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# Key Components for an Ethics Consultation Curriculum

Joseph Bertino

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KEY COMPONENTS FOR AN ETHICS CONSULTATION CURRICULUM

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for

The Degree of Doctor of Philosophy

By

Joseph T. Bertino

May 2018

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Joseph T. Bertino

2018

## KEY COMPONENTS FOR AN ETHICS CONSULTATION CURRICULUM

By

Joseph T. Bertino

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## ABSTRACT

### KEY COMPONENTS FOR AN ETHICS CONSULTATION CURRICULUM

By

Joseph T. Bertino

May 2018

Dissertation supervised by Dr. Gerard Magill, Ph.D.

Due to a lack of formal credentials for clinical ethics consultants, the professionalization of clinical ethics as a normative discipline in contemporary American health care is diminished amongst other health care professionals. While medical specialties, organizational leadership positions, and other miscellaneous health care occupations possess governing bodies that posit credentials that justify these roles, clinical ethics consultants lack a standard of competence.

While this gap has been temporarily reconciled by individual employer criteria, a national standard that attempts to educate and demonstrate a clinical ethicist's abilities does not exist.

Still, various attempts have been made to establish a certification program for clinical ethicists.

These programs contain central concepts in ethics consultation and are effective in demonstrating the impact of a clinical ethicist's knowledge. However, the educational facets entailed in proposed certification programs that clinical ethicist ought to be familiar with do not include

information surrounding the nature of clinical ethics and the role a clinical ethicist must embody in order to perform his job effectively.

The central supposition of this dissertation is that additional work needs to be completed around clinical ethics education and certification. While no formal certification or educational standard exists for clinical ethicists, this dissertation proposes key components for an ethics consultation curriculum. The key components in this dissertation emphasize the nature and value of virtue in clinical ethics and the role virtue plays in orchestrating an effective certification program for ethicists. This dissertation aims to do the following: (i) Clarify and demonstrate the problems associated with a lack of formal certification standard for ethicists; (ii) Define and examine the nature of clinical ethics and the role philosophy plays in this line of work; (iii) Explain and demonstrate the effectiveness of teaching virtues as key components for a formalized ethics consultation curriculum; and (iv) Illustrate how key components for an ethics consultation curriculum manifest in an educational venue for clinical ethicists. This dissertation seeks to contribute a novel approach to educating and certifying clinical ethicists in the United States. By combining knowledge points associated with moral philosophy and medicine with general skill objectives for ethics consultants, this dissertation aids in developing analytic moral reasoning skills for clinical ethicists which in turn fosters the overall education and professional development of clinical ethics consultants.

## DEDICATION

*For my Family.  
Whose love and encouragement made this project become a reality.*

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*Omnēs aequales sola virtute discrepantes*



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## Chapter 1: Introduction

This dissertation presents a critical account of professional ethics consultation intended to aid the development of a curriculum for certification and credentialing clinical ethicists in the United States. The context of this dissertation lies in the emergence of clinical ethics as a major field of scholarship and practical application. The foundation for preparing ethics consultants is based on a variety of methods and standards regarding relevant knowledge and skills, such as those delineated by the American Society for Bioethics and Humanities (ASBH). The analysis of current methods and standards for clinical ethics consultants indicates a lack of formal certification and accreditation standards and thus highlights the contribution of the dissertation. Specifically, the contribution of this dissertation involves the presentation of curriculum components that fill the gap between methods and standards of practice for clinical ethicists and satiates the demand for the professionalization of the field. The gap clinical ethicists face, on a professional level, compromises the quality of clinical ethics consultation as a profession and diminishes its contribution to patients, families, and fellow professionals. Insofar as the established practice for professional education in health care occurs via certifications and credentialing, the dissertation enables clinical ethics consultants to meet this standard as a profession.

The contextual and foundational aspects of the dissertation are demonstrated in a manner that establishes a reliable landscape for systematic and practical perspectives of pivotal curriculum components. From a systematic perspective, a curriculum for certification and credentialing requires a clear-minded approach to moral reasoning that engages virtue ethics from a professional standpoint. From an applied perspective, the curriculum for certification and credentialing requires a substantive residency requirement that dynamically engages professional

ethics in health care organizations. The outcome of this analysis is to propose curriculum components, at a general level, that can be implemented in multiple ways and in different clinical settings. The core purpose of the dissertation is to combine knowledge components with applicable skills to enhance analytical moral reasoning for clinical ethics consultation in a manner that meets accepted professional standards in other fields.

Issues surrounding health care and ethics facilitation are growing at exponential rates in contemporary medicine. Ethical discrepancies concerning care at the beginning of life, genetic modification, transhumanism, end of life care, and an array of other issues that fall under the purview of bioethical debate require professional analysis. However, the professionals responsible for facilitating and aiding these topics have no basis for their status as professionals in the field of health care. The lack of recognized professionals in health care ethics not only degrades the status of trained individuals in health care ethics but also exposes a faulty foundation upon which ethics consultation efforts and clinical support for patients and health care professionals rest. Health care ethicists responsible for holding health care ethics consultations, institutional and clinical ethics meetings, family meetings, and other duties of ethics professionals require a formal basis for their practice.

Various tensions in health care surrounding patient care and ethical decision-making require professional support. Furthermore, professionals in health care not only possess certifications, degrees, and credential standards, but also cannot practice without these credentials. Despite the necessity of these practice standards for health care professionals, clinical ethics consultants possess no requirements for formal credentials, standardization methods, or academic degrees. Due to the severity of ethical issues in health care, trained individuals in health care ethics must possess ample knowledge of moral theory, philosophy, and

ethical facilitation methods that aid in resolving discrepancies between patients, families, and health care providers. However, without a formal standardization method that legitimizes ethical knowledge and skill sets, the confidence in the abilities of clinical ethicist is diminished and thus results in an ultimate lack of professional recognition and quality gaps in health care.

Without a standardized method of training and certification for health care ethics consultants, the various ethical issues that exist in health care are left with no professional resource for consideration or advice. Due to the complexity surrounding individual issues in health care, various parties are often involved when deliberating health care options for patients. These individuals include health care providers, professionals, families, and other stakeholders. Additionally, these issues often result in legal and financial consequences that affect physicians, nurses, health care organizations, and other involved party members. Furthermore, a lack of a professional credential and educational standard for clinical ethics consultants further perpetuates these repercussions.

Currently, no formal certifying body or formal standard of practice legitimizes or provides credentials to health care ethics consultants. The only current effort made to reconcile this discrepancy in health care ethics is a portfolio-style standardization technique introduced by the ASBH's Clinical Ethics Consultation Affairs (CECA) subcommittee on accreditation and standardization.<sup>1</sup> Although this effort was good intentioned, its method lacks various components that must receive consideration before ethics consultants can receive formal recognition as professionals who are in possession of legitimate practice credentials. Health care ethics consultants are extremely valuable yet underutilized as a resource for health care facilities and health care organizations. Thus, the lack of a standardized credential process and curriculum for health care ethics consultants not only damages the legitimacy of these organizations but also

opens patient populations to various risks. Family conflicts, patient wishes, beginning and end of life care, advanced directives, and co-worker relations are just some of the facets that health care ethics consultants can address and facilitate. Without a formal method of training, other health care professionals may not recognize the legitimacy of a health care ethicist's knowledge.

This dissertation provides a historical and contemporary analysis of health care ethics consultation in clinical and professional settings. In doing so, this dissertation provides justification for a formidable and reliable curriculum that allows for formal certification and credentialing of professional ethics consultants. The impact health care ethics consultation has on patients, families, and other involved stakeholders is wildly important due to the nature of ethical facilitation. Various tensions and varying moral facets of ethical deliberation in health care require professional analysis. This professional analysis must possess its foundation in a mutual relationship between knowledge and skills involved in health care ethics and moral philosophy. This dissertation emphasizes the importance of a curriculum that emphasizes knowledge and moral philosophy as prerequisite bases for ethical skillsets.

To demonstrate the importance of the wedding of moral philosophy and ethical knowledge with practical skillsets in ethical consultation, a curriculum that possesses components that address both facets of ethics education for professional consultants must establish its grounding in history and theory. While significant attempts have been made to reconcile this gap, a curriculum that includes key components that facilitate the development of virtue through its identification has not yet developed. Developing key components for an ethics consultation curriculum that add virtue identification techniques to the arsenal of skills for clinical ethicists aids in developing a foundational criterion for professionalizing ethical practice in clinical settings, research, and academic pursuits.

The basis and need for the dissertation's thesis lie in the current lack of formal accreditation for ethics consultants. Furthermore, deeming a clinical ethicist as a health care professional lacks justification for its title and status throughout the health care community. The lack of accreditation for clinical ethicists not only devalues the quality and abilities of ethicists but also diminishes the ethicists' status as a professional. Additionally, the lack of accreditation and standardized certification for ethicists diminishes their expertise amongst families and patients. While most professionals in the medical community possess a grounding of certification and standardization in their practices, clinical ethicists have no basis for their status as professionals in the field of ethics and health care. The lack of a formal certification and accreditation program for clinical ethicists certainly inspires the dissertation's task. However, the goal of this dissertation is not to construct a curriculum, lesson plan, or formalizing body responsible for formally professionalizing clinical ethicists. Instead, this dissertation attempts to work with the already formidable attempts at certifying clinical ethicists by offering contributions to an already strong curriculum in beta development.

Currently, the most formidable standard of ethical professionalism lies in the possession of academic degrees. Doctoral and Master's degrees as well as other professional degrees in health care ethics all serve as academic credentials that indicate an individual's knowledge of health care ethics consultation. However, these academic degrees do not hold a firm basis in professional ethics when addressing the needs of hospitals, clinics, and other patient-based care facilities due to their lack of prevalence in professional health care circles. The educational facets involved in these degrees do not disregard the practical application of their acquisition. Rather, the professional spheres that professionally educated ethicists subsequently enter do not accept clinical ethicists as individuals who are capable and trained adequately enough to perform well in



clinical settings.

