was obviously not doing well and was progressively weakening, and that there was no reason to expect her to recover well enough to live independently, as she had for her entire life. At the same time, her family was receiving mixed messages about the care of the mother, depending upon whether the information was coming from medicine or nursing. The conflict between the doctors and nurses was sufficiently sharp that they brought in a consultation-liaison psychiatrist to help them sort out what to do. After being informed of the nurses' concerns, the psychiatrist queried the medical staff about what they actually hoped to achieve by providing nutrition and hydration to this particular patient. What became clear, as this discussion progressed, was that the doctors, after some resistance, recognized that Mrs. T was dying and that her body was, in effect, shutting down. Providing nutrition and hydration would slow down that process but could not be expected to improve her mental status or functioning in any way. The outcome of this discussion was that the doctors asked the children to come in for a meeting to discuss the mother's care. A social worker long familiar with Mrs. T—and, through her, the children—was also asked to attend. After the situation was explained to the children, they understood that their mother had led a long, rewarding life and that it was now ending. They asked for a day to sort out their feelings and, when they appeared at their mother's bedside the next day, informed the attending physician that they wanted their mother to be kept comfortable but with no further supportive interventions. The doctor informed the family that he agreed with their decision, that the social worker would be contacting them in the next few days to see how they were doing, and that the mother would be kept comfortable, as suggested. Mrs. T was moved to a hospice, where she died a week later.

Through cases such as the above, the separate fields of health care, as well as, more broadly, health care itself, evolve over time. New discoveries and technologies, problems with old ways of thinking, new theories and approaches, and changes in politics and society all encounter and challenge existing elements in one way or another. Potential new elements are then incorporated (or not) into each field—into each interpretive community—through that field's own processes for assessing, criticizing, and building upon what's known and established, to generate a new, but dynamic, status quo.

There is an important lesson for bioethics here—or, indeed, for any academic field that would try to improve or reform another. It is fair to

say that, with its vocabulary of rights and obligations and ethical principles (or virtues or consequences, in different iterations³), the bioethical effort to change or illuminate ethics in health care has fallen short of expectations. Rather than building upon the existing emotional and intellectual resources of health professionals (“here’s how we can improve and enrich what you already do”), the bioethics movement has attempted to displace the clinician’s voice with a framework of ethical analysis and reasoning—such as one involving principles or virtues—that is fundamentally discontinuous from the language, concepts, and goals, and from the interpretive communities, of health professionals themselves. Rather than imposing new values and intellectual demands on those communities, we need to respect and build upon their strengths, including their inherent capacities for growth and change.

NOTES

1. Parental anxiety about, and attention to, functional symptoms are known to trigger and reinforce the symptoms.
2. The idea here is well captured in the (2017) book by Victor Montori: *Why We Revolt: A Patient Revolution for Careful and Kind Care*. As the author notes in his introduction, modern health care has developed “standardized practices for patients like this, rather than caring for *this patient*.” The controlling idea in the book is that health care systems should provide “careful and kind patient care for all.” We can see this idea at work in all three of the clinical situations discussed in this chapter.
3. See comments in our concluding Chapter 11 about principlism, consequentialism, and virtue ethics.

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CHAPTER 8

A Framework for Teaching Clinical Health Care Ethics

Abstract What to teach? How to teach it? These are the central questions for teaching professional ethics to trainees in health care, as they are for teaching any students in any subject in any field. The answers we present here and in the coming chapters build upon the criticisms of bioethics from sociology, history, and anthropology, as discussed briefly in our introductory chapter—and also on the discussions of the self, informal ethical discourse, and interpretive communities, as presented in Chapters 6 and 7.

Keywords Health care • Clinical ethics • Implicit ethical framework
Informal ethical discourse • The self • Interpretive community • Morality of ordinary practice • Touchstones for learning • Personal comfort and safety • Professional power and authority • Reflective practice

THE CHALLENGE OF EXTENDING TRAINEES' EXISTING ETHICAL FRAMEWORKS

Our fundamental assumptions are that health care trainees already know all the ethical principles they need, and that they've been using them their entire lives. Autonomy/freedom and justice/equality/fairness are regularly

recognized, whether explicitly or implicitly, in the lives of children, adolescents, and young adults.¹ They, like people of all ages, recognize the workings of benevolence/beneficence—intending and doing good. Even what appears to be the distinctly medical principle of “do no harm”—re-described by bioethicists as *nonmaleficence*—is well familiar to small children, as when they are playing a bit too rough with siblings or friends or a pet, and are cautioned, for example, “Don’t hurt your brother!” Nonmaleficence also has a ready equivalent in cautionary notes such as “let’s not make things any worse” (typically used in human contexts) or “be careful not to cause any further damage” (typically used in nonhuman contexts such as trying to fix a bit of plumbing).

The pedagogical challenge is to extend each trainee’s existing—informal—ethical framework to the new context of clinical health care. Expressed in the language of Chapter 7, the task is to enable health care trainees to join their respective interpretive communities. This task has various substantive dimensions:

1. The trainee, previously a lay person (at least in most cases), is taking on a *new role* as, for example, a doctor, nurse, social worker, or clinical psychologist.
2. In that role one is generally expected to provide the type of *professional services* associated with that role, such as medicines or surgical procedures, nursing care, social services, or therapy (all of which come in myriad forms, depending upon the setting and one’s precise position).
3. The professional services are to be provided to particular persons, usually described as either *patients* or *clients*.

And all of these elements are organized within a particular setting, which itself has three elements:

4. the *institutional setting* (including *work culture*) in which the clinician-patient encounter occurs,
5. the overarching *health care system*, and
6. the *social/political system* in which all of the preceding are located.

To return to the themes of our first chapter, each of these six elements—professional role, professional services, patients/clients, institutional setting, health care system, and social/political system—has a sociological,

historical, and anthropological/psychological dimension that can help to enrich the trainee's existing ethical thinking. If all goes well, the outcome will be a new ethical persona, with a newly integrated constellation of thought, emotion, and action.

The immediate question for each trainee—and more broadly for each interpretive community—is, of course, how to extend what he or she knows to this new milieu. It's *not* a matter of coming to know ethical principles that one didn't know before. It *is* a matter of seeing how the person one is can learn to think effectively within, and to act effectively in response to, the ethical challenges presented by this new setting. Another way of putting this is that the closer that health care ethics remains to each trainee's existing ethical framework and its foundations in the self, the easier it will be for trainees to extend that framework to their work in health care. Learning is always easier and more effective when it builds upon what one already knows.

But how is that to be done? Our response comes in two parts. In this chapter we discuss some general considerations relevant to the question, and in the next two chapters we discuss various potential formats for teaching clinical ethics. But before we proceed with either of those tasks, it will be helpful to look at how cases were used in "The Terminally Ill Patient: Ethical, Legal, Psychological, and Social Issues," a continuing medical education course that the first author (SS) previously taught at Harvard Medical School. The course was open to professionals in all fields of health care; the attendees were all clinicians, and from various fields. Their common goal was to increase their understanding of terminal care and provide better, more humanly responsive care to their patients.

CASES FROM THE "MORALITY OF ORDINARY PRACTICE"

In that continuing education course, the main cases (one per plenary session, plus shorter, subsidiary cases for the breakout sessions) were factually rich with details about the patient, his or her family, the health professionals involved, and the settings in which care was provided. Notably, the cases were also complete; that is, the patient had died, so there were no questions such as "Whose rights are at stake?" or "Who decides?" or "What should be done?" Instead, the cases presented opportunities for course participants to sort through—ethically, legally, psychologically, and socially—factually complex situations about

the “morality of ordinary practice,” and to think about and discuss, in the first person, their own perceptions of each case: What was done and why? How well were the facts of the case (broadly construed) taken into account by the patient, family, and health professionals involved? What were the perceptions of the patient and family? If I had been the doctor (or the patient, or the family), would I have done the same thing or something different? If the latter, why? Were the settings in which care was provided the appropriate ones? Was the outcome what I would call a “good” or “acceptable” one? What could have been done, if anything, to improve the outcome?

The features of this approach are important to spell out.

- The cases were specifically designed *not* to generate discussions of ethical rights and principles per se and also not to generate conflict. Instead, the goal was for course participants to look at each clinical situation from the perspective of how to provide good, appropriate, humanly responsive medical care. Discussions within such a perspective do not require assertions of rights or the reference to ethical principles. Ethical ideas are often implicit in the case—as in “the patient decided [or wanted or refused]” or “the doctor explained” or “the family initially was initially opposed but, after having some time to adjust, accepted what the doctor had recommended.” But describing any of these phenomena as involving ethical rights or principles simply adds a layer of analysis by substituting the unfamiliar and relatively abstract vocabulary of rights and principles for the more tangible descriptions of what is happening on the human level, which involves wants, emotions, wishes, disappointments, surprises, and so on. We have an immediate understanding of what is involved in these human phenomena, whereas the language of rights and principles draws most people into unfamiliar territory in which their intellectual footing is, at best, unfirm.
- The cases were specifically designed to generate self-reflection, probing questions and discussion, and possible rethinking. It is here that this mode of presentation shows itself to be connected with each course participant’s individual thought, emotion, and action—that is, with the self. The course participants were challenged to evaluate their own beliefs and to compare them with those of others: Would I have done that? Could I have done that? Would any of the rest of us have done something different? Why didn’t the doctor

in the case do something more (or something less)? Importantly, any potential rethinking was, as it were, a victory for the self. When persons changed their minds about some aspect or other of a clinical situation, it was because they had looked critically at their existing perceptions or responses and seen that something better was available. By contrast, in classroom discussions in which conflict is encouraged, changing one's position can be perceived by oneself and others as a *defeat* or *sign of weakness*, meaning that honest, thoughtful reflection and the emergence of new thinking come at a *cost*. The safety of open discussion and critical self-reflection—and the possibility of growth—has been lost.

- All of the six elements mentioned in the preceding section—professional role, professional services, patients/clients, institutional setting, health care system, and social/political system—were potentially in play for every main case. In this respect, the approach used in the course can be reasonably understood as addressing the concerns of the sociologist (Fox), historians (Belkin and Brandt), and anthropologist (Kleinman), as well as bioethicists Callahan and Churchill, as discussed briefly in Chapter 1. The more relevant information on such matters that the presenters and course participants brought to the cases, the better. Participants' understanding of the clinical situations would be richer; they would be more likely to engage with the many dimensions of those situations; and they would be in a better position to integrate any new learning into their future work with patients. Just as importantly, this information on sociology, history, and anthropology/psychology (all broadly construed) was inescapably integrated into the course participants' ethical understanding of the cases presented and interwoven with their own ethical thinking.

As noted above, the cases were specifically designed to promote intellectual and emotional exploration. Another reason why discussions proceeded as smoothly as they did is that the course participants were experienced clinicians with the background knowledge required to understand the full dimensions of the clinical situations presented. In addition to having mastered at least the fundamentals of their own fields, they understood that each health care setting has its own goals and constraints, that these goals and constraints need to be taken into account in any effort to address problems (ethical or otherwise) that arise in that setting, that patients and their families come in endless varieties

(culturally, socially, religiously, politically), that the capacities of patients and families to understand health care and treatment differ dramatically, and that clinical situations are often not as straightforward as they appear. As experienced clinicians they also understood that keeping an open mind is a remarkably valuable asset—one that helps them both to solve problems and, indeed, to avoid them in the first place. They were, in short, mature members of their respective interpretive communities within health care.

When all of the above background factors are taken into account, what emerges is a picture of clinicians who are able to understand and assess the details of clinical situations, to see what is potentially problematic in the situations as presented, and to focus their attention on those potential problems. In a group setting, what drives discussion—especially in a well-constructed or -chosen case for teaching—is the likelihood that different clinicians will see the factual details in different ways and that, as the clinicians describe and discuss their own perceptions, they will come to see the case from a broader, more nuanced perspective. As these perceptions evolve and deepen over the course of the discussion—or over the course of a real-life clinical situation—the exact parameters of any problems presented by the clinical situation will themselves change. And what seemed a problem at one point in the discussion or treatment may somehow disappear into the background and become much less important, whereas other problems, invisible or unnoticed at first, may unexpectedly coalesce and take center stage.

What's important about this process, as mentioned earlier, is that it's basically a process of personal exploration and discovery. In a formal course this process is carried out in a group setting, as it also often is when clinicians practice in institutional settings or as members of a team or group practice. In coming to understand the various dimensions of such situations, participants aren't fighting or opposing each other, and they're not winning or losing. What they are doing—in the process of analyzing and responding to the situations confronted (whether in the classroom or in real life)—is deepening their own understandings of themselves and the human demands and nuances of health care.

The following clinical situation illustrates the evolving cross-currents that can be seen in a single case.

Jim, a 38-year-old stockbroker and partner in an investment bank, has treatment-resistant AIDS that has continued to progress despite university

hospital-based medical care and enrollment in a series of experimental programs. His partner David has been progressively more involved in communicating with Jim's doctor and (for home care) his nurse and social worker. On a recent home visit, Jim's nurse and social worker, who work as a team, found David clearly distressed, presumably because Jim's condition was, they learned, beginning to deteriorate rapidly. On a subsequent visit, however, the team was met at the door by Jim's father, whom neither Jim nor David had ever referred to, and with David nowhere in sight. The father proceeded to criticize the care that Jim was receiving, blamed David for Jim's illness, and then claimed that the reason Jim was dying was that he had been misdiagnosed with AIDS and was dying of some other unrecognized, rapidly progressing disease. The nurse and social worker, stupefied, were about to respond when Jim's mother came in from the kitchen, asked her husband to have a seat in a comfy chair, and suggested to the nurse and social worker that they go for a brief stroll. The mother explained that the father had refused ever to recognize Jim's sexual orientation, that the father's admitting the diagnosis of AIDS now would be tantamount to admitting that he had alienated himself from his son due to his own insensitivity and prejudices, and that he had therefore lost the opportunity to share some large part of his own life with his now dying son. A final bit of information was that the father, in his late 60s, was showing early signs of Alzheimer's disease and had lost his intellectual and emotional adaptability. After returning to the apartment, the nurse and social worker told Jim and his mother and father than they would be back in a few days with an updated care plan. They also asked the mother to contact David and tell him that they would be in touch with him shortly.

