INTRODUCTION

The practice of clinical ethics consultation seems perpetually to be either celebrating its success or attempting to justify its existence. Under siege in the 1980s as a pseudo-profession of bioethical interlopers and self-proclaimed “moral experts,” the field responded with careful counterattacks and restatements of its goals. More recently, in the face of strident attacks in the popular press and cautious critiques in academic journals, some authorities have warned that clinical ethics is at a crucial crossroads, torn by increasing pressures to adopt uniform methodologies, endorse standards of practice, and credential practitioners, or face academic marginalization and increasing skepticism. Others lament the erosion of serious attention to the role of moral theory in clinical ethics.

Behind these ongoing controversies lie persisting questions. Why are ethics consultations morally legitimate? Is an ethics consult like an ordinary medical consult, reflecting command of a specialized body of knowledge? If not, how can ethics consultation usefully contribute in the clinical setting? One of the most influential statements concerning the goals and aims of clinical ethics consultation to emerge from North America in recent years is a report published by the American Society for Bioethics and Humanities and its predecessor organizations, Core Competencies for Health Care Ethics Consultation. The Core Competencies endorses a methodology for healthcare ethics consultation that it calls the model of “ethics facilitation,” the overarching aim of which is “facilitating the building of consensus among the involved parties” within “a range of morally acceptable options.”

This article uses a case that came before the ethics committee of a hospital in my community as a lens through which to view the basic elements of the standards for healthcare ethics consultation in the Core Competencies. The case turned upon a conflict between an obtunded patient’s family and her physician regarding whether she should be aggressively managed subsequent to a stroke. I suggest that the ethics committee intervention in this case failed on several levels, but that its failure nevertheless provides an occasion to consider what it would have meant for it to succeed in the ways the Core Competencies identifies. My aim here is to use this case as a vehicle for illustrating some potential problems with the standards described in the Core Competencies as a workable methodology for healthcare ethics consultation in the clinical setting and to suggest a strategy for surmounting those issues consistent with the larger aims described in the Core Competencies.
CONSENSUS AND LEGITIMACY

Conflicts in the clinical setting over how best to care for the seriously ill are common and reflect both the continuing development of biomedical technology as well as the clash of widely divergent views regarding how best to use such tools. Complex decisions — whether to continue the use of a ventilator to support respiration or to discontinue hemodialysis in patients with end-stage renal failure, whether to move a patient to “comfort care,” or how best to interpret an advance healthcare directive — are a familiar part of the terrain in every healthcare institution, and frequently pit patients or their surrogates against each other or their physicians and nurses. Plainly, some mechanism for addressing these conflicts is called for, a fact recognized by both regulatory bodies (such as the Centers for Medicare and Medicaid Services) and accrediting agencies (such as the Joint Commission on the Accreditation of Healthcare Organizations — JCAHO).

Abstractly considered, there are a number of ways to manage conflicts regarding the appropriate course of care for a patient in a healthcare facility, although in practice nearly all organizations have adopted a similar set of strategies. For example, an institution might have as its policy that whenever disagreements arise between a patient’s family and the attending physician, the physician’s decision is to prevail. Alternatively, the presumption might be that the wishes of the patient (or surrogate) are always to be followed. Arguably the first of these strategies was the de facto presumption for much of the history of modern medicine, during which the strongly paternalistic role of healthcare professionals went largely unquestioned. But modern medical jurisprudence has largely overturned that model, acknowledging the fundamental right of individuals to manage their care in ways previously thought to be the sole prerogative of healthcare professionals. At the same time, physicians in many jurisdictions are barred from acceding to just any request from a patient (for instance, a plea for active euthanasia), and professional codes of ethics hold that physicians are not bound to deliver care that they deem to be futile or in some other way medically inappropriate.

Rather than rely upon such inflexible and unworkable presumptions to manage conflict, healthcare organizations have almost uniformly adopted a model of ethics consultation — interventions conducted by an institutional committee or service, or by an individual consultant. According to the Core Competencies, healthcare ethics consultation is to aim at bringing about a consensus “among all involved parties” described by a range of “morally acceptable options within the context” of a particular clinical case. Healthcare ethics consultants are to assist in “the building of morally acceptable shared commitments” bounded by “societal values, law, and institutional policy.” This preferred account of healthcare ethics consultation, which the Core Competencies calls “ethics facilitation,” is contrasted with two other accounts, both of which the Core Competencies rejects.