Justifying the legitimacy and effectiveness of clinical ethicists can be approached through various aspects. However, an effective way of demonstrating the usefulness and, moreover, the purpose and function of clinical ethicists lies in the historical underpinnings associated with clinical ethics. Chapter two of this dissertation presents an extensive historical analysis of health care ethics consultation while chapter three assess the current state of professional ethics consultation methods and standards of consultants. By introducing historical facets associated with ethics as an intervening discipline, chapter two presents both moral philosophy perspectives and a historical discussion of the developments of consultation efforts in health care.

Beginning with early ancient moral theories of ethics, chapter two dedicates itself to exposing fundamental principles of moral theory contained within contemporary ethics. These fundamental principles of moral theory contained within contemporary ethics involve intricate structures associated with moral philosophy. The discussion is heavily rooted in a discussion of human autonomy, its function, and the ways in which ethics aims to evaluate and assess permissible instances of autonomous action.

Chapter two continues with a formal discussion of ontology which further justifies the importance of autonomy as a principle of biomedical ethics. The discussion expands upon the principle of autonomy as a historical facet of self-care that requires protection and representation through clinical ethicists. Additionally, the discussion applies the principle of autonomy to practical applications like the function and scope of informed consent in medical practice. The discussion surrounding informed consent serves as a venue in which a fundamental aspect of bioethics manifests in practical clinical instances. The discussion in chapter two moves to a practical defense for key aspects of contemporary medicine including informed consent,

paternalism, and coercion. In doing so, the discussion justifies the existence and development of clinical ethics consultants and ethics committees in hospital settings. The historical analysis presented in chapter two provides a basis that not only presents a background and foundation for contemporary ethics consultation methods but also presents justification standards, rooted in history and moral philosophy, that deserve consideration within contemporary health care consultation accreditation. The historical facets explained in chapter two are further elaborated with a discussion of genetic technologies and clinical consent. The historical facets of these topics aid the discussions task of justifying the existence of trained clinical ethicists in a manner that bolsters their professional understanding of virtue and virtue identification in practical instances.

Chapter three expands upon chapter two's historical analysis by addressing contemporary models of ethics consultation. Beginning with a formal definition of clinical ethics, the chapter discusses the advantages and disadvantages of clinical ethics consultation methods that are frequently used and taught. The analysis attempts to demonstrate the effectiveness of these consultation methods while simultaneously exposing their deficits. In doing so, the chapter advocates for additional curriculum components that make up for various contextual gaps in clinical ethics consultations.

Chapter three subsequently uses the analysis of the foremost ethics consultation methods to transition to an analysis of the efforts made by the ASBH and its CECA subcommittee to establish a formal curriculum for clinical ethics consultants. The analysis by the ASBH and its CECA subcommittee describes the professional efforts made in developing a certification and credentialing program for ethics consultants. This chapter demonstrates that although the methods of certification covered by the CECA outline an array of criteria that consultants must

adhere to, the CECA subcommittee's method of evaluation only presents a portion of certification criteria. The subcommittee's standards of certification lack a prerequisite knowledge basis in theory, moral philosophy, and method that must be ascertained prior to developing skillsets in ethics consultation. While the evaluation by the ASBH and its CECA subcommittee present a curriculum that adequately prepares clinical ethicists for performing clinical ethics consultations, the key components for an ethics consultation curriculum presented in this dissertation bolster existing curricula by advocating for and promoting character development through virtue identification, a skillset that has been lost in the annals of practical medicine.

With the establishment of existing certification protocols elaborated, Chapter four expands upon the skills emphasized in chapter three by discussion moral reasoning, ethics facilitation, and virtue. These aspects of a consultant's practice are pivotal and ought to be treated as tantamount if he is to conduct clinical ethics consultation and provide ethical expertise in a health care setting effectively. The skills that ought to be developed require a provision of prerequisite knowledge bases in moral philosophy. In doing so, skills surrounding the effective development of moral agents who can evaluate ethical situations in health care constructively becomes a tenable endeavor for clinical ethics consultants.

Adhering to moral character by engaging in virtue identification enhances the skills associated with good clinical ethics practice outlined in chapter three by the ASBH and its CECA subcommittee. This task bolsters the skills that the CECA present and receives justification through a firm basis in moral theory and applied reasoning. The knowledge portion of this dissertation is a pivotal turning point for professional ethics due to the current lack of philosophical reasoning and training in modern health care settings. Chapter four continues to elaborate on the importance of implementing key curriculum components that are rooted in

virtue identification by extracting the kind of virtue identification that clinical ethicists must be familiar with in their study and application. Beginning with a discussion surrounding moral reasoning for clinical ethicists, the chapter dissects virtue ethics and its development through Immanuel Kant. The discussion advocates for a less stringent focus on dogmatic rules in clinical ethics and a more liberal approach to situation-based criteria in ethical precarious situations in health care.

By subsequently turning toward an Aristotelian view of virtue ethics, the discussion attempts to evaluate the benefits of abandoning dogmatic stipulations of moral reasoning and adhering to virtue identification—an inherently Aristotelian approach. In doing so, clinical ethicists begin to ascertain the key components for an ethics consultation curriculum in that ethicists are trained and encouraged to discern between extremes in moral reasoning. By identifying that which virtue is not, clinical ethicists may pinpoint virtuous behavior and recommendations in their practice.

With the establishment of the key components for an ethics consultation curriculum described in chapter four, chapter five uses the newly amalgamated knowledge and skills discussed in previous chapters to develop a formal curriculum that contains the key components for an ethics consultation curriculum for a standardized practice of health care ethics consultation. This task is completed by first examining the organizational facets of establishing a venue in which a curriculum may manifest. Additionally, chapter five examines the issues that accompany novel curriculum components. This process not only formalizes the process of becoming a professional ethics consultant but also solidifies the professional legitimacy of clinical ethics consultants. By first identifying the need for virtue in health care organizations, a trickle-down effect becomes apparent. The demand and need for virtue across a health care

organization becomes contagious if the mission of the organization is to emphasize virtuous practice. This task becomes more apparent by identifying an organizational ethics case in which virtue is clearly applicable. While the dissertation argues that virtue may be identified in all ethically precarious situations, it is the formal training and certification of a clinical ethicist that allows for the identification of virtue in these instances. The organizational ethics case presented in this analysis aids the discussion by demonstrating the need for clinical ethicists to identify virtue in health care practice and demonstrates the prevalence of ethical issues that contain issues of virtue and its misidentification.

Chapter five continues to justify the professional legitimacy of clinical ethics consultants by outlining a description of a curriculum for clinical ethicists. While the goal of this dissertation is not to establish a formal curriculum or lesson plan for clinical ethicists, a description of an ideal consultation curriculum that houses the key components for an ethics consultation curriculum described in this analysis is a helpful exercise. Although this curriculum cannot necessarily apply to all graduate programs, residencies, or other educational venues in health care ethics or related fields—due to academic institutions’ guise of a privatized criteria for the acquisition of a degree—the curriculum may apply to a residency program for clinical ethicists. The described residency program aids the discussion by demonstrating how budding clinical ethicists may rehearse the practical skills and knowledge points they are responsible for understanding while simultaneously grasping how to identify and implement virtue into their practice.

The second half of chapter five attempts to reveal the issues associated with implementing an ethics consultation curriculum with the key components mentioned in this analysis. While the key components mentioned in this analysis are novel, the associated issues

mentioned in chapter five have the potential to accompany any attempt at professionalizing clinical ethics consultants in the medical community. The issues begin with a discussion surrounding the cultural and professional barriers associated with introducing professional ethicists to contemporary medicine followed by the extent that other professionals understand clinical ethics and its lasting utility. By describing issues like viewing ethics consultation as a service and the lack of understanding associated with the effectiveness of a sole-consultant model of consultation, the discussion elaborates the difficulties that the key curriculum components illustrated in this analysis may not be able to address. By explaining the utility of ethics across a hospital system and the ways clinical ethics can become more effective with the dissertation's proposed key curriculum points, the discussion aims to entice the medical community with the utility and malleability of professional ethicists.

Chapter five ends with a discussion surrounding additional attempts at formalizing clinical ethics consultations through a hospital-based teach model in Europe. By examining Renzo Pegoraro, Giovanni Putoto, and Emma Wray's evaluation in their text *Hospital Based Bioethics: A European Perspective*, the discussion implements yet another wellspring of information regarding the professionalization of clinical ethicists. Subsequently, the discussion demonstrates that the European model of hospital-based teaching for clinical ethicists can become even more formidable if the key components for an ethics consultation curriculum in this analysis become implemented.

Each chapter attempts to build upon the last to both justify the need for a formalized residency program as well as present the necessary criteria for a residency program that contained the dissertation's proposed key components for an ethics consultation curriculum. This dissertation provides a guide for medical institutions seeking to provide credentials and formally

certify ethics consultants by advocating for the use of virtue in clinical ethics education. The following sections delve deeper into the various sections in this dissertation and attempt to provide clarity into the dissertation's goal of advocating for the implementation of virtue identification techniques in clinical ethics consultation curriculums.

## 1.2. Chapter 2: The Emergence of Clinical Ethics

Chapter two presents a historical analysis of clinical ethics by first tracing a relevant history of moral philosophy and subsequently deriving the origins of autonomy, paternalism, and consent in contemporary health care. This lineage demonstrates the foundations of moral theory that, although they may not always remain applicable to clinical situations, solidifies the importance of critical analysis in clinical ethics. The chapter then discusses how the relevant philosophical literature and theories have evolved into contemporary methods and theories of ethics.<sup>2</sup> Section 2.2 continues to discuss the importance of clinical consent and autonomy through an assessment of technological influences in health care. Specifically, the technological influences in health care discussed in this analysis pertain to the use of genetic technologies in both screening and testing of individuals. While this facets of clinical ethics is fairly niche, the importance of this discussion lies in the moral permissibility of these actions and the philosophical justifications that clinical ethicists must become versed in if they are to assist with conflict resolution, joint decision-making, and the provision of professional recommendations.