As with many clinical situations discussed throughout the book, the above situation bristles with human conflicts of one kind or another—for example, between Jim and his father, David and Jim's father, Jim's father and mother, and the father and the health care team—not to mention the father's obvious internal conflict concerning his son and the father's attitude toward gays. Notably, too, one's understanding of what is going on, and why, changes sentence by sentence, with each newly added fact. All of these matters could potentially be described and discussed in terms of formal ethical discourse—the language of academic ethics. But the case can actually be thoroughly described without any formal ethical terminology. By the same token, the many problems and conflicts can be identified and addressed in ordinary language and, if and when necessary, by using informal ethical discourse. It is a deeply human situation, and the solutions to its many problems are, indeed, human rather than theoretical or intellectual.

In the case above, the conflicts and human disconnections were ones that complicated the delivery of care but that were likely to have no impact on the actual care delivered. In the following case, the conflicts and cross-currents create a situation in which all those involved have done their best, though with uneven results throughout, with no effective resolution and no closure.

A 14-year old, indigenous boy has been in foster care with a single Caucasian woman since the age of 2. He had been taken into care because of severe abuse and neglect, and has a mild case of fetal alcohol syndrome. In primary school he experienced attentional difficulties, behavioral impulsivity, and separation anxiety regarding his carer, with whom he has become increasingly violent as he has grown. His contact with his biological family has been minimal.

Over the years, the welfare service has had recurrent conflicts with the boy's carer over such matters as her style of parenting (which involved indulging or bribing the boy to behave better), her requests for more assistance (including financial), and her inability to maintain the boy's regimen of medications prescribed for impulsivity, aggression, and anxiety.

The situation deteriorated when the boy transitioned to high school. The only available high school had many students with externalizing behaviors. The boy became increasingly more oppositional, eventually refusing to attend school. Perceptions of the situation diverge widely:

- His carer developed a fixed belief that the boy was unable to cope with school because of his fetal alcohol syndrome, and she has become a prominent, media-savvy advocate for improving services for fetal alcohol spectrum disorders.
- The high school counselor perceives the boy, when in attendance, as coping well, as liking the small class where they have placed him, and as enjoying some contacts with indigenous male mentors. The counselor feels that the carer is encouraging the boy to avoid school.
- The boy's therapist also experiences the boy as doing well when in attendance at school, as enjoying developmentally appropriate challenges, and as welcoming invitations to function more independently.
- The welfare agency, because of recurring conflicts with the carer and their view that the present situation is likely to deteriorate further, is seeking an alternative placement. The main complication is that the only feasible placement identified is in another community with extended family that the boy does not know, with no high

school, and with a local indigenous dialect that the boy does not understand. The agency itself has no idea how the prospective plan can be made to connect up with the need for the boy to take his place as an adult male member of his particular indigenous community, which requires, among other things, that he go through the appropriate initiation rites, of which he has no knowledge and no preparation.

- The boy himself is afraid of any change and feels that he “can get his mother [i.e., his carer] to get him out” of anything that would provoke too much fear or anxiety in him.

In describing the case, the boy’s psychiatrist notes, “No optimal outcome was possible. We were operating in the gray zone, constantly making decisions involving difficult trade-offs. How do you walk a compromise line all the way through?”

As with the case above (the stockbroker with AIDS), much of this case could have been described using the language of ethics, but there was no need to do so. The conflicts and problems were real, and they were discussed and, insofar as possible, addressed in the terminology of the relevant interpretive communities.

TOUCHSTONES FOR LEARNING

In courses oriented around lectures and readings, topics and materials are established in advance and are typically slow to change over time. But in any other teaching format (see next chapter), the choice of materials and methods are much more flexible. In this section we discuss what we call *touchstones for learning*, and in the next section we discuss some general goals and constraints in teaching clinical ethics to health care trainees.

When the first author taught ethics clinically in Harvard-affiliated hospitals, he encountered an oddity about how people stored “ethical” information. If he asked doctors, individually or in groups, whether there were any *ethical problems* that they were worried about, the answer was almost universally *no*. But if he asked doctors if there were any *cases or situations that were bothering them*, the answer would be an immediate and resounding *yes*. For example: Mr. Smith was doing much worse than expected, potentially because of an incorrect diagnosis by the primary care physician; one of the nurses was complaining about the treatment given to Mrs. Jones; the chief resident was worried

about a junior resident's difficulty drawing the line between a patient's medical problems and his personal problems (the latter being beyond the scope of the resident's work); the children of a dying patient were pushing for much more aggressive care despite the patient's unequivocal rejection of further care; and hospital administration had cut back funding for a new, much needed program that was already in the hiring stage.

All of the above situations raise what are, in effect, ethical issues even though they aren't identified (or, in practice, analyzed) as such. They're just "problems." Moreover, one of the reasons that these problems are experienced as "problems"—rather than simply being addressed as a matter of course—is that they actually *do* involve ethical issues; if the problems were merely technical, medical, or scientific, they would likely already have been solved or at least addressed in some appropriate way. Also worth noting is that the "invisibility" of these ethical issues (i.e., seeing them as "problems" but not as specifically ethical problems) is exactly what we would expect based on our discussion of interpretive communities in Chapter 7. The ethics of health care is embedded in the setting and, indeed, in the professionals who work in it. Trying to separate out ethics from everything else is to distort the ethical issues, whose contours are integrally connected with, and can be understood only in the context of, the health care setting itself.

Another way of understanding the same point is that professionals working in any particular health care setting typically encounter and analyze problems in instrumental terms related to that particular setting and to particular patients or colleagues or institutional demands. If all goes well, goals are achieved; appropriate care is provided; and both health professionals and patients end up feeling satisfied. But if the goals aren't achieved, or if appropriate care isn't provided (or if something goes wrong with it), or if health professionals or patients end up being dissatisfied, then the question is why that has happened: what has gone wrong? Ethical principles or other abstract concepts may be involved—and surely many bioethicists would try to analyze the various dimensions of the situation using rights or principles or other abstract concepts—but that's not how the problems or shortcomings are experienced, and that's not how they're solved.

So, the question is, if ethical issues are not, in the clinical setting, generally perceived as *ethical* issues but merely as problems of one kind

or another, how does one identify them and then address them? The answer is actually given, at least in part, in the paragraphs above. To identify them, one just needs to ask the correct questions: the *touchstones for learning*. In addition to “has anything been bothering you” or “has anything gone wrong” (as above), one can ask any or all of the following: What has puzzled you? Surprised you? Bothered you? Disturbed you? Upset you? Angered you? Unexpectedly challenged, delighted, or disappointed you? Has anyone been acting in a way that puzzled, bothered, or distressed you? These and similar questions can be asked from the day that trainees set foot in professional school, and the answers will change day to day, month to month, year to year.² Trainees’ skills, strengths, weaknesses, challenges, vulnerabilities, and so many other things will vary over time. There will always be something new to discuss, and then potentially to address, in relation to the goals, standards, and practices of the respective interpretive community.

CREATING THE SPACE FOR REFLECTION AND DISCUSSION

From our perspective, the baseline data for teaching ethics to trainees in health care (or in any other field) are their own thoughts, emotions, and actions. The touchstones for learning discussed above are an excellent way of tapping into those data. But the circumstances need to be supportive, too. We suggest that the following aims and constraints be incorporated into the teaching program, as they were into the continuing education course discussed earlier in this chapter.

- *Teaching tied to current needs and experience.* Trainees in health care encounter new challenges and situations of one sort or another every day. Teaching is most effective if it can be tied into these situations, which trainees will be very highly motivated to understand and address.
- *Exploration of own thoughts, feelings, and opportunities for action.* In the end, what will matter to trainees is whether this work on the ethics of clinical practice proves to be something that they carry with them after they have completed their training. Trying to understand what other people have thought or written about such matters may potentially have some impact but may also have no

impact at all, being too abstract, external, outside the self. What will have an impact is learning that is centered on understanding one's own self in interaction with others and one's own particular professional environment.

- *Socratic approach with probing and open-ended questions.* Asking the right sort of questions will encourage trainees to explore their own thinking and feelings, and will encourage more freewheeling discussion. Directed questions make it too easy to provide superficial or "correct" answers. If a question doesn't make the trainees think, it's the wrong question to ask.
- *Use of "natural" language.* As discussed in Chapter 6, using the language of informal ethics, coupled with the language of everyday life to discuss thoughts, emotions, and action, is the goal here. Anything else will distance trainees from their own experience, the foundation (in our view) for learning in ethics that will last a lifetime.
- *Encouragement of open exchange of ideas and concerns, at and between all professional levels.* It is helpful to return, in this context, to the touchstones for learning discussed above. That is, whenever trainees (or teachers or senior colleagues) encounter a situation that, for example, bothers or disturbs or surprises them, it should be considered appropriate to ask (and to discuss with peers or with someone higher or lower in the professional hierarchy) why the situation is triggering such a response. Presumably, not all such questions will be asked all the time; the questions can be asked when timely and not too distracting; and, over time, trainees and their seniors will all learn to ask better, more focused questions as previously unquestioned phenomena come more to everyone's attention.
- *The earlier the better.* Bad habits die hard (Wear 2006), and the failure to confront bad habits serves to perpetuate them. As noted in *Grace Under Pressure* (a dramatic presentation that we will mention occasionally in the next two chapters), some types of "bad behaviour," such as bullying and sexual harassment, are, in effect, "protected because I guess I knew that no-one was ever going to pull me up on it" (Williams and Dwyer 2017, p. 18). But it's best that bad habits not become habits in the first place. So, by legitimating and tolerating open questioning early on, professional schools would enable trainees to learn habits that can set the stage for better, more expansive learning, more respect for, and understanding

of, their own feelings and those of others, and much-needed attention to otherwise neglected parts of the learning and professional environment.

We also suggest that, with the exception of the inevitable core lecture course (see Chapter 9), the standard format for teaching and discussing ethics, conceived along the lines above, should be small groups ranging from five to fifteen trainees (if at all possible). The small size ensures that each trainee will have an opportunity to participate, while the presence of other group members encourages a diversity of viewpoints, which is especially helpful for expanding a person's own ideas and perceptions. As this process proceeds, trainees' currently fast thinking will be challenged by the situations presented or by the thinking of others. That fast thinking gives way to slow thinking, which leads, over time, to new patterns of fast and slow thinking (see Chapter 6). These patterns will be ever changing throughout the course of training, generating new and richer patterns of what we have been referring to here as informal ethical reasoning.

PROBLEMS OF POWER AND AUTHORITY

We have used bullying as an example above because it is an instance of much broader, much more difficult to address problems relating to power and authority. Especially during their first years working in clinical settings, trainees find themselves trapped between speaking up and remaining silent. The cost of the former is a potentially career-endangering (or, early on, grade- or placement-endangering) response from more senior clinicians. Since grades, placements, and, indeed, the shape of professional careers depend so much on the evaluations of senior clinicians, speaking up may come at a very high—unacceptably high—cost. But the cost of remaining silent is also high. In the short term, it compromises both learning and one's sense of self. In the longer term, and as instances of self-imposed silence recur and recur, the professional self can be blunted; creativity can be lost; and trainees may come simply to accept the way things are. And because what goes around, comes around, trainees—when they themselves have reached positions of authority—may well expect the same sort of silence and implicit obedience from their juniors.

Stopping this destructive cycle—with no good escape, at present, for trainees—requires institutional action, not just discussion. The latter

would, if it involved senior professionals, likely just generate more silence from trainees. What is needed, we think, are direct interventions aimed at any clinicians specifically involved in clinical training. Raising awareness of the diverse ways in which senior clinicians exercise their power and authority is the first step, but they also need to learn to deal with their own feelings about, and their responses to, being questioned or even challenged by junior colleagues and by residents. Awareness alone, without some further opportunities to understand how and why one might respond in the way one does, is simply not enough.

One place to begin thinking about these issues and how to address them is with A. O. Hirschman's *Exit, Voice, and Loyalty* (1970). The main insight in the book is that, contrary to the common perception that voicing one's concerns or objections is a product of disloyalty or other form of ill will, *voice* is a form of loyalty that indicates an interest in improving a product—the prime example in Hirschman's book, but it could be an institution or game or way of talking in a group. Disloyalty (or other forms of ill will) is expressed through *exit*; that is, one drops the product (or institution or game or discussion) and moves on to something else. To make this relevant to trainees, voice currently often comes at too high a price for trainees, but exit, except for a decision to leave the field altogether, is unacceptable, too. This bind is created by supervising clinicians, not the trainees, and that's why direct interventions with staff are so important.

There is also a much broader matter at stake. Interpretive communities thrive on open, free expression. Indeed, such expression is the means by which interpretive communities identify and address challenges and problems, and the means by which they change and grow. Additionally within the field of health care, open and free communication enables trainees to ask questions, facilitates evaluation and criticism of health interventions, expedites adoption of new methodologies and treatments, and, by facilitating voice and the early identification of problems, helps to maintain professional morale and avoid burnout.

We have included, as Appendix 8.1, a young doctor's reflection on the difficulties of maintaining a sense of self and self-worth as a pediatric resident.

In her 2006 article, "Respect for Patients" (p. 88), Delese Wear notes that medical educators came to consider the term *hidden curriculum* of particular interest because it was useful in explaining "the unintended (and most often negative) attitudes, values, and behaviors acquired by medical students in spite of a carefully planned, formal curriculum."

The hidden curriculum is not limited to medicine, of course; all fields of health care have their distinctive areas of interpersonal and institutional behavior that have a pervasive influence on the fields but that are functionally invisible and not subject to the critical evaluation they need. We would hypothesize that much of what is currently hidden would come under examination and potential criticism if health care training programs (and health care institutions generally) embraced, as discussed above, the process of open, persistent questioning, as embodied in the touchstones for learning, while also creating and maintaining the requisite spaces for discussion and reflection.

One final, crucially important point. We have, in this chapter, been discussing the challenges of extending health care trainees' existing ethical frameworks to the new setting of health care. This process of learning will fall short, be seriously compromised, or simply fail unless trainees are able to maintain their well-being, mental health, physical health, and sense of self-respect through the process of professional education. To the extent that any of these cannot be largely maintained intact, the process of learning and how any particular trainee approaches, learns from, and integrates experience will be distorted, both short and long term. In this context we draw attention to, and agree with, a 2017 *BMJ Open* article, "Care Under Pressure," by Daniele Carrieri and colleagues.³ One of their central points is that many threats to the mental health of health professionals are institutional in character and that institutional interventions, which would require strong leadership from the top, are therefore required. We expect that training programs and health care institutions that are structured along the lines suggested in this chapter will do much to preserve the mental health of their students and professional personnel.