An impermissibly “authoritarian” theory of ethics consultation commits the error of “misplacing decision-making authority,” as happens when (say) those conducting the consultation insist that a competent and well-informed refusal of treatment by an adult patient simply be overridden because the consultant concludes that the patient’s substantive moral or religious views are false or silly. Here the moral values of the ethics consultant are illicitly allowed to trump those of the “appropriate decision maker.” Equally erroneous, in the view of the authors of the Core Competencies, is a model of “pure facilitation,” in which the only goal is to forge consensus simpliciter. Missing from this model is the idea that ethics consultations must be constrained by, for example, the basic rights of the patient. Thus a consensus decision by the involved parties to permit a procedure previously specifically refused by the patient constitutes “a violation of the patient’s right of medical self-determination.” The remedy for these shortcomings in ethics consultation is the process of ethics facilitation, whereby conflict is managed by seeking consensus in a way that respects certain basic values — for instance, that individuals “do not give up their rights to live by their own moral values” and “those rights set boundaries that must be respected in ethics consultation.”

Three brief points should be made here. First, there is a growing literature about the role of consensus in moral reasoning generally and the relationship between consensus on a moral judgment and the judgment’s moral correctness or truth. These issues are both deep and perplexing, and not ones I shall try to tackle
directly here. Second, and more importantly for present purposes, the endorsement of the idea of consensus presented in the *Core Competencies* does not spring from an engagement with these meta-ethical concerns; rather, the impetus for the *Core Competencies* is decidedly more practical — a self-conscious effort to develop standards of practice for a fledgling profession of clinical ethics consultants. Finally, the *Core Competencies* acknowledges the stumbling blocks to consensus posed by a plurality of diverse viewpoints: “It is easy to see how value uncertainties or even conflict can arise in this pluralistic context.” The standards included in the *Core Competencies* may be read as a guarded attempt to answer skeptical critics who disparage the legitimacy of ethics consultation, worried that it cannot be expected to work when patients, families, and professionals hold widely divergent conceptions of what is of value in human life. The *Core Competencies* tries to delimit a methodology acknowledging this plurality while still carving out a legitimate role for ethics consultation, assigning to it the essentially political task of promoting a procedure through which common ground can be identified as the basis for a resolution acceptable to all.

What is distinctive about the notion of a facilitated consensus is that it is fundamentally a *constrained* consensus: the collective reflection and deliberation that constitute the ethics consultation process are to be guided along particular dimensions and conducted in a way that rules out appeal to certain kinds of considerations and reasons. What might these constraints be expected to accomplish? At least two answers suggest themselves: (1) The constraining factors will focus deliberations so as to make it more likely that a *decision* will be reached; (2) Such factors will constrain deliberations in a way that makes it more likely that a *certain kind of decision* is reached, namely, the morally correct one. The first account says that the purpose of facilitating a consensus is fulfilled just in so far as some decision or other is arrived at; the second account more ambitiously assumes some metric of “rightness” independent of whatever the outcome of the consultative deliberations turns out to be. There are deep metaphysical waters to plumb here, but doing so is not necessary for our purposes. For it is clear that the view presented in the *Core Competencies* is the first of those just framed. The constraints are not in place to ensure that an agreement reached consistent with them is independently morally true or right (whatever that might mean), but only that an agreement is arrived at in a way consistent with a broader context of legal requirements and institutional and community expectations. In such context, as Jonathan Moreno notes, it is pointless to ask “whether a societal consensus is morally right as well as politically acceptable.”

It is important to understand how this idea of a constrained consensus is supposed to clarify moral uncertainties and resolve value conflicts at the bedside. The key lies in recognizing that the possibility, as well as the legitimacy, of a consensus depends upon the way in which it is developed. As others have observed, the process of reaching a consensus view or outcome, regardless of the particular topic, presupposes an agreed-upon initial set of conditions or givens from which further, more detailed claims or judgments may be agreed to. In this way, deliberative inquiry “proceeds from an initial consensus to a final one.” The consensus view is only legitimate if the initial conditions are themselves widely shared (or at least shared among the members of the community served by the institutions and organizations in which the effort to reach consensus takes place). Deliberation occurring against this given background of substantive agreement confers the only kind of moral authority possible when people have differing views: “the state is not permitted to authorize a particularized moral consensus. Individuals, however, are free to join together to endorse particular principles, even though the reasons they give for doing so may differ.” The initial background set of beliefs from which people reason constitutes what John Rawls called an “overlapping consensus” — the intersection of divergent sets of belief that can be taken as a practical starting point to shape and structure more specific discussions. As we shall see more fully below, the constraints within which a facilitated consensus is supposed to be developed through ethics consultation in a hospital purport to be the framework of just such an overlapping consensus. Exactly what the building blocks of that framework are supposed to be, and whether they are up to the job, is a problem to which I return shortly.
THE CASE OF MRS. B