Colloquially understood methods of informed consent and autonomous decision-making primarily lie in clinical decisions regarding care plans, sustenance, and directives. However, chapter two's discussion of technology permeates the idiomatic use of consent by extending the discussion into the realm of transhuman possibilities and the technological advancement of medical procedures and clinical testing for genetic abnormalities.<sup>3</sup>

### 1.2.1 Autonomy, Paternalism & Consent

Despite the necessity of informed consent in medical practice, individuals often disregard the acquisition of informed consent from patients. Important documents that facilitate the understanding of patient wishes like advance directives are often unattained or improperly acquired. This section attempts to analyze the importance of informed consent and the philosophical justification for its acquisition. Chapter two begins by attempting to suture the divided roles of the physician and the philosopher by demonstrating the benefits of their union for the greater good of patients. The amalgamation of these roles shows that a dialectical method of ethical medical practice is achievable by unifying these disciplines under a mutual understanding of common morality. The chapter then discusses the philosophical justification and basis for autonomy, consent, and paternalistic notions in health care ethics.

This section explains the importance and inherent nature of autonomy and indicates the role autonomy plays in informed consent through an ontological investigation of the body. A discussion surrounding informed consent as a process and its necessity is discussed. Next, the difficulties that accompany obtaining consent are presented. This presentation justifies contemporary tactics in health care ethics. Paternalism, as one of the most formidable issues surrounding threats to autonomy, presents as a demonstrative aid in the articulation of institutional ethics committees and consultation-based practice. Section 2.1 concludes with a discussion of the necessity of ethics consultation in clinical practice. A brief discussion of the future of ethics consultation and practice catalyzes the discussion into section 2.2 which applies the aforementioned topics to technological considerations in health care.<sup>4</sup>

Various aspects of consultation do not emphasize the importance of critical analysis and facilitation from the perspective of moral philosophy. Beginning with Aristotelian ethics, the



moral facets of philosophy present fundamental principles of ethical guidelines that aid a consultant's understanding and regulatory methods of evaluation when working with contemporary health care issues.<sup>5</sup> Methods of health care ethics consultation and contemporary moral theory are rooted primarily in Kantian ethics.<sup>6</sup> However, the philosophical corpus of moral theory contains various elements of reasoning that prove beneficial for the contemporary ethics consultant both in critical theory and methods of facilitation.<sup>7</sup> The history of moral philosophy is emphasized further in John Rawles, Alasdair MacIntyre, and John Locke.<sup>8</sup> By tracing the moral concepts of these thinkers, among others throughout the corpus, consultants subsequently become familiar with varying perspectives and theories of facilitation and critical analysis.<sup>9</sup>

Utilitarian and deontological theories in early modern thought paralleled with ancient virtue theories manifest in modern thinkers such as Martin Heidegger, Michel Foucault, and Jean-Paul Sartre.<sup>10</sup> However, the historical lineage of ethics from the ancients to modern thinkers is especially pertinent to the ideas of Hippocrates, Richard Cabot, Thomas Percival, and Chauncey Leake. In effect, the development of moral theory through these thinkers provides an arsenal of pragmatic perspectives in health care. Furthermore, the development of ethical practice in medicine becomes extrapolated by tracing a lineage of moral philosophy that has lost and regained its theoretical priority under a new lens of understanding by analyzing the emergence of traditional western ethics.<sup>11</sup>

Moral philosophers originally used the work of Hippocrates as the basis for their practice and pledged to use their skills for public service. Ethics in medicine had its first modern exposure by Thomas Percival. Percival focused on the etiquette of medical practice and the patient-physician dichotomy rather than the philosophical analysis involved in health care ethics. However, despite the exodus from moral philosophy in health care ethics, Percival's assessment

began to establish the relationship between health care professionals and the public.<sup>12</sup>

From Percival's influence, other moral philosophers like Richard Cabot began to bridge the gap between traditional philosophical analysis and the role of the health care professional by deeming the acquisition of medical data and knowledge as the basis for ethical practice in a clinical setting.<sup>13</sup> For Cabot, ample knowledge of one's practice was synonymous with ethical practice. By analyzing consecutive autopsies, for instance, Cabot could quantify one's skills and knowledge involved in one's medical practice. Cabot redefined ethics as competent practice coupled with an appreciation of the personal needs of the patient. Cabot's influence, although profound, further moved professional ethics away from the foundations of moral philosophy and into the realm of skill-based praxis.<sup>14</sup> This method of praxis as ethical development quickly became a standard in ethical medical practice and solidified an understanding of ethical frameworks in medicine. However, this approach established a faulty groundwork for the future development of health care ethics consultations due to an abandonment of moral philosophy.<sup>15</sup>

Percival's focus on the role of the physician wedded with Cabot's epistemic mission began to shape the practice of medical ethics. However, both thinker's efforts to establish normative ethical practices in medicine fell short due to their disregard for the importance of moral philosophy in ethical practice. Dr. Chauncey Leake envisioned an ethical practice of medicine that combined philosophical analysis with medical knowledge to uphold patient's well-being and dignity. Despite the initial dismissal of his advice, Dr. Chauncey Leake criticized Percival's writings on medical ethics as a misuse of the terms due to his disregard of philosophical literature on ethics.<sup>16</sup> This was perhaps the first indication of a need for moral philosophy in medical practice since ancient moral theory. Leake claims that medical ethics should have its foundation in moral philosophy. Additionally, he claims that ethical education

must emphasize medical practice as a practice that concerns itself with the “ultimate consequences of the conduct of physicians toward their individual patients and toward society.”<sup>17</sup> Leake found that by studying moral philosophy, students in medicine and health care would be able to adapt to ever-changing advancements in medicine and policy in an ethical and practical way. Leake believed students should learn fundamental questions of moral philosophy by a member of the philosophy faculty, followed by a historical survey of ethics in medicine.<sup>18</sup>

Section 2.1 demonstrates the historical influence on contemporary ethics practices in health care. The pragmatic vision of Leake and Cabot expedite the moral tradition into a realm of practical application. However, section 2.2 presents technological constraints placed upon ethical deliberation processes. In doing so, section 2.2 demonstrates the demand for moral amendments to facilitation efforts in contemporary health care.<sup>19</sup>

### 1.2.2 Technology & Clinical Consent

American pragmatism served as a stepping stone that aided health care ethics’ establishment as a normative discipline due to its use of philosophical analysis. As an active component in ethical decision-making, pragmatism aided in upholding knowledge of the medical field and care of patients in a progressive manner. The recognition of autonomous consent set a massive milestone for health care and opened a realm of pragmatic thinking. Two prominent American pragmatists, John Dewey and William James, both developed a style of philosophizing that applied classic philosophical thought to contemporary issues.<sup>20</sup> This style of philosophy was especially applicable to health care ethics because its aim is directed toward making a difference in the lives of the ailing.<sup>21</sup> Although Dewey emphasized the acquisition of knowledge more so than James, both pragmatists attempted to develop the groundwork for a philosophy of morals that was flexible enough to adapt to new contemporary circumstances.<sup>22</sup> Dewey and James

recognized that with the invention of new technologies and medical developments came new moral issues and needed modern solutions.<sup>23</sup> The pragmatic approach of Dewey and James was effective because both philosophers recognized the need to adapt to new technological, social, economic, and medical developments.<sup>24</sup> However, a facet of humanitarian studies that may have eluded these thinkers entails the fact that bioethics must become recognized as a normative discipline if its efficacy intends to permeate the realms of academia, clinical settings, and research settings.<sup>25</sup>

Clinical consent and technology intersect and clash frequently in modern medicine. Contemporary technologies and advancements in medical genetics have made tremendous strides in recent decades. Curing diseases and preventing ailments only breach the surface of possibilities that genetic technologies entail. However, genetic alteration, testing, and screening have become questionable endeavors in recent years due to the moral and ethical implications of their practice as well as the pace at which these technologies develop. Ethical questions surrounding genetic medical science, including the acquisition of consent, involve determining moral judgments. Subsequently, these judgments discern between interventions that are possible and interventions that are necessary. Section 2.2 continues to evaluate autonomy and consent by assessing genetic technologies. American pragmatism established an effective means of adapting moral principles to ever-changing developments in contemporary society, yet the pragmatic approaches established by Chauncey Leake and John Dewey could not have possibly foreseen the extent of technological triumph in medicine.<sup>26</sup>

Dr. Chauncey Leake's vision of an amalgam between moral philosophy and ethical decision-making in medicine was on the precipice of fruition due to the efficacy of the pragmatic approach to moral maxims.<sup>27</sup> However, a moral method that evaluates the dangers of genetic

technologies by examining the use of modern technologies on human beings, as well as the importance of clinical ethics consultation in the field of genetics, requires amendments and imagination. Section 2.2 analyses an alternative assessment of technology with a rather unorthodox approach. By analyzing the dangers of modern technology outlined by German phenomenologist Martin Heidegger, section 2.2 demonstrates that the dangers that accompany man's relationship with genetic modification and technology may become reconciled through properly developed ethics consultation methods. The analysis is divided into two primary sections. The first section begins with a discussion of the Human Genome Project and its influence on genetic sciences. The first section continues with a philosophical assessment of man's relationship with technology and the dangers that accompany this relationship. The second half of the discussion reviews the ethical permissibility of genetic testing and screening in newborns and other patient populations. The discussion stresses the role of genetic ethics consultations and their educational importance, followed by the need for mandatory ethics consultations concerning genetic issues, consent, and autonomous decision-making.