NOTES

1. In walking on the beach, we recently overheard the following as a father was talking to his two boys, who were vying for control of a toy: "In this family, we share!"
2. Such questions are sometimes incorporated into what has come to be known as *reflective practice* in health care (Carroll 2009; Senediak 2013) and into what is known as *personal practice in therapist skill development* (Bennett-Levy and Finlay-Jones 2018). For more on reflective practice, see Chapter 10. Terminology aside, the specific point we are making here and throughout the book is that such questions are effective means of

identifying and addressing ethical issues in health care—via the informal ethical thinking of health professionals—without any need to invoke formal ethics.

3. This article is discussed in more detail in Chapter 9.

APPENDIX 8.1: A YOUNG DOCTOR'S REFLECTION

Throughout my pediatric residency I had to manage physical exhaustion, unsafe workloads, and burnout, as well as my distress when listening to patients' stories and when caring for very sick children. Having a mentor to talk to really helps, but those relationships were hard to establish in the medical system where I worked. In our first postgraduate year, rotations last only ten weeks. In subsequent years, rotations generally last three months, sometimes six. Between the workload and the pressure to get things done, especially in a short rotation, it's hard for residents to find enough time to form decent relationships with attending physicians ("attendings").

Over time I learned which attendings were safe to talk to and which were not safe. The unsafe ones were those who viewed the issues that I was struggling with as personal weaknesses. These attendings trained us—by their example—not to feel or show emotion, and if we did, they communicated their disappointment and used guilt as a form of control. One time, when working a 12-hour shift covering *half the hospital* (all surgical and subspecialty medical patients in every ward)—after 2½ hours of sleep—I noted that my sleep deprivation made me unsafe to see patients: in one brief exchange I used the words "not safe at work," "burned out," and "beyond my breaking point." The attending's response was a raised eyebrow and a question: "Is your exam stress affecting your work performance?" I felt demeaned and dismissed. After that, I was always very careful in deciding what to say to attendings.

Safe attendings were those who saw these problems at work as ones we all experienced, as problems embedded in the medical system and in the role of being a doctor, and that all doctors—young and old—had to manage. These attendings saw the issues as having an ongoing, adverse impact on the well-being of doctors, and they did not pass judgment. Instead, they created a culture of debriefing and of "checking in" after difficult clinical encounters to see how I and my fellow residents were doing. These small acts went a long way in enabling me (and others) to speak up. They acknowledged the suffering we encountered every day, the horror of child abuse, our repeated close encounters with the deaths

of patients, and the many complicated feelings elicited by such events. It was, I was learning, OK not to be OK. With their questions, the attendings opened up a conversation, allowing me and my fellow trainees to feel the difficult feelings, to accept them, to talk about them when asked. Somehow, the mere asking of the questions made it safer for us. Having a senior doctor acknowledge our humanity was powerful and helped us, the junior doctors, speak out.

I was lucky to find a few mentors and to maintain my relationships with them over time. A good mentor is someone you respect and trust, and who you feel safe talking to about difficult topics. You value their opinion and advice. The hardest conversations are ones where your weaknesses come up. How are you going to be judged? A good mentor somehow takes that worry away. Talking about my wants, needs, and emotional responses—even acknowledging them to myself—was always difficult for me. They made me feel like a failure, a disappointment. But one mentor, in particular, made me see these personal experiences differently. It was such a relief. She wasn't just pushing me onto the treadmill of achievement, or the expected path, or the one she chose. Rather, she helped me to realize that there are many paths in medicine. She normalized my struggles and then challenged me to do what was actually right for me. A great mentor, like her, sees you and treats you like a whole person.

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CHAPTER 9

Teaching Clinical Ethics in the Formal Curriculum

Abstract Presenting a full formal curriculum for teaching ethics to health professionals is obviously far beyond the scope of this single chapter. But what we can do here is discuss a range of teaching formats—core lecture course, discussion classes, and observational and participatory activities—that can be used in any field of health care, along with an explanation of how these formats can be used to implement an approach to health care ethics that is centered on the self, informal ethical discourse, and interpretive communities, as presented in Chapters 6 through 8.

Keywords Health care • Clinical ethics • Implicit ethical framework
Informal ethical discourse • The self • Interpretive community
Morality of ordinary practice • Teaching formats • Value of social
sciences • Mental health • Cultural competence • Structural competence
Patient communication • Informed consent • Shared decision making
Counterstories • Reflective practice • Arts-based learning

Since every health care training program will undoubtedly include at least one core, lecture-type course for teaching ethics and other psychosocial issues, we begin this chapter by presenting our suggestions for such a course. We then include suggestions for discussion classes, followed by some remarks on the use of observational/participatory activities such as literature, drama, film, videos, and role playing as methods of moving

past “book knowledge” into the more intimate and more lasting knowledge gained through personal experience. In the next chapter (10), we move into the more open structures and methods of teaching available in clinical settings.

Throughout this chapter—which builds upon the general approach to teaching elaborated in Chapter 8—our emphasis is to encourage programs to reorient their ethics teaching away from ethical abstractions (such as ethical principles), to give less emphasis to unsettled, difficult questions of public policy (such as genetic counseling or distribution of scarce resources), and to move toward questions that challenge trainees to extend their existing ethical thinking to the clinical situations encountered in ordinary practice. It is this emphasis on the self and on the ethics of ordinary practice that, we think, will have the most lasting impact on trainees.

Also worth noting is that as trainees develop their own informal ethical thinking—their implicit ethical frameworks—through the processes discussed in this chapter and the next, they do so as entrants to their respective interpretive communities within health care. Progressively immersed in those communities through professional education, trainees acquire, as it were, the distinctive mode of thinking, feeling, and acting that is characteristic of those communities. In the process, they also inescapably acquire a sense of the goals, values, and methods that are embedded in those communities. It is against this background that trainees’ informal ethical thinking will develop.¹

Finally, given our view that the goal in teaching clinical ethics is to nurture trainees’ capacities for informal ethical thinking, it is fair to ask about the sort of readings that promote that aim. In the section below, we discuss the central role of the social sciences. But what about the vast literature in bioethics itself? Since we discuss that question in our concluding Chapter 11, we give only the briefest of answers here. In short, the bioethics literature is widely varied in just how much emphasis any particular article gives to formal ethical analysis and ethical principles. We would discourage the use of readings with strong emphases on formal analysis, and encourage the use of readings whose analyses and arguments are closer to the informal language, ethical or otherwise, of everyday discourse. It is the latter sort of readings, which are more closely connected with our standard ways of thinking, feeling, and acting, that will have lasting impact on trainees.

THE VALUE OF THE SOCIAL SCIENCES

Here, as in all of the teaching settings we are discussing in this book, the more one knows about the sociology, history, and anthropology/psychology of the situations one encounters, the richer will be one's cognitive and emotional responses, and the more adaptive and functional one's subsequent actions. There are numerous dimensions in which such background knowledge enriches one's experience, but three, in particular, are especially noteworthy.

- *The straightforward facts.* Does something—bullying, for example—actually occur with a frequency that renders it a systemic, versus a rare and scattered, problem? A recent Australian study of young doctors (postgraduate years 1 and 2) by Anthony Llewellyn and colleagues (2018) found that over half reported having been bullied and that nearly a third of all women reported being sexually harassed. Other studies have found much the same (Carrieri et al. 2018; Barrett and Scott 2018; Flynn 2015; Ivory 2015; Monrouxe et al. 2015; Rees et al. 2015a; Rees et al. 2015b; Scott et al. 2015; Walton 2015).
- *Rendering the unfamiliar familiar.* Other things equal, a white, male trainee who had attended a prestigious university prior to professional school would have little to no familiarity with the life experience and challenges of an indigenous, Hispanic, or African American woman who had grown up in poverty or near poverty, who is poorly educated, and who has no expectations of ever holding a “good job” or moving past her current life circumstances.
- *The possibilities for action.* Taking positive, effective action requires understanding and insight. What is the problem? Is it one concerning this particular patient (e.g., providing appropriate care/services to him or her), or is it a larger, systemic issue (dealing with the needs of this group of patients, improving the hospital's system of care for such patients, or even more broadly, achieving change at the local or national political level)? What are the options? Which would be most, or at least decently, effective? These questions all concern the present and future. But understanding these questions will itself depend upon what has happened in the past. How did things get this way? Why wasn't the problem fixed sooner? What forces are still at work and protecting the status quo?²

As trainees extend their understanding of questions such as the ones above, they are, in effect, extending their selves and become capable of seeing, at a glance, things that were not previously within their perceived worlds. They are, to use our earlier terminology (see Chapter 6), extending their slow thinking, which then, in time, gets entrenched within the self as their fast thinking. And it is typically against a person's established pattern of fast thinking that things occur to them as wrong or concerning or puzzling or challenging. In thus extending the limits of the self and how trainees perceive and understand the world, this new, fast thinking extends, in the process, the range and type of questions that trainees ask and will continue to ask, lifelong—their own, dynamically changing touchstones for learning (as discussed in Chapter 8).

CORE LECTURE COURSE

In deciding what issues to cover in a core lecture course in which ethics is a central, if not exclusive, focus, the challenge is to select topics that will facilitate the transition from preprofessional student to health care trainee, that address potential issues in the here and now (for the trainees themselves), and that will set the stage for lifelong learning and adaptation. In this section, we will focus on three topics that are of particular importance to all fields of health care. Courses in each field of health care, however, should also give close attention to the central issues that are currently affecting, or of concern to, that particular field—to that particular interpretive community.

Mental Health

An ongoing issue for all trainees—lifelong—concerns their mental health. On this particular topic, a 2018 article in *BMJ Open* sets the stage for exploring the wide range of factors, both individual and institutional, that potentially compromise the mental health of both trainees and clinicians. As Daniele Carrieri and colleagues note in “‘Care Under Pressure’: A Realist Review of Interventions to Tackle Doctors’ Mental Ill-Health and Its Impacts on the Clinical Workforce and Patient Care” (2018, p. 2), the “incidence of mental ill-health (e.g., stress, burnout, depression, drug and alcohol dependence, and suicide)” is increasing “across all groups of health professionals, and in many countries.” What makes the article so valuable for teaching purposes is

that it concisely sets out the various pressures on doctors—which approximate those on all health professionals—and the various sorts of solutions that have been proposed. Key factors identified through the existing literature include the emotionally demanding work, heavy and increasing workload (partly in response to shrinking budgets), long hours, and increasingly regulated professional environment and associated loss of flexibility and autonomy. Unfortunately, what the Carrieri article does not provide is answers. The article is actually just a description of an ambitious study whose overarching questions are described as follows:

1. What are the processes by which mental ill-health in doctors develops and leads to its negative impacts, and where are the gaps that interventions do not address currently?
2. What are the mechanisms, acting at individual, group, profession and organisational levels, by which interventions to reduce doctors' mental ill-health at the different stages are believed to result in their intended outcomes?
3. What are the important contexts which determine whether the different mechanisms [to reduce doctors' mental ill-health] produce the intended outcomes?
4. What changes are needed to existing and/or future interventions to make them more effective? (p. 3)

We have included the full description of the questions here because they set out so thoroughly the range of issues that core courses might choose to address. And although the specific focus of the Carrieri article is on the medical profession, the article and the many issues it raises can be seen as a template for addressing these issues in any field of health care.

Cultural Competence (Extended)

The easiest place to begin is with the 2005 report by the Association of American Medical Colleges (AAMC), *Cultural Competence Education for Medical Students*. Though specifically concerned with medical education, its contents apply just as much, with appropriate adjustments, to any other field of health care. The report defines “cultural and linguistic competence [as] a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system,

organization, or among professionals that enables effective work in cross-cultural situations” (p. 1). This matter of cultural competence was deemed to be of particular importance for U.S. health professionals because of the “ever-increasing diversity of the population of the United States and strong evidence of racial and ethnic disparities in health care” (p. 1).

In terms of substance, the AAMC report defines five domains in which medical students, by the time they graduate, are expected to be competent.

- I. Cultural Competence—Rationale, Context, and Definition
- II. Key Aspects of Cultural Competence
- III. Understanding the Impact of Stereotyping on Medical Decision-Making
- IV. Health Disparities and Factors Influencing Health
- V. Cross-Cultural Clinical Skills (p. 9)

As is immediately apparent from the full description of these five domains (see Text Box 9.1 and Appendix 9.1),³ they are laudable and crucially important. What we suggest, however—and, in part, why we have added the parenthetical *extended* to the section heading—is that these domains of cultural competence should really be used for all patients. That is, we suggest that all health care trainees should be expected to be competent in these domains in relation to all patients, not just those with roots in other cultures.

Text Box 9.1: TACCT [Tool for Assessing Cultural Competence Training] Content Domains

Domain I: Cultural Competence—Rationale, Context, and Definition

- A. Definition and understanding of the importance of cultural competence; how cultural issues affect health and health-care quality and cost; and, the consequences of cultural issues
- B. Definitions of race, ethnicity, and culture, including the culture of medicine
- C. Clinicians’ self-assessment, reflection, and self-awareness of own culture, assumptions, stereotypes, biases

Domain II: Key Aspects of Cultural Competence

- A. Epidemiology of population health
- B. Patient/family-centered vs. physician-centered care: emphasis on patients'/families' healing traditions and beliefs [for example, ethno-medical healers]*
- C. Institutional cultural issues
- D. Information on the history of the patient and his/her community of people

Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making

- A. History of stereotyping, including limited access to health care and education
- B. Bias, stereotyping, discrimination, and racism
- C. Effects of stereotyping on medical decision-making

Domain IV: Health Disparities and Factors Influencing Health

- A. History of health-care design and discrimination
- B. Epidemiology of specific health and health-care disparities
- C. Factors underlying health and health-care disparities—access, socioeconomic, environment, institutional, racial/ethnic
- D. Demographic patterns of health-care disparities, both local and national
- E. Collaborating with communities to eliminate disparities—through community experiences

Domain V: Cross-Cultural Clinical Skills

- A. Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class
- B. Dealing with hostility/discomfort as a result of cultural discord
- C. Eliciting a culturally valid social and medical history
- D. Communication, interaction, and interviewing skills
- E. Understanding language barriers and working with interpreters

F. Negotiating and problem-solving skills

G. Diagnosis, management, and patient-adherence skills leading to patient compliance

*Pachter, L.M. Ethnomedical (folk) Remedies for Childhood Asthma in a Mainland Puerto Rican Community. *Archives of Pediatrics and Adolescent Medicine* vol. 149, no. 9, September 1995, pp. 982–988.