In order to test the meaning and import of the standards for clinical ethics consultation described in the Core Competencies, consider a particular case on which I was recently asked to consult. The case involved a 70-year-old woman, whom I shall call “Mrs. B.” Mrs. B was admitted to the hospital due to chest pain and nausea. The patient had a history of hypertension, but in the past had not been fully compliant with her medications. Upon admission Mrs. B underwent a cardiac catheterization procedure and, on the following day, the insertion of an intra-aortic balloon pump. She was diagnosed with severe coronary artery disease and underwent coronary artery bypass graft (CABG x6). The surgery went well; however, subsequently, as her sedation level was decreased, it was discovered that Mrs. B had suffered a stroke. A computed tomography (CT) scan of the head, which revealed evidence suggestive of a brain-stem infarct, confirmed this. At this time, Mrs. B was responsive only to pain and failed to follow commands; two days later, her physician noted that she was awake and tracking with her eyes, but otherwise not responsive. Due to respiratory insufficiency postoperatively, the patient had been placed on a ventilator and was being fed through a nasogastric tube.

The attending physician, a cardiologist, spoke with the patient’s family soon after the stroke had been detected. It was here that a deep division of views became apparent. The physician insisted that Mrs. B had “excellent rehabilitation potential” and he expressed this judgment to the family adding that, in his opinion, the support and encouragement of the family would be crucial in determining the length and pace of her recovery. He further advised that a tracheostomy and the surgical placement of a feeding tube be arranged as soon as possible so as to maximize Mrs. B’s ability to strengthen and rally after the surgery, and to expedite eventual weaning from the respirator. These interventions, he believed, would not be permanent, although he did expect that, at a minimum, Mrs. B would be left with long-term moderate impairments due to stroke, including blurred vision and inability to ambulate without the assistance of a walker.

Much to his surprise and dismay, the family responded to the physician’s advice by insisting that Mrs. B would never have consented to surgery for a permanent airway or for G-tube feedings; they furthermore maintained that she would not have accepted intubation for more than one or two days postoperatively, and that she had consented to the CABG procedure only with that understanding. They demanded that the ventilator be disconnected, tube feedings be discontinued, and a “do not resuscitate” (DNR) order be written. In the opinion of the physician, these steps, had they been undertaken at that point, would have resulted in Mrs. B’s death.

The physician felt completely undermined in his efforts to help the patient by what he viewed as the family’s inappropriate requests. He remained convinced that Mrs. B had understood the possibility that she might need some form of respiratory support in the immediate postoperative period and that she had consented to the surgery with that understanding. The occurrence of the stroke served merely to extend that need. Thus, the invasive procedures required to assist her breathing and to provide her with nutrition were consistent with the “spirit” of her decision to undergo the heart surgery, even if not explicitly authorized by her. In the view of the family, however, the clinical situation had changed postoperatively in a way that they insisted would have been of tremendous significance to the patient. Instead of rapid improvement with minimal if any respiratory assistance, Mrs. B now faced a long course of rehabilitation with the aid of interventions she would have refused adamantly.

Although her level of cognitive awareness improved slightly, Mrs. B was not able to communicate her wishes with any clarity to the staff or the physician. The day prior to the ethics committee meeting, when the physician asked her about a feeding tube and a tracheostomy, she reportedly responded with only a shift of position in bed.

At the suggestion of hospital staff, the attending physician agreed to an ethics consultation, during which the clinical picture and the substance of his position was conveyed to me. The physician was taken aback by the family’s refusal to agree with his plan, and he would avoid confronting them again for several days. Later that same afternoon, I met with members of Mrs. B’s family: a daughter and a son, together with their respective spouses, both of whom had known Mrs. B for many years. All were candid and articulate in their expression of what they took to be the patient’s beliefs and wishes regarding medical treatment. A picture emerged of an active and independent woman who, even at age 70, had been working full-time up to the day of her admission. Mrs. B had been for many years the manager of a local grocery store, and had recently moved to an office position in the facilities division of a nearby airport. Although she had moved in with her adult daughter six months ago, Mrs. B maintained separate quarters with a private entry and insisted upon being as self-sufficient as possible. While she had not executed an advance directive, the patient’s daughter recounted...
a number of conversations with her mother concerning invasive, life-sustaining treatments. As it turned out, the occasion for many of these discussions had been Mrs. B’s own brother, who had several years earlier suffered a major stroke that had left him extremely debilitated. Although the brother’s chances for recovery had initially been described as good, he quickly deteriorated and was kept alive for close to two years on artificial feedings. According to the daughter, Mrs. B repeatedly stated that she would never want to be maintained in such a state and abhorred the fate that befell her sibling. “Don’t let that be me,” she was reported to have stated on at least one occasion. All of the family members present that afternoon were united in these convictions regarding Mrs. B’s views.