Bioethics is not purely a practice of moral philosophy and therefore, the casual use of theory in moral philosophy is not enough to aid the development of bioethics. Research regarding genetic technologies and the ethical permissibility of human enhancement are aspects of the discipline that must fall upon professional facilitators. Bioethics and the moral questions involved with genetic developments require ethical theories that evaluate the language of the discipline and the carefully derived terms that achieve rational justification. The rational justification sought after in practical bioethical practice, particularly in health care ethics consultation, is most radically expedited through Beauchamp and Childress' expansion upon the theoretical requirements of bioethics in their work "Principles of Biomedical Ethics."<sup>28</sup>

Beauchamp and Childress' hierarchy is an effective scaffold for bioethical theory due to its comprehensive nature. However, their method simultaneously allows room for various moral experiences and provides a basis for other forms of facilitation.<sup>29</sup> Chapter three expands the argument by evaluating the methods and standards of clinical ethics consultation that derive from the historical foundations listed in chapter two. By examining these methods with an understanding of their origins, this analysis attempts to demonstrate the ways in which ethical assessments become bolstered. Although the methods described in chapter three are by no means ineffective, this analysis argues that each method has significant room for improvement if elements surrounding the original formulations of ethical thought implement throughout their analyses.<sup>30</sup>

### 1.3. Chapter 3: Methods & Standards of Clinical Ethics Consultation

Chapter three discusses two important facets of health care ethics consultation as it stands in contemporary practice. These two facets include common practices of ethics consultation and the current certification standards that have developed from these common practices. Section 3.1 investigates methods of clinical ethics consultation. Approaches to clinical ethics and clinical ethics consultation possess tremendous utility and have proven to be extremely effective. However, no universally accepted method has become adopted into the realm of clinical ethics consultations.<sup>31</sup>

One of the most pressing issues in clinical ethics pertains to the various ethical, moral, and practical factors that accompany individualized clinical cases. To develop an ethical consultation method that may develop in a universal manner, section 3.1 investigates Process and Format, Four Topics, methods of informed consent, situation ethics, and the CASES method of clinical ethics consultation while section 3.2 discusses the ASBH's subcommittee, the CECA.

The CECA committee has outlined an extensive skill-based portfolio requirement that serves as a preliminary basis for a health care ethics consultation certification. By explaining popular methods of consultation, various facets of the knowledge-based criteria set out by the CECA become extrapolated in their report.<sup>32</sup>

### 1.3.1 The Variety of Clinical Ethics Consultation Methods

To address the issues of ethics facilitation and communication amongst health care professionals, section 3.1 attempts to analyze and amalgamate the beneficial aspects of various clinical consultation methods in bioethics while simultaneously establishing a philosophical basis upon which these methods of consultation may become enacted. The chapter begins with a definition of clinical ethics, followed by a description of a clinical case that presents thematically throughout the discussion. The chapter then discusses the foremost contemporary clinical consultation approaches. To develop a consultation method that weds the most beneficial aspects of existing consultation methods, section 3.1 concludes by presenting thematic qualities that trace through each clinical consultation method. In doing so, a comprehensive consultation method from the fragments of contemporary methods develops.

Despite the array of consultation methods that are implemented and used throughout various ethical issues, only the most formidable and popular of skill-based methods receive attention in this dissertation. This dissertation limits the scope of consultation methods because not all consultation methods are credible or relevant. The discussed consultation methods stand among the more popular methods in the corpus.<sup>33</sup> Furthermore, the methods selected for this analysis aid in developing a pragmatic amalgamation of theories mentioned in chapter two. However, prior to introducing these methods, it is imperative that the discussion addresses a definition of clinical ethics. By introducing a formal definition of clinical ethics, the discussion

attempts to combine relevant theories of clinical ethics consultation with direction and a clearly delineated standard for forming a theory.<sup>34</sup>

Although the definitions of clinical ethics rooted in principlism aim to benefit patients in ethically doubtful situations, a far more appropriate and beneficial definition of clinical ethics unearths by amalgamating the ASBH's goals and definition of health care ethics consultation with Bernard Lo's definition in his text, *Resolving Ethical Dilemmas: A Guide for Clinicians*.<sup>35</sup>

Lo's approach begins by defining clinical ethics within the first few pages of his analysis.

Although Lo does not give a strict and concrete definition of clinical ethics, he provides a robust description of clinical ethics and the intricacies that accompany its practice. Per Lo, clinical ethics differentiates itself from traditional bioethics by honing interaction dichotomies and relationships in clinical care.

In clinical settings, patients interact with physicians, nurses, and other medical staff. This facet of clinical care does not necessarily mean that patients foster a relationship with health care professionals or vice versa.<sup>36</sup> However, the ethical aspect in a clinical setting that involves a patient-physician relationship concerns issues of value-judgments, the difference between right and wrong actions and deeds, and decisions about effective or safe treatments.<sup>37</sup> Lo's description of clinical ethics presents insights into the definition of clinical ethics. While various relationships in clinical medicine may pertain to action, the relationship clinical ethics forges result in a dichotomy that answers debates between medical action and inaction.<sup>38</sup>

Lo expands his description of clinical ethics by investigating the differences between morality and ethics. Lo notes that, although these terms are often interchanged, tremendous differences exist between these concepts. In clinical ethics, distinguishing these terms are of the utmost importance. If a clinical ethicist exercises the ethics facilitation approach, he must adhere



and respect the wishes of parties involved while simultaneously upholding ethical norms.<sup>39</sup> Morality entails values and beliefs that have no empirical evidence for their existence.<sup>40</sup> While morality possesses subjective elements, ethics pertains to a formal area of philosophical reasoning that demands argumentative justifications for its import. The distinction between morality and ethics aids in uncovering a definition of clinical ethics by juxtaposing two themes that are mutually inclusive.<sup>41</sup> While morality pertains to individual values and concerns, ethics refers to the formal, argumentative process of identifying the *why* and *how* of value-based questions.<sup>42</sup>

The establishment of a formal definition of clinical ethics aids the proposed dissertation's thesis by demonstrating the importance of a theoretical foundation for clinical ethicists. By formally defining clinical ethics, further examinations into the use of contemporary methods of clinical ethics consultation expedite the overall process of consultation techniques. Presenting the foremost methods of clinical ethics consultation demonstrate the benefits and lapses of these methods.<sup>43</sup> Identifying shortcomings in these methods aid the formulation of a standardized method that must become included within a credential program. Section 3.2 outlines the current efforts made by the ASBH in establishing a formalized credential process for ethics consultation services. Furthermore, the skill-based program outlined by the ASBH and its CECA subcommittee demonstrates the importance of a formal definition of clinical ethics and the inherent need for amended practices in clinical ethics consultation.<sup>44</sup>

### 1.3.2 The Clinical Ethics Consultation Standards of the ASBH

In 2009, the ASBH formed the CECA standing committee. This committee formed to address concerns regarding the competency and professional knowledge of individuals responsible for providing clinical ethics consultations to patients, families, and health care

professionals.<sup>45</sup> These concerns primarily involve the legitimacy of consultations and consultant competence. Furthermore, this committee formed to improve both basic and advanced levels of competency for clinical ethics consultants based on the ASBH's *Competencies for Health Care Ethics Consultation*.<sup>46</sup> Section 3.2 of this dissertation analyzes the ASBH's pilot program for certification, accreditation, and credentialing clinical ethics consultants.<sup>47</sup>

The report begins with an explanation of the current demand for qualified clinical ethics consultants. The primary question the report addresses is whether individuals conducting clinical ethics consultations possess adequate qualifications. The report mentions that, per Fox and Colleagues' national survey, only 5% of consultants have completed a fellowship or graduate program in bioethics.<sup>48</sup> Despite this statistic, the ASBH and its CECA subcommittee have placed an emphasis on other means of accreditation and certification for clinical ethics consultants due to the legitimacy of graduate programs. Per the ASBH and its CECA subcommittee, no bioethics graduate or fellowship program possesses accreditation standards to educate and train ethics consultants.

In this respect, the ASBH asserts that there exists no tangible evidence that asserts the competence of ethics consultants. Instead, the CECA seek to establish a program that ascertains whether individuals possess adequate knowledge of clinical ethics consultation methods.<sup>49</sup> However, a primary issue with this program is the CECA's undermining of various graduate programs in establishing knowledge bases for prospective professionals.<sup>50</sup> These individuals, *i.e.* doctoral candidates, do in fact possess a formidable knowledge base. However, this knowledge base does not receive proper attention in the CECA's program. Rather, this section attempts to demonstrate skills and skill-based assessments required of a clinical ethics consultant.<sup>51</sup>

Initially, the ASBH developed a multiple-choice examination that intends to determine the competency of clinical ethics consultants and other individuals assisting with ethics consultations. The exam is comprised of multiple choice questions that test a range of topics involved with clinical ethics consultation including, bedside manner, role delineations, and basic skill sets that have become established by the ASBH's *Core Competencies for Health Care Ethics Consultation* and *Improving Competencies in Clinical Ethics Consultation*.<sup>52</sup> However, the CECA committee indicates that the multiple choice test the ASBH requires is an insufficient means of testing competencies and skills for ethics consultants.<sup>53</sup>

The CECA in conjunction with the ASBH's requirements suggests that further actions are required with an examination process. These actions include a multiple-choice examination that also includes an essay, written case study analysis that involves an example of electronic medical record documentation, and an oral interview with, presumably, an experienced and skilled consultant.<sup>54</sup> Additionally, the CECA advocates for five additional methods to measure clinical ethics consultation skills and knowledge competencies. These methods include an evaluation based on mock consultations, evidence of having performed a minimum number of consultations as a lead consultant, a graduate degree in the applicant's field, formal evidence of clinical ethics consultation education and training, *i.e.*, clinical ethics degree program, certification program, or continuing education, and a letter of recommendation from a supervisor or colleague who has provided instruction and observed the applicant's clinical ethics consultation skills.<sup>55</sup>