From *Cultural Competence Education for Medical Students*, © 2005 American Association of Medical Colleges. Reproduced with permission.

As we see it, it's simply odd that these five domains have been singled out for application to *cross-cultural* situations. The same issues arise for any patient or client, whether from the same or different culture as the care provider. All cultures, including the dominant culture, have an impact on how patients understand health and disease, how they perceive the need for health interventions, and how they perceive health providers and institutions. And even when a health professional believes that he or she has mastered these five domains for his or her own culture, all sorts of questions inescapably arise in providing care or services. Health professionals need to consider who the patient is: man or woman, married or single, gainfully employed or not, sexually active or not, straight or gay (or transgender), young or old, rich or poor. Does the patient have children, and of what age? Is the patient a good historian (re: providing a medical/family/social history)? Is the patient forthcoming or not in the presentation of self and in responding to questions? Does the patient appear to be psychologically settled or, instead, distressed or preoccupied? The questions go on and on.

There is also another set of questions that need to be asked, which concern what Jonathan Metzl and Helena Hansen (2014, p. 127) characterize as *structural competence*, the capacity to recognize the “forces that influence health outcomes at levels above individual interactions.” One of their examples is that the failure of certain patients to exercise reflects not any lack of desire but the lack of opportunity, as when “their neighborhoods have no gyms or sidewalks or parks” (p. 127).

The controlling idea here is that the factors identified through cultural competence alone are not the sole determinants of how patients present and why. In addition, the

issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health. (p. 128)

Metzl and Hansen’s notion of structural competence is the second way in which we see the notion of cultural competence as needing to be extended. But note: cultural and structural competence are good things not just for cross-cultural patients; they are good things for *everybody*.

Communication with Patients/Informed Consent/ Shared Decision Making

All health care programs already devote careful attention to communication with patients, informed consent, and shared decision making—which is just as it should be since the relationship between patient and caregiver is the central human phenomenon in health care. What we will do here is simply to comment on how these issues play out in relation to the framework we have presented for thinking about clinical ethics.

Communication with patients. We have noted in earlier chapters that the clinical ethics of health professionals should build upon, and extend, their existing, informal ethical thinking. This foundation in the self is the most efficient and reliable foundation for health professionals to think about the ethical issues that they will confront in their future work. Exactly the same can be said for communicating with patients. That is, at the point that students begin their training in health care, they already have a wide range of existing communication skills. This simple statement has consequences, and a simple example will suffice. Suppose that one is working with social work students to improve their communication skills regarding a particular problem or situation. Consider two questions:

1. How should a *social worker* discuss this problem with a client?
2. How would *you* discuss this problem with a client?

The former question requires trainees to make an intellectual leap into the position of a “social worker.” The latter requires no leap at all. That is, trainees have no choice but to start where they are, and as the persons they are. And that’s where the education process needs to start, too.

Informed consent. We would guess that more has been written about informed consent than any other topic in the bioethics literature. As in the paragraph above about communicating with patients, we mention here only a few points that connect up with the framework we have presented in earlier chapters.

As background, informed consent, considered as a legal doctrine requiring the mandatory communication of treatment information from health professionals to patients, arose in response to the medical profession’s general failure to share such information with patients (see Chapter 3). As such, the doctrine was legally imposed upon the various interpretive communities within the field of health care, along with its terminology, concepts, and demands placed on health professionals. When the pristinely simple legal concepts of informed consent—such as legal competence, information about risks and benefits of the different and available treatments, and consequences of non-treatment—encountered the real world of health care, those concepts encountered difficulties. The world proved to be much more complicated, textured, and varied than the one envisioned by the doctrine; among other things, and perhaps most centrally, the supremely rational decision maker envisioned in informed consent, like the supremely rational decision maker of classic economics, simply doesn’t exist. The provision of complete information can lead, among other things, to informational or emotional overload (Bester et al. 2016). And as Christine Grady notes in her (2015) *New England Journal of Medicine* article, “Enduring and Emerging Challenges of Informed Consent,” the fundamental legal requirements of the doctrine remain matters of ongoing debate, including

the scope and level of detail provided and the methods of disclosure, whether and how to assess comprehension, what constitutes necessary and sufficient understanding for valid consent, approaches to assessing persons’ capacity to consent and steps taken when they lack that capacity, how to know when choices are sufficiently voluntary, and issues concerning the documentation of consent. (p. 856)

What makes these problems even more difficult for clinicians is that the *legal* doctrine actually calls, of necessity, for *legal* answers. That is, insofar as clinicians have questions about what is or is not required, they can make good guesses, but they simply don't have the capacity to arrive at legally authoritative answers. To us, it seems that clinicians have thereby been put in the remarkably odd position of being legally required to do something whose very standards and rules, except in central cases, are poorly defined.

What, then, is a clinician to do? Our answer has three interconnected parts: (1) Inescapably, since no health professional constantly has access to a lawyer, health professionals need to rely on their own best judgment in determining whether particular patients have the capacity to make decisions about their care and whether they understand their health situations and information provided about the available options, including a refusal of treatment. (2) The capacity of particular health professionals to make such judgments about their patients can be maximized by their learning, beginning with their formal courses as trainees, about the *limits* and *problems* of the informed consent doctrine (see Grady quote above), which will then help them to recognize these problems in practice and will put caregivers on notice that they need to pay special attention to those elements of the decision/treatment process. (3) The communication process that best promotes (1) and (2) is *shared decision making* (see following subsection) as complemented by training in communication with patients (see preceding subsection and Chapter 10).

Shared decision making. As we noted in discussing informed consent, the more that health professionals know about the limits and problems of informed consent—in this context, the limits and problems of patients in deciding what treatment they want—the better prepared clinicians will be to identify and address such problems in providing care to their patients. But the differences between informed consent and shared decision making are dramatic. Informed consent arose out of an effort to *protect* patients from the failures of health professionals, and it defines what is, legally speaking, the *legally minimum standard* for discussing health care options with patients (or their families or substitute decision makers). Such a standard is, for those working in the various interpretive communities of health care, both externally imposed and, as discussed above, unable to capture the complexities of clinical practice. By contrast, the process of shared decision making represents an *opportunity*. It connects up directly, at least in theory,⁴ with the central aim of health

professionals to provide the best, most responsive care to their patients; this aim is embedded in the very organization of health professionals' respective interpretive communities; and the process highlights and builds upon the very achievements of those communities. In short, shared decision making is a process through which clinicians and patients come to agree on the best care for that particular patient. And because modern health care has so many options available and also has the capacity to describe the options and their likely and possible consequences, shared decision making is actually a product of the health professions' strengths, not their failures. Importantly, too, since numerous options are typically available for any particular health care situation, the decision process cannot reach closure by consulting the health care "facts." On that basis alone, no single best option can be objectively determined. What does make something the best option is that, when provided the needed information and the opportunity to discuss the available options with the clinician, the patient has chosen that particular option.

The implication of the above is that shared decision making provides the opportunity for health professionals to use their communications skills effectively to assist patients in making their health care decisions. Just what information to provide, how to provide it, how to discuss it, and such matters are all things that health professionals need to decide. It challenges them to use every bit of their communication know-how to frame the decision process and move the patient through it. In this respect, teaching health professionals about shared decision making is a direct extension of any other work that they do to improve their communication with patients (as discussed in the first of these three subsections on communication).

DISCUSSION CLASSES

Regularly scheduled discussion classes could take place in conjunction with lecture courses, as part of freestanding discussion courses, as workshops, or potentially even as portions of clinical rotations (for this last type, see "Formal Clinical Modules" in Chapter 10). Depending upon the flexibility of the discussion classes, the specific choice of discussion topics might be set in advance by the course syllabus, at one extreme, or could be chosen by the trainees themselves on an ad hoc basis via the touchstones for learning discussed in Chapter 8, at the other. For reasons also discussed in Chapter 8, ideal group sizes would be from five to fifteen, though that depends upon the availability of resources of various types.

But our concern here is on process and materials, not course structure as such. Our recommendation would be for discussion classes to focus on clinical and other work-related situations, to use literary, dramatic, and video/film materials whenever available and relevant (see Sect. “[Observational and Participatory Activities](#),” below), and to supplement both with appropriate readings in sociology, history, and anthropology/psychology. The closer that the discussion materials can get to the actual, current lived experience of trainees, the better. The use of materials that lead to exploration and reflection, rather than conflict, is to be preferred. No matter what the materials, the goal is, of course, to extend and enrich trainees’ informal ethical thinking.

Selecting Topics for Discussion

In any discussion course in which the touchstones for learning, with their very personal orientation, are considered a primary means of identifying issues for discussion—and also for *maintaining* discussion—a potential threshold matter is getting trainees to “open up.” To address this problem and also to reveal, at the outset of any discussion course, both the commonality of various problems and the range of possible topics for discussion, an excellent place to start is with *Grace Under Pressure* (Williams and Dwyer [2017](#)). This 90-minute dramatic presentation, available in script form, draws from actual interviews with health professionals (doctors and nurses, at various stages of their careers) and gives central attention to professional training. In the course of the presentation, the characters discuss matters such as bullying by senior professionals, overly long working hours (including dangers to patients and to oneself, as in driving home after long or night shifts), sexual harassment, the need to care for oneself, and mental health and suicidal ideation among trainees, among various other topics. This brief presentation, whether read in segments or in its entirety, is a remarkably efficient way of legitimating these sorts of topics and creating a space that is safe for discussion.

In other discussion courses the topics for discussion will be largely determined in advance. The following clinical situation, drawn from the early years of the AIDS epidemic, is an example of what can be used to generate discussion—in this instance to explore the limits of health professionals’ obligations to patients:

A mother, a widow, is taking care of her son, who is dying of AIDS, at home. Hospice care is available, but the mother is unwilling for her son to be moved there from the family's apartment, where they have lived ever since moving to the United States from Haiti twenty years earlier. She wants the son to spend his last weeks in the room he lived in as a child, and she requests that the available health care services—from his doctor, a nurse, and a social worker—be provided at home. The health professionals balk at providing the services there when hospice care is available, and they also note that the mother has been unable to comply with general precautions concerning bodily fluids. The bedroom and bed are filthy, and the rest of the apartment is presumably contaminated. In an agonizing decision, the health professionals decide that they are unable to provide further care to the patient in that location (though they also noted [among themselves] that they had no overarching theory of where to draw the line between what they should or shouldn't do in meeting the personal preferences and needs of individual patients; the line they drew here was ad hoc). The mother, on being informed of the team's decision, calls them "selfish brutes" who "obviously don't give a damn for patients, just themselves." Several weeks later the patient dies at home, with no further medical/nursing/social interventions.

The above situation presents many questions about the limits of professional obligations and the extent to which health professionals should make adjustments for the needs of individual patients. A separate question is whether some middle ground, such as an effort to provide training on issues of safety or to provide counseling to address issues of loss and grief, might have been pursued before any final decision was made.

Stories and Counterstories

But once an event or phenomenon or situation has been identified as the subject for a discussion, what happens then? In addition to the standard ways of encouraging and maintaining discussion—including the use of hypotheticals, the touchstones for learning (e.g., "Why does that bother/surprise/please you?"), and probing and open-ended questions—we strongly support the ongoing work in the field now known as narrative ethics.⁵ There can be no doubt that stories, or narratives, are valuable both in teaching and in understanding the complexities of clinical health care. What we want to do here, however, is explore the use of *counterstories* as a variation on that particular theme—and, in particular, as an especially efficient and effective way of helping trainees

(and others) to perceive and come to understand clinical situations from diverse, even unfamiliar perspectives.

In his classic, 1989 article, “Storytelling for Oppositionists and Others: A Plea for Narrative,” Richard Delgado set out the notion of *counterstories*, which are stories, or narratives, by or about members of outgroups—groups of persons/outsideers who have been “suppressed, devalued, and abnormalized” (p. 2412). The example that Delgado makes the centerpiece of his account concerns a law school’s decision not to hire a particular African American to fill an advertised opening on its faculty. In explaining the decision, the members of the tenured faculty, all white, provide

an account that justifies the world as it is. It emphasizes the school’s benevolent motivation (“look how hard we’re trying”) and good faith. It stresses stability and the avoidance of risks. It measures the black candidate through the prism of preexisting, well-agreed-upon criteria of conventional scholarship and teaching. (p. 2421, footnote omitted)

But the various alternative counterstories—by the candidate, his lawyer (in a court submission), a radical student, and an anonymous leaflet—all challenge the status quo, though they do so in different ways, with different emotional tones and with ultimately different chances of swaying the opinions of those who had initially accepted the standard story.

As Delgado notes, counterstories “invite the listener to suspend judgment, listen for the story’s point, and test it against his or her own version of reality” (p. 2440). They can

challenge the received wisdom . . . [and] can open new windows into reality, showing us that there are possibilities for life other than the ones we live. They enrich imagination and teach that by combining elements from the story and current reality, we may construct a new world richer than either alone. Counterstories can quicken and engage conscience. Their graphic quality can stir imagination in ways in which more conventional discourse cannot. (pp. 2414–2415, footnote omitted)

So understood, many of the situations identified through the touchstones for learning will potentially be subject to different interpretations, different narratives, with the trainee being the outsider who sees the status quo as disturbing or concerning or surprising. *Grace Under Pressure* itself presents many such situations from the trainees’ perspective (Williams and Dwyer

2017). In other situations—which would be more common in relation to topics taken up as part of a predetermined syllabus—the outsider is more likely to be someone other than the trainee or the health professional involved (as in the AIDS situation above). The teaching challenge, in those situations, is to lead trainees to see (and potentially, through literature, drama, or video/film, to experience) the situation through an outsider's eyes and even to construct a story, or narrative, that captures that perspective. As with Delgado's case of the African American who was rejected by an all-white faculty, there is no single, unique counterstory; for any particular situation, different counterstories capture different perspectives and reflect different interests and goals. This diversity is exactly why they can be so useful to trainees in expanding their intellectual perspectives and increasing their emotional resources.