Having listened to the family’s position, I recommended that we arrange for them to meet with the physician and the ethics committee to address the issues of code status, the physician’s recommendation for further surgery, and the family’s request for extubation. Hasty arrangements were made for a meeting on a Friday, only to have the physician cancel due to a last-minute schedule conflict. The meeting was thus held on the following Monday, by which time Mrs. B had been in the intensive care unit (ICU) for more than a week. The committee chair, a physician, called the meeting to order and asked first the social worker and then the attending physician to review the case. Only later was the family invited to join the group. The family members present, including the patient’s daughter — the most outspoken among them — were noticeably agitated. After perfunctory introductions and brief remarks from several of the family members, the daughter read from a prepared text, at once impassioned, tearful, and resigned. “Mom would never have agreed to a tracheostomy or PEG tube under these circumstances, nor to the indignity of a prolonged convalescence and a life hobbled by walkers and limited vision. I can’t bear to see her like this. But it’s too late now,” she concluded. “You’ve taken over and made the decisions. Don’t ask me to consent to anything. Just leave us out of it. Do whatever you want to, but don’t ask us to be involved.” Moved by the statement, the room was momentarily quiet. I asked if the family had seen the patient that morning. They had not. The chair asked if the other family members present wished to add anything to the statement just made. None did. With startling abruptness, the family rose and left the room. The chair did not attempt to stop them. The meeting was over. A conversation then ensued among the physicians and other committee members remaining in the room. Would any of the physicians have respected the family’s expression of the patient’s wishes and withheld life-sustaining technology? None would have done so. Was the patient’s postoperative care managed appropriately? Yes. “Maybe this woman would not have wanted to live this way,” someone remarked, “but that’s not our problem.” A tragic circumstance had befallen Mrs. B, seemed to be the prevailing opinion, but not as a consequence of anything for which the physician or hospital might have to answer morally.

I pointed out that if the family were correct, an argument certainly could be made that further surgery would be in contravention of the patient’s considered views. Plainly, the family believed that to be the case; yet the daughter’s admission that she “couldn’t stand” to see her mother in such a debilitated state raised a concern among several committee members that the refusal of the trach and PEG was motivated by an inability to acknowledge Mrs. B’s new circumstances and prognosis, with all that it might mean for the family, financially and emotionally. The discussion paused over this point. Doubtless, the family was struggling. Yet plainly it is unreasonable (and perhaps unwise) to ask that surrogates always come to their decision-making role purged of any concerns for how their decisions might affect themselves, as well as the patient. Still, some committee members may have harbored a suspicion that the family was neglecting Mrs. B’s well-being. Arguing against this, in my view, was the evidence the family purported to possess. The episode with her brother had left its impact, for example, as one family member made clear by relating one of Mrs. B’s specific comments: “Please leave me and close the door if you find that I have had a stroke.” Her son had noted in my initial meeting with the family that Mrs. B regarded her “very elderly” and frail acquaintances with a mixture of pity and dread, hating the prospect of encroaching debility. Finally, both the son and the daughter explained that they had conversed with Mrs. B prior to the heart surgery and each had the impression that their mom had to be “talked into the surgery” (although obviously not by them).

To all of this, Mrs. B’s physician countered that the kinds of measures he believed were now indicated had been anticipated preoperatively and consented to by Mrs. B, thus supplanting, at least for those purposes, whatever earlier remarks she had made. The only source of information regarding the consent process came from the doctor himself. He said he had explained the risks and benefits of the procedure to Mrs. B, and believed her consent reflected her optimism that the odds would be in her favor, that the surgery would go well, and that she could then continue her life more or less as it had been. He felt she viewed the possibility of postoperative supportive interventions as just one more potential stop
in the recuperative process. But the doctor's confidence that Mrs. B would have retained a willingness to endure intubation and the rest despite the long-term limitations in functioning that she would now very likely confront seems to have stemmed, not so much from her own testimony, as from the (unarticulated) assumption that no one would consent to such surgery and then decline subsequent treatment necessitated by that intervention, especially where those procedures would likely be temporary. (When, in the meeting, the physician was pushed on what “temporary” might mean, he replied “six months or less, although I can’t be certain.”)