In addition to the above-mentioned modifications to the ASBH's examination process, the CECA subcommittee outlines five points that are necessary components for an individual to receive a standardized accreditation for conducting clinical ethics consultations. The five-point certification involves a written exam, portfolio, observational assessment, formal reviews from

supervisors, and interview process.<sup>56</sup> The CECA report to the board of directors both outlines the ASBH pilot program and demonstrates various suggestions and points of improvement. The report insists on developing a curriculum that consists of both skill and knowledge areas. Upon successful completion of various assessment methods, clinical ethics consultants develop a knowledge base that aids in conducting professional ethics consultations.<sup>57</sup> Provided an ethics consultant pass all assessment method procedures, consultants are then able to receive accreditation and professionally practice consultations under the licensure of the ASBH.<sup>58</sup>

By examining the array of clinical ethics consultation methods and formalizing a definition of clinical ethics, chapter three continues to work toward a refined method of clinical ethics that incorporates beneficial aspects of existing methods and works toward a refined method of ethical reasoning. The CECA's attempt to formalize consultation practices in health care is a tremendous step toward formalizing an ethics criteria for consultants.<sup>59</sup> However, the lack of virtue ethics, moral reasoning, and moral philosophy as a whole in the CECA's analysis and existing consultation methods indicates a lapse in moral fortitude and character. These components are discussed in chapter four and present a demand for these aspects of ethics consultation.<sup>60</sup>

#### 1.4. Chapter 4: Moral Reasoning, Ethics Facilitation & Virtue

Chapter four articulates the various knowledge and skill-based facets of clinical ethics. These facets are elements for ethicists and are necessary accompaniments to a formalized certification program in clinical ethics. While skill and knowledge-based criteria in normative methods of ethics are independently vital aspects of clinical consultations, identifying the correct skills and knowledge points are necessary for the sake of this analysis. Areas such as informed consent, conflicts of interest, refusal to treat, and medical futility are all necessary knowledge

components. However, these components must become understood by ethics consultants with an accompanying ability to philosophically deliberate with analytic moral reasoning skills.<sup>61</sup>

Furthermore, these topics, among various others, must accompany a formal ethics curriculum for clinical consultants in a philosophical context. In conjunction with the philosophical themes and the consultation methods discussed in chapters two and three respectively, chapter four of this dissertation combines philosophical theories with an expansive knowledge base that clinical ethics consultants must understand to receive certification.<sup>62</sup>

#### 1.4.1 Moral Reasoning for Ethics Facilitation

Section 4.1 illustrates the importance of virtue-identification in clinical health care ethics consultation and the subsequent moral reasoning skills that follow. Identifying virtue in health care ethics reveals the philosophical underpinnings of moral decision-making and the proper methods of facilitation involved in health care ethics consultation. The chapter begins with an analysis of Kantian and Aristotelian virtue ethics. In doing so, philosophical methods of identifying virtue, a key prerequisite understanding of analytical moral reasoning skills, unearth and permeate several facets involved with health care ethics consultations. Uncovering these analytical moral reasoning skills ultimately aids the consultation process by providing consultants with an applicable set of reasoning skills that ground themselves in analytic moral theory.<sup>63</sup>

To uphold the ethical practice of medicine and the various facets of a formidable approach to clinical ethics consultation, certain areas of moral knowledge within health care ethics must receive attention. Specifically, the ethical facets of virtue ethics and the development of analytic moral reasoning skills through the identification of virtue. Attaining moral reasoning skills allow ethicists to understand the roles of medical professionals.<sup>64</sup>

Synonymous with Kant's moral theory, treating human beings as means to ends rather than ends in themselves do not adhere to the canonical principles of bioethics.<sup>65</sup> For instance, exploitation in medicine may become identified in medical practice if certain maxim criteria are met. First, patients are in jeopardy of succumbing to unethical practices if the treatment proposed to them benefits the health care professional in a manner that violates fiduciary duties.<sup>66</sup> Second, exploitation takes place if the mutual benefits of a treatment violate the integrity or authenticity of the acquisition of consent.<sup>67</sup> These two criteria demonstrate the exploitation of patients by treating them as means to ends rather than ends in themselves. Obtaining consent from patients can certainly serve as a medium for exploitation through its improper acquisition.<sup>68</sup>

Chapter four demonstrates how a clinical consultant's understanding of philosophical concepts in ethics aid patient autonomy by allowing individuals to make informed decisions about their course of treatment. Furthermore, a clinical ethicist's knowledge regarding philosophical concepts in ethics bolsters advocacy for patients in vulnerable populations, including the economically disadvantaged, the disabled, and the elderly. These individuals are especially susceptible to exploitation because of their economic, physical, and socially discriminated situations.<sup>69</sup> Simply excluding these groups from medical treatment or research is not an option because it would be unjust and discriminatory.<sup>70</sup> Furthermore, excluding these individuals from or coercing them into a treatment plan that they may not understand or agree to violates their autonomy and violates the physician's role as a healer and philosopher.<sup>71</sup>

Health care ethics consultants require an ability to critically analyze situations, facilitate discussion, and make analytic moral judgments.<sup>72</sup> Under the guise of Kantian virtue ethics, this analysis shows that agents who flourish as a moral authority and also promote the happiness of others are cornerstones in ethical work. However, both ends must become framed within a

practical receptacle if an ethics consultant is to make analytical moral judgments in health care.<sup>73</sup> Among the skills ethics consultants must acquire, analytic moral reasoning is a category of imaginative skills that do not receive priority. The practical skills that ethicists learn and enact typically involve proper bedside manner, conversational mediation, and rules that dictate permissibility. However, by examining a philosophical basis for virtue, ethicists may become moral agents in their practice and subsequently engage in analytic moral decision-making when exercising practical consultation skills.

A moral agent accomplishes the specific ends toward which he must project by exercising virtues that inevitably engage in ends themselves. In other words, virtues are ends in themselves rather than means to various ends. For the sake of this analysis, the virtues of wisdom, justice, compassion, and humility serve as demonstrative skills that promote a consultant's analytic moral reasoning abilities.<sup>74</sup> By identifying these virtues through an Aristotelian lens, the discussion evolves into a critical analysis that promotes the function and use of Aristotelian virtue ethics in the everyday practice of clinical ethics consultations.

While this task is demonstrated in practical terms, the discussion advocates for the implementation of educational facets of Aristotelian virtue ethics into a formalized ethics consultation curriculum. While various clinical ethicists are already familiar with Aristotelian ethics, forming curriculum components that become teachable for budding clinical ethicists allows these individuals to implement virtue identification into their practice becomes a tenable endeavor. Furthermore, understanding and implementing Aristotelian virtue ethics into a formal consultation curriculum for clinical ethicists allows these individuals to balance moral decision making with practical knowledge points outlined by the ASBH and its CECA subcommittee. These skills are further elaborated in a research ethics venue. In doing so, the discussion

demonstrates the effectiveness and malleability of Aristotelian virtue across an array of bioethical venues.

#### 1.4.2 Reasoning & Virtue: A Research Ethics Model

Section 4.2 takes the knowledge and skill sets acquired from identifying virtue in an Aristotelian fashion and applies them to a research ethics model. The knowledge aspects of clinical ethics listed in chapter four are necessary components for clinical ethicists. Furthermore, these components must receive comprehensive understanding by clinical ethicists. Subsequently, clinical ethicists can apply moral knowledge through analytic moral reasoning skills.<sup>75</sup> Analytic moral reasoning skills become the focus of the dissertation's contribution and these skills only come to fruition if the practical skills for becoming a clinical ethicist outlined by the ASBH and its CECA subcommittee are combined with the moral and philosophical aspects of Aristotelian virtue identification. In doing so, a formidable ethicist is trained in both practical terms and may begin to hone their abilities to identify moral issues and facilitate discussion.

Clinical ethics consultants are responsible for an array of issues. These issues span across various departments and specialties in clinical settings. In this respect, the ethical responsibilities of clinicians have no bounds. However, it is imperative that clinical ethicists understand fundamental knowledge points that allow their subsequent application within different departments and clinical situations.<sup>76</sup> In terms of research ethics, institutional review boards (IRB) and clinical consultations possess tremendous clout when determining ethically permissible situations. By refining a clinician's ability to morally reason in an analytic fashion, ethicists can maneuver and curtail their skills for research contexts.<sup>77</sup> Section 4.2 examines the philosophical foundations of informed consent in medical research by addressing the philosophical theories of deontological and utilitarian ethics.



By examining ethical theories and the problems that accompany them, this analysis promotes a turn toward virtue ethics as a practical means of obtaining mutual understanding between researchers and research participants. In turn, the virtuous relationship formed between researchers and research participants becomes applicable to other clinical scenarios. The discussion begins with a historical account of informed consent via the Nuremberg Code. From this historical analysis, the discussion turns toward deontological and utilitarian theories of philosophy followed by the difficulties that accompany these theories and their influence on informed consent in research. The discussion then explains the existence and importance of morality in medicine and the virtues that accompany morality.