To return to the vignette above concerning the AIDS patient who died at home, the basic *story* from the perspective of the health care team is that they were unwilling to put their own lives at risk through avoidable exposure to the AIDS virus in a contaminated home environment. But consider two *counterstories*:

- *From a critic of the U.S. health care system.* The health care team did exactly what it has been trained to do: treat the disease, not the person. It is obvious that, had the team seen the situation more broadly, the mother was determined, no matter what, to see her son die at home. This baseline problem could have been identified and addressed much earlier, before the problem of contamination got out of control. The social worker, who was meeting with the mother to support her in her grief (and maybe to negotiate things financially), could have brought this growing problem to the team's attention and also started working with the mother, aiming either to secure her understanding that hospice care could be an acceptable option (allowing her regular, intimate access to her son) or that, if the son was to stay at home, she would need to learn and follow sanitary precautions for home care of AIDS patients. What we can't know from the vignette is whether the social worker had explored the patient's living situation, whether she was effectively blinded by having medicalized the situation (seeing only the medical problems), or whether she and possibly also the nurse had found themselves powerless to protest the treating doctor's narrow view of the situation and the available options.

- *From a community organizer/political activist.* The story presented is one of racism. The presumably white health care team made a decision regarding a Haitian patient (and his mother) that they would never have made if the patient and mother had been white. They conceived the situation as “us versus them,” comfortably setting the cost of proceeding with home care as so high that they needed to exit the situation. Their loyalty to this patient and his mother was too thin to justify the risk or to motivate the team to identify possible alternatives (see A. O. Hirschman’s *Exit, Voice, and Loyalty* [1970]).

These two counterstories put the initial vignette in different, much more critical lights. What’s noteworthy, too, is that seeing these criticisms as stories rather than simply as summary criticisms—the first as reflecting a narrow, medicalized view of the situation and the second as demonstrating its implicit racism—makes the criticisms much more powerful and personal. Stories connect up with the whole person, whereas the bare criticisms connect up mainly with the intellect, making it much easier to rationalize and disregard what happened and why.

OBSERVATIONAL AND PARTICIPATORY ACTIVITIES

The literature on the use of observational and participatory activities in health care education is already extensive, of course, but our particular focus here is on using these media not only to connect up learning with the self but to do so in a way that enhances or extends what might be called one’s *ethical self* or *ethical imagination*. In this context, it’s helpful to draw again on the notion of counterstories.

The central idea behind counterstories is that actual or imagined factual situations that include a variety of different human perspectives provide rich material for thinking about, and learning about what it is to inhabit, the world from those different perspectives. The potential for learning is even further enhanced when the situations are, as it were, given human form, as in live dramas and videos or role playing. Even if the factual situation is “closed”—that is, with the events already over and with no further decisions to be made—the cross-currents of the stories, embodied in human form, invite observers to occupy various positions both intellectually and emotionally, and to construct a story from that perspective. Similarly, as in role playing through a situation that presents

human conflicts or difficulties of one kind or another, participants (and also, indirectly, observers) find themselves living a story or counterstory, and constructing a view of the world, and experiencing it, from that perspective.

To return briefly to our example of *Grace Under Pressure*, the counterstories take human form as the relatively powerless, striving, vulnerable trainees discuss how they have been sexually harassed, bullied by their seniors, or unable to protest overly long hours (Williams and Dwyer 2017). At the University of Sydney, a number of these counterstories from *Grace Under Pressure* have been re-filmed close-up, for use in teaching (personal communication, Paul Dwyer and Louise Nash). At many other universities, health care training programs have collaborated with members of the institutions' art faculties to develop drama workshops (de la Croix et al. 2011). Another potentially valuable format is *forum theater*, "an interactive approach for exploring a difficult situation and possible solutions by having actors perform a short scene, and then inviting members of the audience to come forward with different options for addressing the problematic situation" (Brett-MacLean et al. 2012, p. 1; Booton and Dwyer 2006; Ivory et al. 2016; Kumagai et al. 2007; Brown and Gillespie 1997).⁶ During a replay, "audience members . . . are invited to stop the performance and suggest, or act out, an idea for how one of the characters could have acted differently to effect a positive change that would have resulted in a better outcome" (Brett-MacLean et al. 2012, p. 1). As the original scenario and suggested alternative actions are discussed, what emerge, in effect, are a series of stories and counterstories—for example, as those in power change their behavior or those with less power take less subservient, more self-expressing stances.

Some health care training programs have even developed formal courses in collaboration with their universities' drama departments or programs (Willson 2006; Willson and Jaye 2017). In the resulting teaching modules, trainees interact with actors or with each other to develop communication skills, deal with conflict, interpret body language, and experience the problems, complications, and challenges characteristic of each particular field of health care. These opportunities also provide some form of lived experience of occupying perspectives other than one's own and, in the process, of generating and experiencing a range

of stories and counterstories (Scott et al. 2017; de la Croix et al. 2011; Jeffrey et al. 2012; Reilly et al. 2012; Bell et al. 2014; Hammer et al. 2011; Willson 2006; Willson and Jaye 2017).

This formal coursework—lecture courses, class discussions, and observational/participatory activities—serves as a bridge between trainees’ preprofessional, informal ethical frameworks and the challenges of their clinical work. Most importantly, through the touchstones for learning and trainees’ complementary learning in sociology, history, and anthropology/psychology, trainees should be better able—in their own, informal ethical thinking—to identify various problems and deficiencies in their professional environments (i.e., their respective interpretive communities), articulate what is wrong, think about how it got that way, and formulate potential means of improving the situation. They should feel more confident in raising their ethical and other concerns with their peers and their seniors, and should come to appreciate the value of discussion, both for bringing out various dimensions of the problems encountered and for reaching some sort of consensus, a way of going forward. They should, in short, be well prepared, at least on a human level, for the clinic.

NOTES

1. See Sects. “Interpretive Communities” and “Health Care as Overlapping Interpretive Communities” in Chapter 7.
2. These questions would be considered to fall within structural competence (Metzl and Hansen 2014), as discussed later in this chapter.
3. Appendix 9.1 provides a sampling from different models of cross-cultural communication. These descriptions of the different models, reproduced from the same (2005) AAMC report as the material in Text Box 9.1, provide an easily accessible overview of how to facilitate communication with cross-cultural patients (and, indeed, with all patients).

The online resources on cross-cultural communication in health care are vast. Good places to start are with U.S. Health Resources and Services Administration’s *Culture, Language and Health Literacy* Web page, and Georgetown University’s National Center for Cultural Competence.

4. It would be wrong to infer that shared decision making always leads to optimal choices and the best outcomes. The title of the review “Shared Decision Making and Improving Health Care: The Answer Is Not In” (2017), by Victor Montori, Marleen Kunneman, and Juan P. Brito, speaks for itself. Shared decision making remains, in this context, a work in progress. But it is a work that is progressing in the right direction, that incorporates the respective perspectives

- of both patients and health professionals into decision making, and that unequivocally recognizes and respects the stake of patients in their own health care.
5. See, for example, Howard Brody, *Stories of Sickness* (1987); Rita Charon and Martha Montello, eds., *Stories Matter: The Role of Narrative in Medical Ethics* (2002); Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (2006); and Martha Montello, ed., “Special Report: Narrative Ethics: The Role of Stories in Bioethics” (2014).
 6. It is also possible to use student actors to perform the scene, thereby both saving money and potentially increasing the educational impact.

APPENDIX 9.1: MODELS OF EFFECTIVE CROSS-CULTURAL COMMUNICATION AND NEGOTIATION

<i>Models</i>	<i>Sources</i>
BATHE	Stuart, M. R., Leibermann, J. R. (1993).
Background (What is going on in your life?)	<i>The fifteen-minute hour: Applied psychotherapy for the primary care physician.</i>
Affect (How do you feel about what is going on?)	New York: Praeger
Trouble (What troubles you most?)	
Handling (How are you handling that?)	
Empathy (This must be very difficult for you.)	
BELIEF	Dobbie, A. E., Medrano, M., Tysinger, J., Olney, C. (2003). The BELIEF instrument: A preclinical teaching tool to elicit patients' health beliefs. <i>Family Medicine</i> , 35, 316–319
Beliefs about health (What caused your illness/problem?)	
Explanation (Why did it happen at this time?)	
Learn (Help me to understand your belief/opinion.)	
Impact (How is this illness/problem impacting your life?)	
Empathy (This must be very difficult for you.)	
Feelings (How are you feeling about it?)	
Eliciting Patient Information and Negotiating	Carrillo, J. E., Green, A. R., & Betancourt, J. R. (1999). Cross-cultural primary care: a patient-based approach. <i>Annals of Internal Medicine</i> , 130(10), 829–834
Identify core cross-cultural issues	
Explore the meaning of the illness	
Determine the social context	
Engage in negotiation	

<i>Models</i>	<i>Sources</i>
ESFT model for communication and compliance	Betancourt, J. R., Carrillo, J. E., & Green, A. R. (1999). Hypertension in multicultural and minority populations: Linking communication to compliance. <i>Current Hypertension Reports</i> , 1(6), 482–488
Explanatory model	
Social risk for noncompliance	
Fears and concerns about the medication	
Therapeutic contracting and playback	
ETHNIC	Levin, S. J., Like, R. C., Gottlieb, J. E. (2000). ETHNIC: A framework for culturally competent ethical practice. <i>Patient Care</i> , 34(9), 188–189
Explanation (How do you explain your illness?)	
Treatment (What treatment have you tried?)	
Healers (Have you sought any advice from folkhealers?)	
Negotiate (mutually acceptable options)	
Intervention (agreed on)	
Collaboration (with patient, family, and healers)	
Kleinman's questions	Kleinman, A., Eisenberg, L., Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. <i>Annals of Internal Medicine</i> , 88, 251–258
What do you think has caused your problem?	
Why do you think it started when it did?	
What do you think your sickness does to you?	
How severe is your sickness? Will it have a short or long course?	
What kind of treatment do you think you should receive?	
What are the most important results you hope to receive from this treatment?	
What are the chief problems your sickness has caused for you?	
What do you fear most about your sickness?	
LEARN	Berlin, E. A., Fowkes, W. C. (1983). A teaching framework for cross-cultural health care. <i>The Western Journal of Medicine</i> , 139, 934–938
Listen with sympathy and understanding to the patient's perception of the problem	
Explain your perceptions of the problem	
Acknowledge and discuss the differences and similarities	
Recommend treatment	
Negotiate treatment	

<i>Models</i>	<i>Sources</i>
Model for Cultural Competency in Health Care	
Normative cultural values	Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. <i>Journal of Pediatrics</i> , 136, 14–23
Language issues	
Folk illnesses	
Patient/parent beliefs	
Provider practices	
“Review of Systems” domains of the Social Context	
Social stressors and support network	Green, A. R., Betancourt, J. R., & Carrillo, J. E. (2002). Integrating social factors into cross-cultural medical education. <i>Academic Medicine</i> , 77(3), 193–197
Change of environment	
Life control	
Literacy	

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CHAPTER 10

Teaching Ethics in a Clinical Setting

Abstract In this chapter we focus specifically on teaching health care ethics in clinical settings rather than the classroom, through formal courses. The clinical opportunities are diverse, often ad hoc, and usually connected up with current clinical cases. We also discuss the use of formal clinical modules and the role of mentoring as ways of enriching and reinforcing what has previously been taught through formal courses. The discussion here, as in the two earlier chapters on teaching clinical ethics, is centered on efforts to extend and enrich trainees' informal ethical thinking within their respective interpretive communities, as discussed in Chapters 6 and 7.

Keywords Health care • Clinical ethics • Implicit ethical framework
Informal ethical discourse • The self • Interpretive community
Morality of ordinary practice • Clinical training • Teaching formats
Case conferences • Formal clinical modules • Reflective practice
Evidence-based health care • Mentoring • Arts-based learning

CLINICAL OPPORTUNITIES

The clinical opportunities for teaching ethics vary dramatically from one field of health care to another. What we describe here is a general approach that can be adapted to the particular field of health care and the particular clinical setting. Independent of the field, however,

developing an effective program for teaching clinical ethics is a matter of overriding importance. Since so much of health care is provided in non-institutional settings or behind closed doors or even by sole practitioners, the time of clinical training is, for many health professionals, the only time in their careers when they will be exposed to teaching in a clinical setting.

As noted in discussing the touchstones for learning (see Chapter 8), the central challenge is to identify problems that trainees (or health professionals at any stage) are currently encountering. That's one of the two main uses of the touchstones; the other is to use them to probe thoughts and feelings once a problem has been identified for discussion. In many fields of health care—nursing, social work, psychology, psychiatry, and medicine—such discussions are considered the means of promoting *reflective practice* (Jarvis 1992; Yelloly and Henkel 1995; Morrisson 2005; Senediak and Bowden 2007; Carroll 2009; Mann et al. 2009; Senediak 2014, 2015; Fisher et al. 2015; Bennett-Levy and Finlay-Jones 2018), which is a good characterization of what we're trying to achieve here through clinical teaching opportunities. Reflective practice will, by its very nature, incorporate and promote informal ethical thinking, and generate an ever changing balance of fast and slow thinking (see Chapter 6).

The opportunities for clinical teaching in medicine and nursing are especially rich since so much of the training occurs within institutional settings, such as hospitals and clinics, that might be said to *embody* the goals, values, and practices of various interpretive communities, including those of doctors, nurses, and social workers. All such settings, especially if they are affiliated with teaching programs, include regular meetings of one kind or another, any of which can easily produce cases to discuss. Insofar as teaching programs want to include an ethics component, one practical approach is to schedule, say, a small but ongoing proportion of meetings to address ethical issues (e.g., once or twice a month in the case of a clinical meeting that is scheduled daily). If the trainees are themselves asked to select the case or set of cases for discussion (using touchstone-for-learning questions), it will ensure that the case is relevant to their current experience, and it will also encourage them, more generally, to speak among themselves about what is troubling or bothering them. Over time, that sort of conversation among trainees can serve to legitimate certain types of conversations that would otherwise be lost. Importantly, too, asking and respecting such questions in a clinical setting can help to identify and explore matters that are part

of the informal and hidden curricula—especially those matters that are, on the human level, unacceptable, abrasive, or otherwise not what one would want if given a choice.

Another possibility is for someone savvy in the ways and byways of clinical ethics, *as presented in this book*—potentially (even) a bioethicist or suitably trained and oriented philosopher, psychiatrist/psychologist, other health professional, or mediator¹—to work regularly (as a team member) with clinical teams of doctors, nurses, and doctors and nurses in training (from students through the graduate level), as well as with, when available, social workers and psychologists. Such persons—we could call them *ethics facilitators* since *ethics consultants* suggests the possession of substantive expertise and the transmission of authoritative judgments—could rotate among teams as a shared resource, beginning with morning work rounds, continuing through the various meetings scheduled throughout the day, and maintaining availability for ad hoc discussions, group or otherwise, whenever needed. This kind of low-key but regular presence has the capacity to change professional perceptions and behavior, improve patient care, reduce conflict of all kinds, and enhance professional satisfaction.