The ethics committee meeting ended with a conversation about strategy. "How can we treat the patient if the family refuses to consent or even to come to the hospital?" Several moments of ensuing discussion resulted in an agreement that the hospital should encourage the family to acquiesce in the appointment of a conservator for the patient. “Of course, that will smooth things out,” added the attorney on the committee, “since we all know that court-appointed conservators almost never agree to limitation of aggressive interventions.” A conservator would surely support the physician’s plan. The hospital risk manager (a member of the committee) wanted to know how we could “salvage the relationship” with Mrs. B’s family, presumably with the goal of forestalling a lawsuit. It was suggested that since I had established some degree of rapport with this family, I should be part of such efforts. I determined not to support the decision to cajole or pressure the family into accepting a conservator, given what amounted to a hidden agenda on the part of the risk manager. Nor did I agree to participate in the “salvaging” operation, since it appeared that this would amount to a self-interested attempt by the hospital to show the family how much the organization cared, while yet seeking to convince them that the physician’s plan was the only allowable path.

FACILITATED CONSENSUS

Perhaps enough information has been given to indicate that this ethics committee intervention was a failure, and on several levels. Starting with stipulation made in the Core Competencies that consensus minimally involve an agreement among all involved parties, it is obvious there was here neither consensus as to what would be the most appropriate treatment for Mrs. B, nor upon who had the right to decide that question. No real effort was made to conduct a meaningful dialogue among the involved parties, and inappropriate concerns and motivations seem to have marred what discussion did take place. But suppose these problems had been avoided and an effort conscientiously made to guide the committee’s consultation according to the standards articulated in the Core Competencies. What sort of consensus might have been expected to emerge?

As the Core Competencies notes, it might be thought necessary, for something to “count” as a consensus view, that it represent unanimity of opinion. “Consensus” would then merely name an outcome, as if a committee were to take a poll and discover (perhaps to its surprise) that everyone voted the same way. But the mere fact that members of an ethics committee happen to arrive at the same moral judgment in a given case would not be sufficient grounds for claiming that a consensus decision had been facilitated. The discussion of “facilitation” in the Core Competencies indicates that it meant to require more than merely a discovery that everyone gives assent to a given proposition, regardless of how that mutual assent came about. “Consensus” names not simply an outcome but an achievement — something produced by a form of collective moral reflection and deliberation, a process of being mutually convinced by reasons. This again stresses the point made earlier — the way in which the moral authority of such an agreement develops depends upon how it was developed. In the case of Mrs. B, the upshot of the meeting was that the patient would continue to be managed according to the treatment plan deemed by the physician to be best. But this result did not spring from collective reflection or mutual examination — the conduct of the family, for example, was more in the nature of an act of defiant capitulation than of reflective engagement.

The comments of the risk manager about reaching out to the family and seeking to placate them in some way suggest an effort at negotiation. But the facilitation of consensus should not be viewed as the negotiation of a compromise. That is because parties strike a compromise when each is willing to settle for an option other than the one he or she would rank first; following this strategy would be inappropriate for ethics consultation. Imagine, for example, that a doctor recommends a bilateral amputation of a patient’s lower extremities because of progressive peripheral vascular disease. The patient is confused, and her surrogates
strongly object to the doctor’s plan on grounds that the patient is severely deconditioned from multiple medical problems and has firmly rejected amputation in the past. Whatever might be the best outcome in such a case, surely it would be wrong for the parties to settle their differences by agreeing to amputate one leg and not the other, so that each side “comes away from the table” with a concession. Each side might prefer the removal — or the preservation — of one extremity to the alternative of acceding completely to the other’s decision. Nonetheless, this can’t be right. Why would it be a mistake for the process of ethics consultation to reach an agreement in this way by “splitting the difference” between rival views? The answer must have something to do with the belief that the goal of the consultative process is to identify a course of action collectively deemed to be best for the patient. Striking a bargain or reaching a compromise between two opponents may meet their need to resolve their differences and move on, but the consultation must not so privilege the needs of those around the table as to neglect altogether the patient’s well-being.