Again, the discussion elaborates upon the importance of virtue identification in both clinical ethics situations and ethically precarious research issues. By implementing virtue and virtue identification techniques to a clinical ethics consultant's arsenal of skills, various resolutions to problems that otherwise do not receive adequate attention become far more manageable from a bioethical standpoint. Examining the deontological and utilitarian facets of informed consent expose the issues associated with these theories in specific clinical instances. To reconcile these issues, the discussion advocates for a virtue identification model for clinical ethics consultations that aids in both analytic moral reasoning and promotes the practical skills associated with already instantiated education programs. Finally, the discussion continues to elaborate upon the practical use of virtue ethics and moral virtues to demonstrate a philosophical theory that upholds autonomy while simultaneously providing agreement and understanding from all parties involved in research. In doing so, the issues surrounding medical morality, the implementation of virtue ethics, and the practical virtues associated with Aristotelian virtue ethics become clear.<sup>78</sup>

## 1.5. Chapter 5: Residency Requirements for Clinical Ethics Consultation

Chapter five describes the practical aspects of establishing a formalized certification program and curriculum for health care ethics consultants and the ways in which the key components for an ethics consultation curriculum presented in this analysis pertain to a formalized certification program for ethicists. The discussion achieves this task by amalgamating the skills established by the ASBH and CECA with the analytic moral reasoning skills derived through virtue identification. The dissertation asserts that the skill and knowledge points described by the ASBH and CECA, when amended with the virtue identification skills presented in this analysis, contribute facets of analytic moral reasoning skills to budding ethicists. In turn, this task aids the overall legitimacy of clinical ethics consultants. The proposed curriculum points culminate with a practical application of moral reasoning skills and recognize the necessity of moral theory and philosophical discourse in contemporary ethics.<sup>79</sup> This task is achieved by uncovering the practical manifestation of a curriculum in an organizational framework.

Additionally, chapter five attempts to identify the various issues that accompany an ethics consultation curriculum that contains the key components mentioned in this analysis. Issues that accompany establishing clinical ethicists as professionals in health care range from amending the cultural and professional barriers that clinicians face to the overall medical community's acceptance of ethics consultation as a service in clinical medicine. While these issues are made apparent, a solution to these issues lies in the establishment of clinical ethicists as sole-consultant models. In doing so, the sole-consultant model allows clinical ethicists to implement the already formidable knowledge and skill points and the proposed curriculum points of virtue established in this analysis.

Finally, chapter five concludes with an important discussion regarding the already established methods of implementing ethics education in hospital settings via the European model of ethics education presented by Pegoraro, Putoto, and Wray. The presentation of their attempts at establishing an educational component for ethics in hospital settings both bolsters the relevance of this dissertation's goals and simultaneously presents a venue where the key curriculum components mentioned in this analysis may apply.

#### 1.5.1 Professional Ethics in Organizations

The role of ethics in organizations is far more debated than the presence of ethics within organizations. However, the current difficulties in determining the role of ethics, including its limitations, stem from a misuse of ethics education and a misunderstanding of ethics in general. By identifying instances of ethics in professional practice, organizations, and other health care institutions, both the role and scope of ethics at the organizational level becomes clear. Additionally, the curriculum components addressed in this analysis becomes clearer upon revealing the practicality of their function within an organizational framework. Examining the ethical components that ought to be entailed within organizations both contribute additional knowledge points for ethicists and aid in justifying the need for the proposed curriculum points presented in this analysis.

The concepts of professional character, integrity, and stewardship play vital roles in the betterment of an organization and the development of an effective clinical ethicist. These characteristic elements of organizational ethics are both indicative and obligatory of a moral institution.<sup>80</sup> A clinical ethicist's knowledge base must expand beyond their practical skills and permeate the institutions where they work or perform consultations. For instance, a Catholic-affiliated health care institution enforces different standards than a secular institution.<sup>81</sup> In this

respect, clinical ethicists must possess ample knowledge regarding the ethical and religious directives for Catholic health care (ERD), Catholic social teaching, and Catholic identity.<sup>82</sup>

Since clinicians must become versed in areas that span beyond secular ethics, various religious perspectives and private health care facility policies must become entailed within a comprehensive certification curriculum. This example intends to demonstrate one of the many practical knowledge points clinical ethicists ought to understand if they intend to become productive and effective professionals in ethics. However, while this specific example demonstrates a field of expertise that should be taught to ethicists in training, the beauty and effectiveness of an ethics consultation curriculum shines through its ability to adapt and conform to demands in contemporary health care while simultaneously maintaining its roots in fundamental ethical themes.<sup>83</sup>

By entailing these facts within a certification standard, ethicists may possess credentials that recognize their overarching knowledge. Furthermore, since the goal of clinical ethicists is to facilitate discussion and aid patients, families, and other health care professionals in moral decision-making, each consultant must understand how the same facilitation skills are used in organizational ethics issues.<sup>84</sup> These issues may include the permissibility of lethal force by security officers, rights of transgender patient populations, billing and coding for electronic medical records, and mission and identity standards.<sup>85</sup>

While this proposal does not deviate from the already proposed consultation education programs for clinical ethicists, it is imperative that these methods are observed in a manner that factors in this dissertation's proposed curriculum components of virtue through an educational process for clinical ethicists. While the novel approach to key curriculum components in virtue seem like an onerous undertaking, uncovering the virtuous facets that ought to be entailed in a

clinical ethicists education can seamless integrate into the overall training and development of clinical ethics consultants.

Section 5.1 elaborates the importance of a clinical ethicist's proficiency regarding institutional ethics knowledge and skills by discussing the interdisciplinary function of ethics across various hospital departments. One of the major areas in which ethics intersects another field is mission integration. While many secular hospitals may not have a mission integration department or team, these hospitals still possess an identity and role within their community. By ensuring an ethicist's knowledge and subsequent skill bases for mission integration and identity, ethicists are then able to participate in strategic planning and administrative deliberation.<sup>86</sup>

The abovementioned knowledge and skills ultimately culminate with curriculum components that aid an ethicist's ability to facilitate discussion and resolve conflict. The ethicist's ability to recognize and defuse conflict amongst stakeholders inherently entails their ability to recognize the difference between futile and non-futile treatment standards, capacity standards, and surrogate hierarchies.<sup>87</sup> A clinical ethicists' role must present in a professional manner. In this respect, the ethicist is a source guide or resource for all individuals in need of moral, ethical, and practical guidance regarding all facets of health care. Despite this vast undertaking, the ethicist can facilitate health care situations due to their expansive knowledge and overarching application of skills.<sup>88</sup> Instances such as beginning and end of life care, non-terminal requests to die, advanced directives, and cooperation standards are all under the guise of an ethicist, provided a discrepancy is present or is foreseeable.<sup>89</sup>

While section 5.1 attempts to demonstrate the lasting utility and efficacy of virtue ethics and analytical moral reasoning skills throughout health care organizations, the proposed dissertation argues for a novel means of ethical training for consultants. Specifically, the use of

virtue ethics in health care ethics training.<sup>90</sup> Introducing a virtue component to aspects of organizational ethics like professional integrity, organizational stewardship, and mission integration already possess inherent aspects of virtue. However, these virtuous aspects only come to fruition once a formal education program for clinical ethicists emphasize the importance of implementing virtue identification techniques into its curriculum.

Clinical ethics consultants are inherently involved with an occupation that involves the integration, implementation, and dissemination of virtue.<sup>91</sup> While virtue presents itself in different clinical instances, it is the task of the clinical ethicist to recognize and explain the ways in which virtue manifests. In this respect, the trained ethicist is the first line of defense for ethical deliberation. From this standpoint, the clinical ethicist is responsible for not only assessing instances of virtue, its deficiencies, and its excesses, but he is also responsible for articulating the methods in which virtue manifests in health care organizations. Furthermore, since the ethicist is familiar with the ethical concepts that derive from virtue, he is also responsible and obligated to educate other professionals in health care about virtuous practices and how to regulate their application.<sup>92</sup>

Since clinical ethicists are the most qualified individuals for facilitating virtuous behaviors in a health care system, a formal education in the form of a residency program expedites the integration of virtue throughout an institution. The integration of virtue ethics into organizational curriculums justifies the virtuous nature involved in the profession of clinical ethics and demonstrates the need for both formalizing ethics education in health care organizations and implementing virtue ethics as a standard competency.<sup>93</sup> While a robust philosophical background is an extremely helpful asset for clinical ethics consultants, it is simply impossible to expect a multidisciplinary field like bioethics to accommodate individuals to

possess this prerequisite. Alternatively, a health care organization's educational emphasis on virtue-identification techniques yields a set of analytic moral reasoning skills that serve as a profound substitute for an extensive background in moral theory. These analytic moral reasoning skills are fundamental and infinitely useful due to their ability to bolster and adopt practical competencies, promote ethical character, and further establish an organization's duties toward stewardship and integrity.<sup>94</sup> However, according to Aristotle, virtue is a teachable skill that can be refined and developed through practice and practical instances. By implementing the key components of virtue into an ethics consultation curriculum, clinical ethicists can be trained and practice virtue as a practical skill.<sup>95</sup>

Ethicists achieve moral reasoning skills that are relevant to their practice by understanding the nature of virtues in health care and how to identify instances of virtue throughout health care. While an ethics program that teaches analytic moral reasoning skills is both possible and needed, many issues surrounding philosophy's position in contemporary health care must receive further attention. Examining the issues that surround this proposed dissertation's method of ethics education allows practical development of residency programs for clinical ethicists. A primary issue surrounding philosophy's role in health care ethics involved the implementation of conflict resolution techniques in an ethics curriculum. The portrayal of diffusion techniques that surround a virtue-based model of ethics facilitation is a method that is both rooted in contemporary evidence and proves effective in contemporary instances.<sup>96</sup>

### 1.5.2 Applied Program Issues

Part 5.2 of chapter five culminates with an examination of the issues that accompany the implementation of the key components for an ethics consultation curriculum mentioned in this analysis. In effect, analyzing the issues that accompany implementing key components to an

ethics consultation curriculum aids the formalization of a residency program and the provision of a venue in which medical institutions may provide a recognized and accredited certification for clinical ethics. Although the CECA committee presents a series of protocols for certifying ethicists, including an extensive portfolio, these protocols do not emphasize the knowledge points explained in the proposed dissertation.<sup>97</sup> Thus, the CECA certification protocols require further modification. Furthermore, the proposed curriculum components must become inherently entailed within a program that facilitates the professional development of practicing ethicists.<sup>98</sup> In this respect, the residency program curriculum and structure may become altered in accordance with the individual residency program's guidelines.<sup>99</sup> The analysis attempts to reconcile these issues by advocating for a sole-consultant model in clinical ethics. The benefits of this model are expansive and both aid the development of a professional program and improve upon already established methods of training.