As a variation on the above, senior clinicians (e.g., doctors, nurses, or social workers) could be trained to assume the primary responsibility for teaching clinical ethics, patient communication, and shared decision making (potentially in combination with methods of evidence-based health care) and to be available, in real time, to advise trainees on how to address these issues as they work on the wards or in outpatient clinics or on other outpatient rotations day by day. As a complementary, but more formal, approach, the clinical modules discussed in the following section could be used, potentially with the same clinician supervising all the modules for any particular trainee, thus helping the trainee to integrate how the various elements actually fit together in providing care to patients.

In clinical settings, the diverse perspectives and approaches of different fields of health care are potentially a source of enrichment. Although some questions identified (e.g., through the touchstones for learning) may be best discussed by the trainees by themselves (as in the personal doubts of medical or nursing trainees when they first move onto the wards), other questions are ones for which a diversity of perspectives improves the discussion and brings into play matters that one field would recognize but not another. As an example of the latter, the Morbidity and Mortality conferences that are held regularly in hospitals can often

profit from diverse perspectives; given the complexity of hospitals as social systems, understanding what went wrong in anything but the most straightforward medical situation requires input from numerous fields. What did the doctors do (or not do), and why? What did the nurses do (or not do), and why? Why was social work not consulted, or consulted too late? What did the patient and family know or want, or not? What questions should we have asked but didn't? Why not? What information didn't get properly shared? Why not? How can these problems be avoided in the future?

Here's a case from an ethics-oriented Morbidity and Mortality conference that raises many of these questions:

The patient, Mrs. H, was a 78-year-old nursing home resident with a long history of congestive heart failure and slowly deteriorating health, punctuated by occasional visits to the local hospital for acute episodes of respiratory distress. On this visit, unlike previous ones, she needed to be placed on a mechanical ventilator. She and her son (a doctor at the same hospital), daughter, and primary care physician were in agreement that the ventilator support should be considered temporary only. After her medical condition stabilized, the ICU staff attempted to wean Mrs. H from the ventilator, but these efforts, spread over a week, were repeatedly unsuccessful. After consulting with their mother, the son and daughter requested a meeting with the mother's primary care physician and the chief of the ICU. As the daughter explained at that meeting, it seemed clear to her, her brother, and the primary care physician that the mother was not going to be successfully weaned from the ventilator, in which case her clearly expressed desire was to return to the wards and to let nature take its course. But the ICU chief disagreed; in his view, weaning was still a realistic goal, with the consequence that the condition for discontinuing intubation had not yet been met. In response to this sharp rebuke from the ICU chief, the brother noted that the chief had a point and that it would be wrong for the family to intrude into the chief's medical judgment. After another couple of failed efforts to wean the mother, and in light of the ICU chief's refusal to release her short of completely satisfying the relevant physiological criteria, the primary care physician ordered an increase in tidal volume to promote oxygenation and decrease CO₂ retention. After several days of near weaning that generated ever increasing distress from the nursing staff, Mrs. H qualified for independent respiration and was released from the ICU for terminal care. Treated with oxygen and anxiolytics, she died peacefully within 48 hours, with her family around her.

The main story, told by the most powerful actor—the ICU chief—is that he was simply doing his job and following the highest medical standards, as the patient’s son, a doctor at the same hospital, himself finally acknowledged. But there are counterstories aplenty. In brief:

- *From the nurses.* The ICU chief is a hard-core technician, an old-school intensivist, who received his professional training before it came to be accepted that doctors and patients would collaborate in making decisions, who defines the primary goal of his work as saving lives, and who never bought into patients’ rights and the need to work with families, too, in determining appropriate treatment. His insistence that the patient satisfy standard weaning criteria was a form of denial, something that enabled the chief to avoid recognizing that his efforts to save the patient had failed. Instead, we had to deal with the hour-to-hour distress of the patient and family, with the chief checking in only a couple of times a day.
- *From the sister.* My brother has always been an opportunist and ultimately a coward. I had thought that he and I were on solid ground as we worked together—as a family—to ease our mother’s last years and months, and finally her death. But when push came to shove, my brother found himself at odds with the ICU chief, and instead of standing up for himself and his mother, he wimped out, needlessly prolonging our mother’s suffering and spreading distress everywhere else.
- *From the social worker.* I’ve known this family a long time but was never called in near the end, which was too bad. My sense is that the ICU chief got locked into a position where he found it impossible, at least psychologically, to back down. I think that I could have helped the family and the two doctors (the ICU chief and the patient’s son) find some sort of middle ground where the ICU chief could save face. I continue to be surprised at how much inequalities in power influence what happens in hospitals. It’s not just that doctors are the dominant professionals. They act as if they’re the *only* professionals.

What one sees here is that when anything has gone wrong in the care of a patient, there are almost always diverse perspectives, different stories and counterstories, that capture the forces at work in the situation. When seen together these different sets of perceptions, woven into

stories, provide a way of understanding what happened and why, and point to a way of moving forward so as to avoid the same sort of problem in the future.

FORMAL CLINICAL MODULES

In addition to the clinical opportunities discussed above, which build upon existing formats, establishing dedicated clinical modules for ethics is a potentially attractive option. As background for our discussion, we draw on the clinical modules that are used for teaching evidence-based clinical practice skills as developed by Per Olav Vandvik and colleagues at the University of Oslo Faculty of Medicine (Vandvik et al. 2013; Kongerud and Vandvik 2013). Such clinically integrated teaching in evidence-based clinical practice has been shown to be effective, for medical trainees, across the domains of knowledge, skills, attitudes, and behaviors (Coomarasamy and Khan 2004). Other structures have also been used for such modules. In a module that has much in common with what we describe in this section, students at Albany Medical College in New York “were assigned to write an essay about an episode on the rotation that taught them something about professionalism, and then later [met] with a preceptor in a small group to discuss their experience” (Dexter and Mann 2013, p. 422). Another type of module, quite different from what we describe in this section, is the Peer Experiential and Reciprocal Supervision model, which aims to promote self-awareness and reflective practice. This model requires paired clinicians (genetic counselors in the published study) to observe and comment on each other’s performance in actual sessions with patients/clients (Sexton et al. 2013).

We focus here on the approach used at the University of Oslo because it can be so easily adapted to a wide range of clinical contexts and problems. We present modules for clinical ethics, patient communication, and shared decision making. As noted in the preceding section, these modules could potentially be integrated into real-time clinical practice, under the supervision of senior clinicians, for further enhanced learning and impact on patient care.

Clinical Ethics Module

In the University of Oslo modules, which are incorporated into broader clinical rotations, students are asked to move through four steps—

(1) formulation of questions, (2) searching for relevant research evidence, (3) critical appraisal, and (4) application and evaluation of new knowledge in practice—and to memorialize those efforts through an online *work file* incorporating answers to each of these four questions (Vandvik et al. 2013; Kongerud and Vandvik 2013).

Since the goal of the above modules is to promote and assess each student's individual skills in evidence-based medicine, the students choose their own specific questions and then also proceed through the other three steps on their own. For an ethics module, it's not possible to justify decisions by consulting scientific evidence. Some other method needs to be used to generate an evidence base. Here's what we propose as a reasonable process for challenging students to develop these skills at ethical reasoning through formal clinical modules. Like the strictly evidence-based practice process, our suggested process has four steps, which we have tried to keep as close as possible to the ones used for medical decisions.

1. *Formulate a question.* The formulation of a clear, precise question is essential, as it is with the medical process. Just how to identify the questions to be used will be up to the specific training program (which could be in any field of health care, not just medicine). There is surely, too, going to be a learning curve here. The questions obviously need to be open-ended rather than calling for a yes/no or single determinate answer, but just how broad or narrow a question should be will need to be worked out with experience. The range of possible questions should be defined broadly and include matters of professionalism and the work culture (e.g., bullying, harassment, abuse of power/authority, limits of one's professional obligations).
2. *Informal ethical analysis.* On one's own, and consulting any sources deemed to be useful from sociology, history, and anthropology/psychology,² trainees should analyze the question in (1) as thoroughly as they can (within the range of time/effort allocated for preparation and for the presentation itself, and also in accordance with what the program or the module director considers "thorough").
3. *Critical appraisal: Presentation to group.* Each trainee should present, either orally or in writing, a summary of the informal ethical analysis above in an effort to solicit different perspectives, identify points of agreement and disagreement, and determine what points need further thought or clarification.

4. *Application and evaluation of new knowledge in practice.* Trainees each consolidate steps 2 and 3 to generate the final analysis of their own initial questions (which have potentially been sharpened or adjusted in response to those two steps), and they submit the analysis in writing to the module director (= the work file).

An easy way of understanding the above steps in relation to the original four steps (which were for medicine) is that the evidence base is, in effect, the informal ethical discourse of persons (in general) and health care trainees (in particular): step 2 helps trainees to gain access (which may be difficult at first) to their informal ethical reasoning regarding the particular question identified; step 3 puts that reasoning to probing examination; and step 4 provides the opportunity for each trainee to put everything together into a well-reasoned, and tested, analysis of the original question.

The four steps might seem daunting for trainees with little or no previous course work in ethics (either during their professional training or earlier), but the four steps merely demand that the trainees undertake, in a structured way, something that they do all the time—and that people are capable of doing earlier than one might think. An impressive example of just how early can be seen in the elegant, probing essay written by fourth graders from the Friends Seminary in New York City—ten-year-old students!—regarding the controversy over American football players kneeling, rather than standing, when the U.S. national anthem was being played. The essay, reproduced in a January 2018 *Washington Post* article (Strauss 2018), presents a remarkably balanced and thoughtful response to the controversy.

Patient Communication Module

In the ethics module the emphasis was on presenting an informal (versus formal) ethical analysis of a particular problem or question. The emphasis in patient communication is different in that there isn't a question to answer. Instead, there's a process to understand and potentially master. For those purposes, some adjustments to the ethics module are required. The first step, as we have formulated it, requires the availability of live (e.g., acted or role played, including videos) or written (e.g., drama, literature, or clinical vignettes) examples of communication with patients

or, let's add, families. For teaching purposes, these examples should generally involve problems of one kind or another that trainees need to be able to identify, analyze, and determine how to address.

This preliminary step will require some additional effort by the module's director, but once a set of examples has been prepared, they can be used again and again with each new batch of trainees. It's also worth noting, though, that rich, engaging examples, if using clinical vignettes, are not hard to come by; a group of seasoned professionals could likely generate a list of cases just by summoning up difficult cases from their past practice. Here are two clinical situations from the experience of the first author (SS):

A 60-year-old woman with advanced ovarian cancer was asked by a group of medical residents on morning work rounds whether she wanted to undergo surgery, already scheduled, to remove the visible tumors from her abdominal cavity. This surgery, if she survived the surgery itself and the immediate postoperative period, would give her a chance to live for several more months instead of days or possibly weeks without surgery. While expressing a vehement desire to leave the hospital and revisit a city in which she had had an especially pleasant time ten years previously (which she might be able to do if the surgery was successful), she also expressed a strong, unqualified opinion that she did not want to undergo surgery. The residents were outraged at what appeared to them to be the oncologist's blatant disregard of the patient's clearly expressed wishes. After being informed of the resident's concerns, the oncologist accompanied the residents back to the patient's room and proceeded to discuss the scheduled surgery with her. He explained the operation (and its risks) to her; asked her about what she wanted to do with her remaining days, weeks, or months; made sure that she realized that there was no guarantee whatsoever that she would leave the hospital again or be capable of making her trip; and assured her that he was quite willing to accept whatever option she chose. At that point, he asked her whether she wanted the surgery, and she expressed the same strong, unqualified opinion that she had given to the residents. But then the oncologist added one more piece of information that the residents had neglected: she would almost certainly die very soon, and in no more than a few weeks, without surgery. The patient then said, quite emphatically, "That's exactly why I want the surgery!!"

What we see in this first case is, in part, the inexperience of the residents. What they saw was a very sick, dying patient whose life was limited in time and scope, and who could scarcely be expected to have any

interests beyond her present circumstances. Instead, the patient was able to identify her own desires, acknowledge her strong, conflicting impulses (between avoiding surgery and extending her life), speak about them with clarity and even elegance, discuss her own death, and make a decision about what care, if any, she wanted. And it is also important to note that it was only the skills and patience of the oncologist that enabled the patient to obtain the particular care that she wanted. The less experienced, though equally concerned, residents were unable to present or elicit the full range of considerations that the patient deemed relevant to her decision.

The second vignette is as follows:

A cardiologist had scheduled a meeting with the available family members of a patient who, he wanted to inform them, was dying after a long series of medical and surgical interventions. The cardiologist, feeling uncomfortable with the situation, asked the first author to join the conference. When the family was assembled, the cardiologist went through a long series of past interventions and noted, in turn, that they had each worked for a time but were now, for one reason or another, no longer having the desired effect. As the cardiologist was going through what he had done and why, it was clear that the family were becoming more and more uncomfortable. The cardiologist ended by saying, "So, I don't know what else to do." The family, at that point, were quiet, obviously anxious, likely puzzled by the last comment, and literally sitting on their hands. The first author then asked the cardiologist if he (the first author) could say something, which was fine with the cardiologist. The first author then noted to the family that the cardiologist had not mentioned something important: their father was *dying*. Two things then happened: the family immediately relaxed, and the cardiologist sent the first author a remarkably dirty look, clearly communicating his view that something horrific had been said.

What we see in this case is a well-intentioned cardiologist who recognized the need to talk to the family, who understood that having the first author in attendance would be helpful and supportive, but who then couldn't quite get himself to say what needed to be said and then, even at the end, still found the outcome unsettling. We also see that the cardiologist's circumlocutions left the family confused and in discomfort, and that they were well able to understand and appreciate that even the efforts of this dedicated cardiologist could not, in the end, save the life of their father.

The number of cases (of whatever type/format) needed for the patient communication module will depend, of course, on various factors, to be decided by the clinical program, and it may be that different modules would be used in different years. It is also possible that the trainees could take some important role in designing the vignettes. Our overall idea, though, is that the module would run for four to twelve sessions, roughly once a month, with a different clinical case used each session.