The importance of the patient’s interests also restricts the kinds of reasons that can be allowed to operate upon the process of facilitating consensus. Under the standards described in the Core Competencies, even agreements issuing from collective reflection may be out of bounds. Suppose a woman with shortness of breath and abdominal pain is diagnosed with a liver mass. As her respiratory status worsens, the physician notes that her advance directive (the substance of which she reaffirms) refuses mechanical ventilation. The patient becomes disoriented, and an ethics consultation is scheduled with her family and caregivers. After brief discussion, everyone agrees that the patient’s decision is simply to be ignored. This is just a variant of the “authoritarian” model that the Core Competencies has already rejected. The patient’s right to refuse treatment forms a presumptive boundary beyond which the outcome of the ethics consultation process may not be allowed to stray absent an extraordinary and compelling justification.
obeyed in ethics consultation. Contra Moreno, people from some cultures and religious orientations, for example, simply do not agree that patients must be subjected to full disclosure of a fatal diagnosis; others flatly reject brain death as a measure of when an individual’s life has ended. Merely invoking such precepts does not appear helpful. Much the same can be said for Moreno’s reliance upon the familiar quartet of bioethical principles — autonomy, beneficence, nonmaleficence, and justice. For example, Mrs. B’s physician seemed to believe that beneficence requires treatment for the predictable sequelae of a procedure to which a patient consents when her considered views about those sequelae are not clear; the family assumed that respect for autonomy precludes this. Without knowing how to weigh these competing claims against each other, the parties to an ethics consult are left with insufficient direction.

According to the Core Competencies, the types of principles, norms, and policies that constrain ethics consultation “comprise a large portion of the bioethics literature.” What does that literature say about how the consultative process in the case of Mrs. B might have unfolded? Some guiding norms can be found. It is generally acknowledged that decision making for the (now) incompetent should be guided in the first instance by instructions or decisions of the patient herself (perhaps through a written document); such subjective expressions take priority over any purported exercise of substituted judgment, and both of these take priority over an assessment of the patient’s best interests. It is also widely believed that evidence concerning a preference that is inferred by a surrogate from facts about a person or her life does not carry the same moral weight as a deliberate choice by the patient. Much more, of course, could be said about these general agreements. But without pursuing that further, we should ask how far such norms could usefully have constrained properly conducted deliberations in the ethics consultation for Mrs. B. Since the patient herself was unable to articulate her wishes and had not attempted to implement them through the mechanism of an advance healthcare directive, the first source of guidance is unavailable. At the other end, it is plain that Mrs. B’s physician and her family were deeply divided over what was in her best interest postoperatively.

According to Jonsen, Siegler, and Winslade, seeking to promote the patient’s best interests means “making those choices about relief of suffering, preservation or restoration of function, and the extent and sustained quality of life that reasonable persons in similar circumstances would be likely to choose.” Application of this standard is complicated by the disagreement it invites over which substantive preferences for medical care are to be regarded as “unreasonable.” Not only Mrs. B’s physician but all of the physicians on the ethics committee found it hard to believe that a person would choose death over life with a walker and poor vision, limitations with which many people cope daily and continue to live productively. Surely such a preference, they believed, was prima facie unreasonable. Yet if, as Jonsen and colleagues contend, “what counts as an interest [for the best-interest principle] should be designated, as much as possible, from the viewpoint of the one for whom the judgment is being made,” the conclusion that limited mobility and vision might constitute burdens sufficiently significant to outweigh whatever benefits might be expected to accrue from continued treatment becomes less unreasonable.

The substituted judgment standard calls for an endorsement of the decision the patient would make, had she the capacity to guide her care and were apprised of the relevant facts. The complexities of implementing surrogate decision making are well known, particularly in the case of patients facing slow but progressive deterioration of personality (as in dementia) or loss of functional abilities (as was arguably the case with Mrs. B). For example, was the family perhaps too hasty in concluding that Mrs. B would never tolerate a life of moderate debility? During the (all-too-brief) ethics committee meeting, Mrs. B’s daughter shared her fear that her mother would not be able to adjust to a life with diminished capacity. But we are all adaptable to some degree. As one of Carl Schneider’s patients divulged:

When I was young and physically strong, to live life from a wheelchair was unthinkable. When I became disabled it was unacceptable, but gradually, over the years, not only did it become acceptable, but I found it satisfying as well. Now, at those times when even the freedom I have in my wheelchair is threatened, I wonder if there is anything that is really unacceptable from my subjective standpoint. Or, if on the other hand, I will not be willing to accept most things.
Could Mrs. B’s own convictions about self-sufficiency and her antipathy toward a life of decrepitude fade with time, to be replaced by new values adapted to her changed circumstances? Perhaps. But surrogate decision making is not speculation on what new sets of values and goals a person might come to adopt, but rather an effort to extrapolate from those deeply held and stable convictions through which the surrogate has come to know and understand that person, to a decision in a particular situation that reflects those convictions. Had she survived, Mrs. B might have adjusted over time to living with functional limitations that she had previously thought intolerable. And she might not have done so. Yet this is just to restate the problem: namely, that the result of following a substituted judgment standard in Mrs. B’s case may remain undecidable. Her family was utterly convinced she would reject further use of life-prolonging interventions as she only meant to accept them for a day or two postoperatively, and would not agree to long-term maintenance on a ventilator because she would find a life of even moderate impairments unacceptable. Her physician was equally certain the patient had consented to the heart surgery knowing there was a chance she would need supportive interventions postoperatively and was aware that such procedures always carry a non-negligible risk of stroke. Our best evidence, on the surgeon’s view, was that Mrs. B would agree to the further procedures now indicated. Which of these views better pursues what Mrs. B would herself have chosen we may just not know.

Combing the available sources of constraints for substantive guides to how an ethics consultation for Mrs. B might have proceeded has thus far yielded inconclusive results. Indeed, it may turn out that the constraints to be obeyed in an effort to reach consensus in a difficult set of clinical circumstances simply cannot be expected to channel the consultative process to the point where we can reasonably expect any one solution to emerge from the deliberations. Recognizing that the basis of a consensus decision among all parties may not in this way be possible, the Core Competencies repeatedly invokes a procedural constraint: all those who are a part of the consultation ought at least to seek agreement on who has the right to decide. This resort to procedural consensus as a fall-back position represents an appeal to what is believed to be a reliable common ground of belief among otherwise substantively divided discussants — the bare bones of an overlapping consensus, as if to say “at least we can agree on this much.”

Unfortunately, things aren’t so simple. The Core Competencies tells us that consensus is constrained by existing law. Complicating matters here are the boundaries set by law with regard to substitute decision making. Increasingly, the law places upon those who wish to forgo life-sustaining interventions, and those who do not, asymmetrical burdens of proof. Many jurisdictions are imposing heavy evidentiary burdens upon families in cases when, in their capacity as surrogates, they request that life-sustaining measures be forgone. Demanding proof by “clear and convincing evidence” that the patient would, if competent, refuse the intervention or treatment the surrogate wishes to forgo creates a de facto presumption against forgoing certain measures, and many families have thus discovered that they do not have the right to make the kinds of decisions their loved ones wanted them to make. By contrast, those — like Mrs. B’s cardiologist — who advocate for the use or continuation of life-prolonging treatments in patients whose wishes are not clear bear only a very slight evidentiary burden — in essence, merely to claim that the treatment contemplated is not completely ineffective medically. Thus, when a family is unable to surmount such an evidentiary threshold, the question of who has the right to deploy substituted judgment remains undecided.

**CHALLENGING THE CONSTRAINTS**

The forgoing reflections suggest that cases like those of Mrs. B, in which an ethics consultation is most needed, are also those in which the model of facilitated consensus is least likely to succeed. But if that model is flawed in these ways, where should surrogates, clinicians, and ethicists turn to resolve a difficult moral conflict? The logic of ethics facilitation can offer only one remedy here: we must tighten up the constraints. That is, we must revisit the initial conditions that are supposed to channel deliberation and clarify — or revise — their meaning. But the model of facilitated consensus, as it stands, does not appear to allow for this. The Core Competencies makes it clear that an ethics consultant or ethics committee member may only
identify the nature of the relevant constraints and guide the discussion in a way that respects them. What seems to be needed, however, is permission for the discussants to engage in moral inquiry at the point where the constraints run out or are in conflict. For example, a key point of controversy in the case of Mrs. B lies at the intersection of questions both about the application of substituted judgment and of the “right to decide.” Apart from the specific fact of her consent to the particular surgical procedure undertaken, what broader set of values and understandings did Mrs. B bring to the decision to undergo that surgery? If we ask who is more likely to have such knowledge, we might well conclude that it is her family, not her doctor. Yet the family also likely lacks the “clear and convincing” proof that existing law (and resulting institutional policy) might demand.

It is here that the goal of the ethics consultation should move from facilitating consensus within the constraints to enabling moral inquiry about the constraints. In such cases the parties need to debate to see if they can agree upon what the constraints should look like in application to the particularly difficult questions before them. So in the case of Mrs. B, they might continue by asking the following questions: Why should it always be necessary for a family to demonstrate with “clear and convincing” proof that their sense of what a patient would want is correct? Why should their inability to proffer such hard proof undermine their decision-making authority? If a physician believes that the treatment goals and preferences the family ascribes to his patient are substantively unreasonable, why ought his view be presumed correct? And may it be overridden only by definitive proof that the patient reflectively endorsed those seemingly unusual preferences? More generally, it seems that the standards for “ethics facilitation” need to be modified to permit the parties to an ethics consultation, at the point when the factors constraining their deliberations cease meaningfully to channel their discourse, to step outside the constraints in order to critique and extend the reach of the constraints themselves by asking questions like these. Naturally, there is no script for such an undertaking, and different ethics consultations may well result in different outcomes.