Naturally, practical concerns regarding these programs are vast. Issues concerning cost, staff, administration, and resource availability are all concerns that require internal review and institutional discussion.<sup>100</sup> While a program has the potential to run smoothly in teaching hospitals, introducing residency-style programs for ethics departments in hospitals that do not have a resident staff is problematic. Further practical concerns reside in administrative approval. While developing an ethics program is appealing for ethicists, non-ethics staff may identify a program's efforts as self-serving or inapplicable for a practical medical framework. These issues are addressed by examining the possible reasons behind the inherent lack of ethics acceptance, including gaps in education about ethics consultation services and fears surrounding ethics-policing. Additionally, the section addresses practical concerns surrounding professional ethics



training, including viewing ethics as a billable service and the utility of ethics in non-clinical departments.

A final concern in the proposed dissertation includes the existing efforts to establish hospital-based residency programs for ethicists in European models of ethics training. The discussion addresses the efforts made by Renzo Pegoraro and examines the benefits of his approach. The discussion then explains the benefit of implementing the key curriculum components mentioned in this analysis to a model like Pegoraro's. In doing so, the risk of a program's disapproval based on its rootedness in philosophical concepts becomes thwarted. The health care industry works on a practical basis and rarely presents opportunities for theoretical analysis or deliberations. While virtue plays a primary role in developing analytic moral reasoning skills and serves as an educational focal point for the program, the way in which virtue manifests in a contemporary care setting does not need to deviate from practical standards of practice and medical care. By introducing an ethics residency program in a manner that demonstrates institutional benefits across a health system, a virtue-based model becomes far less intimidating for health care professionals and allows philosophically rooted concepts to permeate professional health care.

#### 1.6. Chapter 6: Conclusion

Despite the difficulties that accompany a residency program for ethicists, the proposed dissertation asserts that a residency program for clinical ethicists rooted in analytic moral reasoning and virtue ensures proper educational aspects of clinical ethics education. Although issues like cost, resource allocation, jobs, and continuing education are still present, this dissertation indicates the possibility of a residency program for ethicists that is rich in moral theory. This type of education for clinical ethicists contains necessary knowledge and skill

components that an ethicist must possess if he seeks to perform consultations, clinical meetings, and institutional facilitation effectively.<sup>101</sup>

Chapter two of this dissertation begins with a historical analysis of both the philosophical lineage of moral theory as well as the development of normative methods in contemporary bioethics.<sup>102</sup> This chapter intends to trace an ethical history that bolsters and justifies the educational components involved within a formalized ethics program.<sup>103</sup> The advantage of chapter two lies in the historical transition from theory to practice. In effect, the historical tracing of ethics demonstrates pragmatism's influence on contemporary bioethics. Alternatively, chapter three demonstrates the breakdown of theoretical wisdom into skill-based criteria.<sup>104</sup> While the contemporary models of health care ethics demonstrate a formalized definition of clinical ethics, the CECA's emphasis on skill-based practice is indicative of a degradation of moral theory. However, the effectiveness of the CECA's accreditation program lacks a fundamental emphasis on knowledge-based elements derived from the history of philosophy and moral theory. Chapter three exposes half of the criteria necessary for certification for clinical ethicists.<sup>105</sup>

Chapter four exposes the second half of the criteria necessary for certification for clinical ethicists by presenting several knowledge components of clinical ethics. These knowledge components divide into two sections. The first section emphasizes the importance of the philosophical wisdom and theory that supports fundamental facts of clinical bioethics, including informed consent, paternalism, and exploitation.<sup>106</sup> These knowledge components are important for clinical ethicists due to their rootedness in moral philosophy. While skill-based components in bioethics are applicable insofar as clinical situations present an applicable venue for these skills, knowledge-based criteria are fundamental components that may apply throughout various instances.<sup>107</sup> In this respect, developing a certification program through an individualized ethics

residency program is far more tenable. The second half of chapter four discusses conflict resolution, futility, and addressing patients within an organizational framework. While clinical ethics presents various facets of moral theory, understanding how ethical facilitation works at an organization level is an imperative component for a clinical ethicist if he seeks accreditation.<sup>108</sup>

The dissertation concludes with a final chapter that both combines the theoretical and skill-based practices of an ethicist as well as demonstrates how a clinical ethics residency program may manifest. This is accomplished by outlining the organizational details that surround the establishment of a program as well as the accompanying issues that require attention. Furthermore, this chapter also demonstrates how a clinical ethics residency program justifies a certification for professional ethicists.<sup>109</sup> The chapter describes the importance of amalgamating both the knowledge and skill facets of clinical ethics and addresses the issues that accompany the proposal of the key components mentioned in this analysis.<sup>110</sup>

Formal certification requires a curriculum of knowledge and skill sets that ensure a professional's complete understanding. A professional in ethics must understand facilitation techniques as well as the theoretical frameworks in which health care ethics derive these techniques. Formalizing a residency program through the amalgam of theory and skills yields a qualified individual capable of ethics consultation both clinically and organizationally.<sup>111</sup>

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## Chapter 2: The Emergence of Clinical Ethics

Establishing key components for a contemporary ethics consultation curriculum requires a retrospective analysis of clinical ethics. Additionally, this task requires an analysis of the themes that clinical ethics is historically responsible for developing. Despite a health care provider's obligation to provide informed consent in medical practice, the acquisition of informed consent from patients is often dismissed, ignored, or improperly obtained by healthcare professionals. Chapter two analyzes the importance of informed consent and the philosophical justification for its acquisition by tracing a lineage of clinical ethics. This task is accomplished by addressing how and for what purpose clinical ethics holds relevance in medical practice. The theoretical framework of consent, as well as the contemporary consultation models that attempt to uphold autonomy, are examined and presented as historical landmarks that indicate the progress of moral philosophy's involvement with human health. This analysis aids the way in which key components for an ethics consultation curriculum form.

This discussion begins by attempting to suture the divided roles of physicians and philosophers by demonstrating the inherent benefits of their union as well as the historical lineage of their partnership. The amalgam of these roles shows that a dialectical method of ethical medical practice is achievable by unifying these disciplines under a mutual understanding of a common morality; a concept that has been thwarted with the emergence of modern medical technologies and behavioral paradigm shifts.

This chapter subsequently discusses the philosophical justification and basis for patient and physician autonomy; two facets of mutual respect that are often biased. This discussion explains the importance and inherent nature of autonomy and indicates the role autonomy plays in the informed consent process through an ontological approach to human health. Additionally,

this discussion emphasizes the difficulties associated with obtaining informed consent to illuminate the importance behind legitimizing clinical ethics in contemporary health care. Paternalism is then discussed as one of the most formidable ethical themes surrounding contemporary threats to autonomy and aids in demonstrating the need for professional ethics consultants.

This analysis indicates that ethics committees and ethics consultations are necessary components for maintaining the integrity of informed consent and upholding human autonomy. However, the ways in which these moral themes manifest in contemporary medicine are further illuminated by demonstrating their presence in practical instances. These practical instances are further expedited with examples that model ideal instances where moral deliberation and methods of clinical ethics consultation are necessary. These instances are prominent in discussions surrounding contentious topics in genetic technologies and emerging medical technologies.

The continued discussion elaborates upon the issues that surround human autonomy and the role of ethical intervention by delving into the complexities surrounding genetic technologies and the methods of ethics consultation that are currently used to facilitate discussion amidst value-laden discrepancies in health care. Genetic alteration, testing, and screening have become questionable endeavors in recent years due to the moral and ethical implications of their practice as well as the pace at which these technologies have developed. To expand upon the necessity of implementing key curriculum components into a clinical ethics consultation curriculum, the areas of health care that contain some of the most pressing issues must receive attention.

### 2.1. Autonomy, Paternalism, and Consent

Ethical questions surrounding genetic medical science involve determining moral

judgments, upholding autonomy, and obtaining informed consent. Subsequently, these judgments aid in discerning between interventions that are possible and interventions that are necessary. Chapter two continues to evaluate the impending issues surrounding autonomy and consent by evaluating the dangers of genetic technologies. To expand upon the theme of suturing the divide between the physician and the philosopher, the discussion implements continued philosophical themes by analyzing the dangers of modern technology outlined by German phenomenologist Martin Heidegger. Heidegger's emphasis on the dangers that accompany man's relationship with technology can be compared with contemporary issues surrounding the ethical permissibility of genetic modification and have the potential to reconcile modern debates found in ethics consultation models. This analysis stresses the role of genetic ethics consultations and their educational importance for researchers. In doing so, the discussion continues to shape the key components that ought to be included in a consultation curriculum for clinical ethicists.

#### 2.1.1. Physician and Philosopher

To formally examine the necessity and requirements for key components for an ethics consultation curriculum, the role of the physician is examined historically. The role of the physician, although commonly understood as an individual who heals, must be examined through a multi-faceted lens to grasp the full extent of his duties. Due to the vast conglomerate of information and responsibilities that accompany the role of a physician, an appropriate method in which this occupation may be explored is by examining the physician as a philosopher. The multitude of attitudes about physicians may be defined and explicated properly if the physician's roles are explained in terms of healing and engaging in an affinity for knowledge. This section attempts to show that as a healer, the physician must inevitably engage in a co-dependent relationship with himself as a philosopher and physician.