Once the cases have been chosen, we suggest the following structure for the module:

1. *View or read the clinical situation selected for each session* (for trainees to do on their own).
2. *Background reading and analysis.* On their own, and consulting any sources deemed to be useful from sociology, history, and anthropology/psychology, trainees should analyze the clinical situation in (1) as thoroughly as they can (within the range of time/effort allocated for preparation and also in accordance with what the program considers “thorough”). At the discretion of the module director, a selection of relevant readings could be made available for trainees to consult. Just for a start, readings in this module could include, on the patient side, studies and analyses of the “sick role,” of how patients respond to illness of various kinds, of how being sick affects how patients communicate, and of how families respond to the illness of a family member. On the caregiver side, readings could include studies and analyses of the caregiver’s role, of how health professionals deal and communicate with very sick patients and their families, of how health professionals deal with patients who resist treatment, and of the nonverbal communication between health professionals and patients.
3. *Group discussion.* Trainees meet together to discuss their perceptions of the case, of what went wrong and why, and of how things could have been done better. If the clinical situation lends itself to counterstories, they should be presented/formulated and discussed. The module director (or whoever is leading the discussion) should also present minor variations on the facts of the case to give trainees an opportunity to work through exactly what they think and why. In this context, possible variations include factors that would be considered under cultural competence (extended) (see Chapter 9).

4. *Application and evaluation of new knowledge in practice.* Trainees each consolidate steps 2 and 3 to generate their final analysis of the clinical situation and its possible variations, and submit the analysis in writing to the module director (=the work file).

The rationale and steps here are very similar to the clinical ethics module. The main difference is that the ethics module presents an unfamiliar, potentially uncomfortable challenge: setting forth, in writing, a thorough, but informal, analysis of a particular ethical question or situation. There's real value in pinning down what one thinks and seeing how others react. By contrast, the patient communication module deals with much more familiar material. Leaving oneself open to, and seeing the situation from, a diversity of perspectives (and counterstories) is the fulcrum for learning.

Shared Decision Making Module

As noted in Chapter 9, shared decision making should be considered the central mode of decision making in health care. As such, it should have an important place in any series of formal clinical modules used in training programs.

In lieu of repeating ourselves, we suggest that the four-part structure of the patient communication module would also be appropriate here for shared decision making. Likewise, the clinical situation presented in that module of the 60-year-old woman with advanced ovarian cancer could also be used to explore the process of making decisions.

MENTORING

Mentoring is one of the most powerful and lasting modes of teaching, and with regard to the teaching of ethics, it is surely one of the most important. Mentoring is a form of personal contact that is different from any other form of teaching. Even when the mentoring occurs in a small group rather than one-to-one, a mentor's impact can be profound.³ And it is a form of teaching that is basically as good as the mentor himself or herself. For our purposes, a richly human mentor leaves one legacy through teaching, a narrowly focused mentor quite another. And universities do not necessarily reward only the former. Mentoring is, indeed, more or less irrelevant to career advancement within universities, including professional schools. Consequently, those in a position to be mentors are not necessarily well suited for that particular role.

That said, good mentoring is a gift to any student, and most trainees in health care can point to certain teachers who made an important difference for them. One example (from the first author's ongoing experience of fifteen years) comes from observing Shelly Greenfield, a professor at Harvard Medical School who is also the Editor of the *Harvard Review of Psychiatry*. As background, the journal's editorial staff includes roughly a dozen Assistant Editors who have been drawn from the medical school's training programs in psychiatry. At the journal's weekly editorial staff meetings, it is common for questions to arise that concern the ethics of publication, what can be reasonably expected (or not) of authors, what safeguards are needed to ensure the integrity (defined in several ways) of the journal's articles, what needs to be done to ensure that the Assistant Editors understand their work and have time to do it, and so on. What has always been so impressive, in the first author's experience, is how Professor Greenfield has, in such situations, always stopped any discussion of business as usual to discuss the ethical/publication matter at hand. If the issue has been addressed in the past, she explains to the Assistant Editors how and why the decision was made. If the issue is still open, she explains why things used to be handled in a certain way and why that way no longer works, and then she solicits, against that background, input and advice. What emerges from these discussions is a richer sense of the past and present, an understanding of the many facets of current policies, and, perhaps most importantly, an overarching sense of how to function both humanly and intellectually at one's highest level.

To take a step back from this example, what mentors can communicate, and literally give, to trainees is part of themselves. What they know, who they are, what they care about, how they feel—these are the gifts that mentors can provide. Importantly for our purposes, what they also have, as we saw above, is institutional knowledge, and in conveying that to trainees, mentors move them closer and more intimately into the institution itself, into the interpretive community. So, when senior health professionals realize that it wasn't always this way, or that certain questions need to be rethought, an opportunity for mentoring is at hand. It shouldn't be lost.

MAINTAINING THE SELF

At the end of Chapter 8, we mentioned the importance for trainees to maintain their well-being, mental and physical health, and sense of self-respect. We reiterate that point now but also mention that, especially because of the stresses involved in clinical training, some formal

interventions should be considered. In this context, and as one type of intervention oriented toward learning by doing, we mention the *Performing Medicine* program created by the Clod Ensemble, a UK theater company. In developing programs for professional training, *Performing Medicine* “uses methods found in the arts to develop skills essential to clinical practice and healthcare.” The range of skills is impressive: “non-verbal communication, self care, resilience, vocal clarity, leadership, teamwork, appreciation of diversity and difference, reflective practice, observation skills and anatomy.” What’s at stake in such interventions is of paramount importance for trainees: protecting and maintaining the self, both short and long term, not to mention better patient care and more awareness of the values and ethics of professional practice. And with its learning-by-doing approach to their material, *Performing Medicine* is able to deliver all this in a week (e.g., the program developed for medical trainees in their first clinical year takes the equivalent of seven days’ time, with seven weekly sessions).⁴ We can almost hear program directors saying that they would love to do such things, but where do you find the time. Our guess is that any time lost will easily be regained by the many efficiencies generated by better-adapted, more reflective, more self-aware trainees.

But we are just using *Performing Medicine* as an example—in two respects. First, programs in the arts, especially those that adopt a learning-by-doing approach, can do much to supplement and advance the approach to health care ethics that we are presenting in this book. Second, the conception of health care ethics that we have presented here is one that is intertwined with the self and with each health trainee’s and each health professional’s personal history, in all its facets. Learning by doing, especially in the ways that have been advanced by groups such as *Performing Medicine*, connects up directly with these personal phenomena.

For ethics teaching, the clinical setting has a unique position. In the move to the clinic from the classroom, trainees engage the real world, begin to have an actual stake in, and responsibility for, patient outcomes, and have the opportunity to interact with, and learn from, senior clinicians—some or even many of whom will have gained, through their own thought and experience, what we can call *ethical wisdom*. Altogether, the clinic is a setting in which health care’s various interpretive communities intersect; it provides a singular opportunity for trainees to observe, act, learn, and grow.

NOTES

1. A potential problem with using psychiatrists or psychologists is that the main phenomena to be examined are ethical, institutional, and various sorts of goal-directed and pragmatic reasons, as well as how those phenomena are interconnected with how people feel about, or respond to, particular clinical situations; the “why do you think/feel” questions would need to look mainly for such factors rather than the standard, more personal and idiosyncratic matters addressed in psychiatric/psychological encounters. A potential problem with using mediators is that they often are satisfied with consensus—the elimination of conflict—without trying to understand and sort out the underlying reasoning of the people involved. These underlying reasons are important, both individually and institutionally, for growth and stability.
2. Just what to do with materials from the bioethics literature is discussed in Chapter 11.
3. See Appendix 8.1, A Young Doctor’s Reflection.
4. For more information on *Performing Medicine*, readers can contact Bella Eacott, Research Manager, at admin@performingmedicine.com.

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CHAPTER 11

Empowering Clinicians

Abstract This chapter weaves together the various themes presented in earlier chapters: ethics and the self; informal versus formal ethical discourse; fast and slow thinking; the embeddedness of informal ethical discourse in the various interpretive communities of health care; the need to rely on, and use, informal ethical discourse in teaching health care ethics to trainees; and clinicians' need to rely on themselves and their colleagues in determining how to act ethically.

Keywords Health care • Clinical ethics • Implicit ethical framework
Informal ethical discourse • The self • Interpretive community
Morality of ordinary practice • Fast and slow thinking • Systems thinking

The central theme of this book is remarkably straightforward. Ethics starts with, and ends, with the self. Our informal ethical discourse, which emerges from our individual social experience and all its facets, is legitimate, powerful, and persuasive. It is the form of ethical discourse used by all but a tiny handful—perhaps several thousand, less than one in a million—of the earth's seven billion inhabitants. It is used daily, and exclusively, in business and in politics, as well as in private or personal interactions. It is our natural and first ethical language, and an effective and clear means of communication. It is sophisticated enough to address the most complicated problems that we face as individuals and groups

and citizens. And it is deeply embedded in our selves, in everything we do, and in every organization or group of which we are members—including all of our interpretive communities, both within and outside health care. As such, informal ethical discourse should be recognized and embraced as the proper language of clinical health care and of health care clinicians. The present book is, in effect, an elaboration of that simple theme.

For clinicians, the advantages of informal (versus formal) ethical discourse are many. First and foremost, it is our native language for ethics. We typically use it and apply it more or less automatically, as part of our fast thinking. We typically make judgments about our beliefs and actions, and about those of others, without any conscious process of reasoning. We immediately see most situations as fair or unfair, good or bad, mean-spirited or not; we respond to the world, in most cases, with straightforward ethical conclusions, and without even using explicitly ethical language. If asked, or when we find ourselves in a conflict or disagreement, or encounter a situation that puzzles us, we can make our reasoning explicit by engaging our slow thinking. But usually that's not necessary. To think that health professionals are somehow different, and that they need to think consciously and in terms of ethical principles or some other form of ethical theory, is to expect too much. For each of us, informal ethical discourse is a reflection of how we have come to think, over a lifetime, about the social world—including, for clinicians, health care—with all its complexities. In thinking (in informal ethical discourse) about the situations we encounter, we might judge that some situations violate rules ("he broke his promise") or principles ("what he did was really unfair"), that other situations have unacceptable consequences ("he just didn't realize that others would be hurt so badly"), and that still others reflect an absence of virtue, or good character ("if he had any sense of decency, he never could have done that"). These sorts of judgments come to us naturally, in the moment. And we slide seamlessly from one sort of judgment to another—from rules/principles to consequences to virtues—just as naturally, though without seeing ourselves as applying principles or weighing consequences or judging actions on the presence or absence of virtues. We are, in a way, natural philosophers when it comes to ethics. Our informal ethical discourse can be rich and probing and every bit as good as anything any philosopher or bioethicist would present—and without invoking philosophy or bioethics.

A philosopher or bioethicist might see this slide back and forth between rules/principles and consequences and virtues as a product of intellectual inconsistency, for these different frames of reference could be interpreted as reflecting three different theories from formal ethical discourse: principlism (or *deontological ethics*), consequentialism (or *utilitarianism*), and virtue ethics.¹ For philosophers and bioethicists, each of these different approaches—considered as formal ethical theories—excludes the others. There is no way of balancing one theory, or one set of considerations, against any of the others. From the perspective of informal ethics, however, the inability to balance such considerations is a *deficiency*; we engage, and see a need to engage, in such balancing all the time. Situations are different; they call for different ways of thinking; and ethical wisdom is the capacity to understand when one approach, one set of considerations, is needed, or needs to be emphasized, rather than another. In the process, informal ethical discourse inescapably takes into account both social context and local knowledge (Geertz 2000), which is precisely what formal ethical discourse—with its commitment to unified, abstract, all-inclusive theories—finds difficult to do.

Given the above, efforts to teach formal ethical discourse to clinicians are arguably misdirected. There is no reason to think that clinicians, unless they set themselves on the lengthy, academic path (e.g., through graduate work in philosophy) of becoming experts in ethics, will ever master the field of formal ethics. And there's no reason that they should. Their informal ethics, supplemented when necessary by discussions with colleagues and even by the occasional referral to an ethics committee or ethics consultant, is adequate—better than adequate—for addressing the challenges of clinical practice. Informal ethics is something that clinicians not only understand but take with them wherever they go. From the institutional setting of the hospital, at one extreme, to the independence (and isolation) of clinicians who practice solo, at the other, informal ethics is always available as part of the self and as embedded in one's interpretive community. To displace it with formal ethics is to displace what's known and always available with something that's much less well understood and that's ultimately available only through experts.

It would be wrong to infer, however, that clinicians can and should simply sort things out as they see fit and that they should act by their own lights. Most notable in this context is each clinician's respective interpretive community itself. Empathy, respect for persons and their

autonomy, attention to the interests and rights of patients and families, presumptive efforts to benefit patients and protect them from harm, cost efficiencies and savings, and all the other principles, values, and goals of bioethics are already embedded in the community's informal ethical discourse and in baseline rules for clinical management, in processes for dealing with patients and families, in the need to work collaboratively with other health professionals, and in methods of resolving conflicts when they arise. Responsible professional conduct requires attention to all of these matters, which are given central attention in health care training; they are not discretionary, though they are generally to be addressed in terms of informal, not formal, ethical discourse.

It may be helpful in this context to go back to what Stanley Fish saw as so central to interpretive communities.² Each member is an "embedded practitioner whose standards of judgment, canons of evidence, or normative measures are extensions" of the community itself (Fish 1989, p. 144), with its institutional practices defined by established "distinctions, categories of understanding, and stipulations of relevance and irrelevance" (p. 141). An interpretive community, so defined, allows for disagreement and for freedom of action, but both are constrained and channeled by the goals, values, and standards of the community itself. In health care's various interpretive communities, these goals, values, and standards all orient themselves around the care of patients.

This informal ethical discourse embedded in health care's various interpretive communities provides a thread of continuity and commonality among all health professionals, and it also provides them with a common language in communicating with both patients and other health professionals.³ In any particular society, the particular variations of informal ethical discourse embedded within health care's various interpretive communities will necessarily be ones that grew out of the local, informal ethical discourse that trainees bring with them into their professional training and that they then proceed to build upon and expand through their professional training in particular fields and subsequent clinical careers. Over time, the local varieties of informal ethical discourse within the different fields of health care evolve in response to new knowledge and new challenges. In this context one obvious advantage of that discourse is its flexibility and adaptability—its capacity for interpretation and reinterpretation. Over time, new, highly nuanced rules or behaviors can emerge and become entrenched in the practices of an interpretive community. In health care, where baseline knowledge is always growing and

modes of delivery are now evolving rapidly because of computerization and the Internet, this capacity for growth is especially important.