But this does not mean that consultations in which the constraints of consensus are themselves critically examined must fail to be legitimate. For institutional mechanisms should require that the outcomes of deliberations taking place within ethics consultations be openly justified through careful documentation; such documentation should include an account of how the existing constraints were supplemented or extended and why doing so was necessary to resolve a difficult case. This portion of the record should be available to all members of the care team, as well as to the patient’s family, so that all involved parties understand the decision reached and the grounds for it. In this way, we might hope to bolster the moral credentials of the consultation process. When ethics consultation must in these ways move a step beyond the guidelines afforded by existing constraints, the demand that a reasoned account of any such action be available to all involved parties can go at least some distance toward garnering persuasive moral authority for the ethics consultation process. In this way, then, it may be possible to retain the basic model of ethics facilitation and yet also structure the work of ethics committees and consultants sufficiently to overcome the skeptical worries about the enterprise of clinical ethics consultation.

It might be objected that it is unwise to engage in the kind of critical moral inquiry I have suggested during or as part of an ethics consultation, for there is no guarantee that this critical process will result in consensus, nor any real reason to think that consensus is more likely to emerge when discussants debate about the constraints than within them. This objection is not completely without merit. It is certainly possible that questioning the existing constraints governing ethics facilitation may lead to a deliberative dead end. But, then again, it may not. It is worth stressing that moral inquiry into or debate about the constraints is largely recommended on pragmatic grounds: when adherence to the current set of constraints has failed to help participants in an ethics consultation to reach a mutually acceptable conclusion, little if anything is lost by permitting them the freedom to examine critically the constraints themselves, and, if they can, to clarify or revise them in ways that might yet make agreement possible.

How might this process have produced a better outcome in the ethics consultation for Mrs. B? One way in which this might have happened comes as a consequence of challenging certain assumptions. Recall the persistence with which Mrs. B’s doctor defended his belief that she had indirectly or impliedly consented to
the trach and PEG placement. There was some evidence from the discussion in the meeting that the physicians regarded the tracheostomy and placement of a G-tube as so routine that consent to them is just obviously what any reasonable person would give — and (thus) what Mrs. B must have given. In answer to a question about whether the endotracheal and feeding tubes might be withheld, one physician on the ethics committee commented, “we just don’t think of a trach or a PEG that way,” implying that such interventions, postoperatively, were regarded by the staff as importantly different morally from those procedures or treatments that could permissibly be forgone. Had these framing assumptions been exposed through a critical examination of the prevailing constraints on consensus formation, it is at least possible that the physician’s seemingly perfunctory assessment — that a preference to refuse a postoperative tracheostomy and feeding-tube insertion is *a fortiori* unreasonable — might not have dogmatized the consultation to the degree it did.

**POSTSCRIPT**

Mrs. B remained in the hospital subsequent to the ethics committee meeting. A member of her family (not the daughter who had been so outspoken) did eventually consent to a tracheostomy. Mrs. B remained on the ventilator for another three weeks, unresponsive and with no signs of improvement in her neurological status. The cardiologist who had initially and so vigorously opposed the family went on holiday, leaving a colleague to cover for him in his absence. Aware of the ethics committee meeting and of the general tenor of the disagreement between the cardiologist and the family, the second physician was nonetheless unfettered by the animosity that had built up between the parties. He held several meetings with Mrs. B’s family. Her children requested she be extubated and referred for hospice and comfort care. These steps were taken; Mrs. B expired in the hospital very shortly thereafter.

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**NOTES**


9. Ibid., 7.

10. Ibid., 6.

11. Ibid.

12. Ibid.

13. Ibid., 4.


15. *Core Competencies*, see note 7 above, p. 4.


19. See note 17 above, p. 460.


21. All details in the narrative of “Mrs. B” that might identify any person or institution involved have either been removed or altered so that the substance of the issues raised may be presented without infringing privacy.

22. See note 16 above, p. 63.

23. Ibid., 19.

24. Ibid., 61.

25. *Core Competencies*, see note 7 above, p. 4.


28. Ibid., 110.