That said, informal ethical discourse is sometimes not enough. The problem at hand may resist closure or be so complex or novel that one doesn't know quite where to start, even after discussions with colleagues, senior or otherwise, and trusted friends. In such circumstances, the various dimensions of the bioethical presence in health care may prove to be valuable. Bioethicists (e.g., institutionally based consultants) may be able to bring new light to the situation by separating out and clarifying problems or interwoven threads. Ethics committees may do the same. Lawyers and administrators, whether institutionally based or otherwise available for consultation, may have the type of information that will simplify a problem or perhaps even determine the solution.

The tools of bioethics—in particular, the capacity to see problems from the more general perspective of ethical theory—are both a strength and a weakness, depending upon one's frame of reference. First, the strength. Informal ethics, unless pursued with considerable energy and intelligence, may sometimes fall short, especially in relation to what one might call the major "issues of the day," including genetic engineering, cloning, disputes over the possession and disposal of frozen embryos, and so on. In this context bioethicists, as well as philosophers and theologians, might well be seen as having a special capacity to advance public discussion and understanding. Such contributions are of fundamental importance to the life of a nation. That said, closure—no matter how intense the discussion or how rich the insight—is likely to remain elusive and will ultimately be decided by courts, legislatures, or some other sort of deliberative body (including, perhaps, a country's own electorate).

Second, the potential weakness. Looking at ethics expertise from the perspective of teaching health care trainees and, more broadly, informing and educating practicing clinicians, the value to health professionals of formal bioethical discourse is an open question. We have presented the view that each field of health care is a separate interpretive community with its own standards, goals, and values of various kinds. By the same token, each of these interpretive communities embodies, as it were, the informal ethical discourse of that very community. Ethical standards and values are embedded in the thoughts, emotions, and actions of the community's own members. Persons trained in philosophy or bioethics may or may not be able to work, as they must on this view of clinical ethics, from the "inside." Except in unusual

situations, and certainly not day to day, formal ethical discourse does little to elaborate or illuminate the embedded standards, values, and goals of health care's various interpretive communities. If a philosopher or bioethicist can work using the Socratic method and translate his or her own knowledge into informal ethical discourse and into a form that is internal to the particular interpretive community—then that's good. If not, professional schools need to look elsewhere and perhaps train their own members to do that kind of work (perhaps even with the help of philosophers or bioethicists).

By the same token, the bioethics literature itself will not necessarily be helpful to clinicians. If clinicians are interested in particular ethical problems that have been addressed in the literature, reading articles or books or reports may prove valuable, or it may not. The judge of that is each individual clinician. If the articles or books prove helpful and serve to inform a clinician's informal ethical thinking, then that's all well and good. But if the material isn't helpful (e.g., because it is too abstract, couched in unfamiliar language, or not sufficiently connected to the clinician's concerns), then the clinician should just move on. On the approach presented in this book, the clinician and clinical practice—and more generally, the standards of the respective interpretive communities—are the parameters for judging relevance and usefulness. We are confident that clinicians can make those judgments themselves.

Through all of the above discussion—and, implicitly, throughout this book—the constant thread is that the formal ethical discourse of bioethicists and the informal ethical discourse of clinicians operate, from a systems perspective, on different levels of complexity (Bateson 2000; Capra 1997; Checkland 1981). For situations that resist consensus or that raise significant, complex issues of ethics or public policy, the formal tools of bioethical discourse may well prove useful. For a flexible, workable approach to the ethical challenges, small and large, of day-to-day clinical practice, informal ethical discourse is sufficient and, indeed, preferable (Scher and Kozłowska 2011). What has been, and remains, unfortunate is that one domain has come so much to dominate the other over the history of the bioethics movement, and that the informal ethical discourse of health care trainees and clinicians has come to be considered not good enough. We think it is time to restore the balance.

NOTES

1. The *Stanford Encyclopedia of Philosophy*'s entry on virtue ethics (2016) provides a succinct comparison of these three theoretical approaches to ethics. Virtue ethics may, initially, be identified as the [theoretical approach] that emphasizes the virtues, or moral character, in contrast to the approach that emphasizes duties or rules (deontology) or that emphasizes the consequences of actions (consequentialism). Suppose it is obvious that someone in need should be helped. A utilitarian will point to the fact that the consequences of doing so will maximize well-being, a deontologist to the fact that, in doing so the agent will be acting in accordance with a moral rule such as "Do unto others as you would be done by" and a virtue ethicist to the fact that helping the person would be charitable or benevolent.
2. For more on Fish and interpretive communities, see Chapter 7.
3. As Merrilyn Walton and Ian Kerridge note in "Do No Harm: Is It Time to Rethink the Hippocratic Oath?" (2014, p. 20), effective communication in today's world of health care is itself a patient-safety issue:
For a patient to benefit from his or her health care, health professionals must be both technically competent and able to effectively communicate with their patient, the patient's carers and with one another. This idea that a patient's care relates to the capacity of other health practitioners to communicate efficiently, accurately and in a timely manner in all their communications is central to understanding health care as a system.

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INDEX

A

American Medical Association, 19, 20
Applied ethics, 37–39
Association of American Medical
Colleges (AAMC), 117–120,
132–134
Autonomy, 3–6, 20, 39, 42, 46, 47,
95, 96, 117, 159, 160. *See also*
Bioethical principles; Principlism

B

Beauchamp, Thomas, 14, 47–49
Beecher, Henry, 31, 32, 35, 39
Belkin, Gary, 4, 99
Bioethical principles, 2–6, 17, 20, 21,
24, 29, 39–41, 45–54, 55, 59–62,
157–162
Bioethics
distinguished from moral philoso-
phy, 37–40, 52–54, 74–76
history of, 31–41, 45–47
Brandt, Allan, 4, 55, 99
Brody, Howard, 132
Bullying, 106–111, 115, 125, 145

Burnout, 108, 110, 116, 117

C

Callahan, Daniel, 5, 99
Carrieri, Daniele, 109, 116, 117
Charon, Rita, 132
Childress, James, 14, 47–49
Clod Ensemble, 152
Closure, 22–24, 49–54, 57–69, 89,
102, 124, 161
Code of Medical Ethics (American
Medical Association), 19, 20
Collaborative problem solving, 85–88
Consumer rights, 14, 15, 35–39
Counterstories, 126–130, 143, 144,
149, 150
Cultural competence (extended),
117–121, 132–134, 149

D

Decision making, principled, 5, 6,
47–49, 54
Delgado, Richard, 127–129

Depression, 22–24, 116, 117
 Discussion, selecting topics for,
 98–100, 103–105, 125–129,
 139–152. *See also* Touchstones for
 learning

E

Empowering clinicians, 157–162
 Ethical discourse, informal
 as element of interpretive commu-
 nity, 88–93
 clinical teaching and, 139–152
 collaborative problem solving and,
 85–88
 defined, 74–80
 distinguished from formal ethical
 discourse, 47, 74–80
 empowering clinicians and, 157–162
 formal teaching curriculum and,
 113–131
 framework for teaching clinical eth-
 ics and, 95–109
 strategic flexibility and, 83. *See also*
 Vignettes
 Ethical frameworks, implicit, 71–73
 as extended through professional
 training, 95–109
 clinical teaching and, 139–152
 formal teaching curriculum and,
 113–131
 in interpretive community, 88–93
 teaching clinical ethics and, 95–109
 the self and, 71–80. *See also*
 Vignettes
 Ethics anxiety, 24–27
 European bioethics, 39–41
 Experts and expertise
 ethical, 16–28, 48–54, 67–69
 health care, 52–54, 90–93
 legal and judicial, 62–69. *See also*
 Thinking, fast and slow

F

Feelings and ethical experience, 2–6,
 16, 17, 71–80, 103–111. *See also*
 Touchstones for learning
 First, do no harm, 48–52
 Fish, Stanley, 89–91, 160
 Flexner, Abraham, 34, 35
 Formal ethical discourse. *See* Ethical
 discourse, informal
 Forum theater, 130
 Fox, Renée, 3, 4, 99
 Friends Seminary (New York City),
 146

G

Georgetown mantra, 39, 40
Grace Under Pressure, 106, 125–130
 Grady, Christine, 122, 123
 Greenfield, Shelly, 151

H

Hansen, Helena, 120, 121, 131
 Harvard Medical School, 16–19, 28,
 32, 55, 97, 151
Harvard Review of Psychiatry, 151
 Hastings Center, 5, 14, 15, 32, 33,
 38, 45, 47
 Hirschman, A. O., 108, 129

I

Implicit ethical framework. *See* Ethical
 frameworks, implicit
 Informal ethical discourse. *See* Ethical
 discourse, informal
 Informed consent, 18, 20–24, 35–37,
 45–47, 121–124, 147–150
 International Association of Bioethics, 38
 Interpretive communities
 clinical teaching and, 139–152

defined, 88–90
empowering clinicians in, 157–162
formal teaching curriculum and, 113–131
framework for teaching clinical ethics and, 95–109
in health care, 90–93

J

Jahr, Fritz, 39, 40, 42
Judicial appeals process, 61–67

K

Kahneman, Daniel, 76–79. *See also* Thinking, fast and slow
Kass, Leon, 4
Katz, Jay, 54
Kennedy Institute of Ethics, 32, 33, 38, 45
Kennedy, John F., 35–37, 46
Kerridge, Ian, 47–49, 59–62, 67–69, 80, 163
Klein, Gary, 76, 77
Kleinman, Arthur, 4, 5, 88, 99

L

Legal regulation of health care, 6, 15–21, 24–27. *See also* Informed consent
Leotsakos, Agnès, 10
Limitations
of bioethics (a personal history), 13–28
scope of book, 6
Löther, Rolf, 39

M

Martin, Jean, 41
Mental health, 109–111, 116, 117, 125, 151, 152

Mentoring, 110, 111, 150, 151
Metzl, Jonathan, 120, 121, 131
Montello, Martha, 132
Montori, Victor, 93, 131
Multistep processes, 59–69, 80
Muzur, Amir, 39, 40, 42

N

Nader, Ralph, 36–39, 46
Narrative ethics, 126–131
New England Journal of Medicine, 32, 39
Nie, Jing-Bao, 9
Nonmaleficence, 48, 49, 54, 55, 96. *See also* Bioethical principles

O

Observational and participatory activities, 129–131
Ordinary practice, morality of, 4, 97–103, 114

P

Patient communication, 121–124, 146–152
Patient rights, 35–41, 45–47, 49–52, 58–62
history of, 31–41, 45–54
Patient safety, 6, 10, 36, 39, 163
Performing Medicine, 152, 153
Power and authority, problems of, 107–111, 125–131
President’s Commission for the Study of Ethical Problems in Medicine, 47
Primum non nocere, 48
Principles of Biomedical Ethics, 14, 15, 47–49

Principlism

- criticisms of, 3–6
- defined, 2
- integration into Universal Declaration on Bioethics and Human Rights, 40, 41
- reception in Europe, 39, 40. *See also* Bioethical principles

R

- Rawls, John, 37, 38, 75, 76
- Reflection and discussion, space for, 4, 22–24, 98, 99, 105–109, 110, 111, 125, 151, 152
- Reflective practice, 103–109, 140–144, 151, 152
- Rothman, David, 42

S

- Salgo v. Leland Stanford, Jr., University Board of Trustees, 35, 46
- Scientific medicine, rise of, 33–35
- Self, The
 - clinical teaching and, 139–152
 - empowering through informal ethical discourse, 157–162
 - ethics and, 71–80
 - formal teaching curriculum and, 113–131
 - framework for teaching clinical ethics and, 95–109
 - in an interpretive community, 83–93
 - need to maintain and protect, 107–109, 151, 152. *See also* Bullying; Burnout; Depression; Sexual harassment; Suicide
- Self-doubt, ethical, 21–27
- Sexual harassment, 106, 107, 115, 125, 130, 145

- Shared decision making, 121–124, 131, 141, 144, 150
- Simon, Herbert, 77
- Social Controls and the Medical Profession, 13–15, 29
- Social sciences
 - critiques of bioethics, 3–6, 9
 - value and use in teaching clinical ethics, 95–103, 113–134, 144–150
- Social Transformation of American Medicine*, 14, 15, 41, 42
- Solidarity, 41, 42
- Starr, Paul, 14, 15, 39, 41, 42
- Strategic flexibility, 73, 74, 80, 83–85, 90–93
- Structural competency, 120, 121, 131
- Suicide, 116, 117, 125
- Swazey, Judith, 4
- Systems thinking, 75, 115, 162

T

- Tarasoff v. Regents of the University of California*, 69
- Teaching clinical ethics
 - general framework, 95–109
 - in a clinical setting, 139–152
 - in the formal curriculum, 113–131
 - Socratic approach, 16, 17, 106, 161
- A Theory of Justice*, 37, 75
- Thinking, fast and slow
 - defined, 76–80
 - interpretive communities, 90, 91
 - incorporation of new viewpoints, 107, 116, 140, 158
 - strategic flexibility, 83–85
- Touchstones for learning, 103–109, 124–131, 140, 141. *See also* Feelings and ethical experience
- Turner, Leigh, 9

U

United Nations Educational, Scientific
and Cultural Organization, [40](#), [41](#)
Universal Declaration on Bioethics and
Human Rights, [40](#), [41](#), [47](#), [54](#)
Unsafe at Any Speed, [36–39](#)

V

Vandvik, Per Olav, [144](#), [145](#)
Veatch, Robert, [51](#), [52](#)
Vignettes
 cardiologist who couldn't quite talk
 about death, [148](#)
 collaborative problem solving,
 [85–88](#)
 contaminated apartment, [125](#), [126](#),
 [128](#), [129](#)
 dying patient trapped in the ICU,
 [142–144](#)

 ethical confusion, [22–24](#)
 ethics anxiety, [24–27](#)
 forgoing artificial nutrition, [91](#), [92](#)
 indigenous boy in foster care, [102](#),
 [103](#)
 morbidly obese, developmentally
 delayed boy, [57–65](#)
 ovarian cancer patient who wanted
 surgery, [147](#), [148](#)
 patient who had no money, [49–52](#)
 stockbroker with treatment-resistant
 AIDS, [100](#), [101](#)
 strategic flexibility, [83–85](#)
Virtue ethics, [92](#), [93](#), [158–160](#), [163](#)

W

Walton, Marilyn, [163](#)
Wear, Delese, [108](#), [109](#)
Work files, [144–150](#)