### 2.1.1.1 A Philosophical Method for Medical Professionals

Establishing a fundamental philosophy that fuses the nature of medical practice with dialectical analysis adds disciplined elements and criteria to the process of ethical decision-making.<sup>1</sup> This process both aids in ethical decision-making on the part of the physician and avoids ambiguity or superfluous practices in ethical decision-making. For the physician to become a philosopher and thus practice ethical medicine, a formalized method and philosophy must be established. Philosophical pursuits must be viewed as dialectical pursuits.<sup>2</sup> In other words, the philosophical aspect of medicine must be viewed as a tool that can approach problems or sets of problems in a constructive manner.<sup>3</sup> The problems associated with medical practice and ethics are vast and can range from differing ideas to contentious concepts. The range of issues exemplifies the nature of the history of moral philosophy and the contemporary issues that accompany medicine today.<sup>4</sup>

To develop a disciplined philosophy of medicine and thus establish the physician as a philosopher, the language, functions, and goals of a philosophy of health must be defined and recognized.<sup>5</sup> This establishment process emphasizes the need and inherent nature of dialectical practice in medicine. This dialectical practice serves as a means that is recycled and revisited to solve the limiting factors of a discipline.<sup>6</sup> In medicine, problematic issues include the role of physicians as healers, acts that are implicitly involved in medicine, and administering healing techniques. The most pressing issue, however, involves the prerequisite act of receiving consent from ill individuals. These issues are problems that a philosophical dialectic can solve if the theory, practice, and role of philosophy in medicine are properly defined. Specifically, dialectic serves as a significant means of resolving the discrepancies surrounding informed consent due to the philosophical nature of consent's acquisition. As a philosopher, the physician must partake in

dialectical processes that develop critical reflections on issues like informed consent.<sup>7</sup> However, dialectical examinations must start at the beginning of care and at the outset of a professional's education.

The physician-philosopher must begin with issues that coincide with the praxis of medicine and subsequently implement a philosophy of experience for medical practice.<sup>8</sup> For the purposes of this analysis, the issue of informed consent and the philosophical justifications for autonomy are presented as a primary dialectical focus for the physician-philosopher. By amalgamating the nature of medical practice as a practice of healing and the philosophical analysis of dialectical problem solving, the physician may then serve a professional role in achieving new aims of medicine and bolster the inherent ethical aspects of his practice.<sup>9</sup>

#### 2.1.1.2 Common Morality: Development and Issues

The establishment of the physician as a philosopher is a professional amalgam of two disciplines that attempts to resolve the discrepancies of ethical issues through dialectical means. To address an ethical issue in medical practice as pressing as informed consent, these disciplines must communicate in a common language that permits the practice of philosophy to engage in the art of medicine. However, this language must be consistent and understood throughout cultural barriers, practices, and customs. A philosophical standard is no easy task and can only be developed through a common morality. Common morality ensures that a moral norm or disposition is established and is shared by all committed persons who engage in ethical practice.<sup>10</sup>

Due to modern advancements in medicine and the accompanying difficulties of new ethical conundrums, an ethical standard that stretches across several instances must be established if a mutually respected ethic is capable of development.<sup>11</sup> In order to develop a universal standard of ethical practice, or, common morality, basic ethical principles must be

identified and used as the grounding for further development of ethical determinations in clinical practice.<sup>12</sup> Since many variances in medical practice exist, philosophy must intervene and play a central role in forming ethical principles that practitioners can both abide by and use to aid in advancing the practice of medicine.<sup>13</sup> In this respect, philosophy aids medicine as a means to ending relativistic notions and practices of medicine. For example, who is to say what harm is or what medical treatments are excessive? What qualifies a physician to make these claims and how do these claims impact patient rights?<sup>14</sup>

In order to suture the divide between philosophical principles and medical decisions, the dialectical amalgam of judgments and morals must be established through specific contexts.<sup>15</sup> By examining ethical situations on a case-by-case basis, while simultaneously maintaining a set of principles and moral norms, ethical discrepancies may be resolved by partaking in dialectical conflict resolution.<sup>16</sup> This process involves defining the specifics of a case and clarifying both the language of medicine and philosophy. This process not only aids the implementation of philosophical practice in medicine, but also reaffirms the commitments of the individuals involved in clinical cases and reduces conflicts between parties involved in ethical decision-making.<sup>17</sup>

The common morality serves as a universal ethical grounding that clinical ethicists may find useful when dealing with multi-faceted and variant ethical dilemmas. Common morality serves as an applied ethical standpoint that develops general principles while the philosopher-physician serves as a medium through which these principles apply.<sup>18</sup> Although this point becomes clear throughout this analysis, the common morality serves as a set of principles that can only be upheld through a group of individuals who both understand the letter and spirit of the ethical law. These individuals both address issues of ethical authority in healthcare and aid in

negotiating between stakeholders. Common morality must also become understood as a language that requires skilled interpreters and translators. The key components for an ethics consultation curriculum described in this analysis aid in training clinical ethicists to become translators of common morality.

### 2.1.2. Philosophical Analysis of Human Autonomy and Self-Care

There is an inherent necessity for the physician to reconcile his relationship with the philosopher if he is to partake in dialectical practice. The philosophical method in which a dialectical approach may be used to examine issues in contemporary bioethics both sutures the divide between theory and praxis and presents a foundation upon which a common morality may be formed and respected. Now that the philosophical methods of medical practice are established, various issues in medical ethics may be addressed. However, the issue of informed consent stands out as one of the more pressing issues in contemporary healthcare. To understand the purposes of informed consent and the benefits it yields in ethical practice, a philosophical analysis of human autonomy and the ontological justifications that accompany human autonomy must be examined. This examination, like the discussion of common morality, grants informed consent a foundation upon which its practice is based.

#### 2.1.2.1 Autonomy as a Precondition for Ethical Practice

In order to promote and respect the practices behind medical practice, informed consent must be justified by acknowledging personal autonomy.<sup>19</sup> Achieving personal autonomy as a prerequisite condition for ethical practice begs the questions of how, why, and when autonomy is achieved.<sup>20</sup> The precondition or prerequisite function of autonomy is to provide aid by treating persons as ends in themselves.<sup>21</sup> By taking charge of one's decisions and recognizing one's capacity to approach their ends (*telos*) as ends in themselves, autonomy becomes a reflective act

that promotes an individual's ability to formulate and endorse a self-determined plan.<sup>22</sup>

Autonomy only becomes a genuine act of self-care and a precondition for ethical practice when the agent remains consistent in his plan regarding his reflections and considerations toward self and others.<sup>23</sup> In this respect, the act of becoming autonomous is synonymous with the physician's role as a philosopher. The autonomous agent amalgamates praxis and theory by both taking charge of his circumstances and acting reflectively upon his decisions.<sup>24</sup>

Although taking charge of one's circumstances and engaging in self-reflective exercises serve as key elements in autonomy, autonomous action becomes problematic when authoritative figures threaten the ends toward which one directs themselves.<sup>25</sup> The physician is commonly the authoritative figure that is accused of hindering personal autonomy in healthcare. Theorists speculate that autonomous individuals lose their ability to remain consistent in their reflective capacities when authoritative figures, like the physician, sway the decisions of individuals who were, at one time, self-determining. In this respect, the autonomous individual is never fully autonomous because the influence of external authorities always threatens personal decision-making.<sup>26</sup> However, this discrepancy is not an issue if no influential problems exist between external authorities and individuals. An autonomous individual may make independent choices even with the external influence of other individuals.<sup>27</sup> Following a medical authority in a situation where medical expertise is needed does not necessarily limit one's autonomous decision-making. Instead, the autonomous agent must take the information from the medical authority objectively and decide upon a treatment or action based upon proper dialectical deduction and regulation of information.<sup>28</sup>

Although various issues arise when considering the limitations of autonomous choices in medical practice, the possibilities and concepts presented to an individual do not necessarily



inhibit the individual's autonomy. Often, the autonomous individual encounters a problem with external influence because the agent presenting external information does not perform this task in a conducive manner to one's autonomous flourishing.<sup>29</sup> Although the autonomous individual is equipped with the necessary tools and skills for adjudicating between various types of information, he may not be able to do so without the aid of a conglomerate of professional individuals that aid in honing these skills.

This conglomerate of professional individuals manifests in the form of ethics committees and ethics consultants. However, ethics committees and ethics consultations serve as sects that respect the autonomy of individuals in a manner that all individuals ought to abide by.<sup>30</sup> The need for ethics committees and consultation arises due to the shortcomings of medical professionals and healthcare professionals, especially when attempting to obtain consent from individuals. Ethics committees provide actions for individuals while keeping a distance to allow the autonomous agent to exercise self-care.<sup>31</sup>

#### 2.1.2.2 The Ontological Justification for Autonomy: Ontology of the Body

In continuing to justify the process of informed consent by establishing the role and nature of autonomy, an ontological discussion of the body is a necessary component for identifying the uniqueness and differentiating factors for human beings. Furthermore, an ontological analysis aids the discussion by demonstrating the role of medicine and its influence on the body. Since medicine is a practical theory of human experience, physicians are primarily concerned with remedying illnesses, healing the body, and uncovering causes of disease.<sup>32</sup> In this respect, medicine is a praxis applied to a theory. Specifically, medicine is a praxis that is dedicated to uncovering wisdom about human beings.<sup>33</sup>

This act is inherently ontic by definition and requires attention due to its relevance to

informed consent and autonomous decision-making. Furthermore, the ontological nature of medical practice is further explicated because the study of the body attempts to discover human ends and purposes.<sup>34</sup> The crux of autonomy rests upon the pursuit of uncovering individual ends in themselves, and the ontic side of medical practice attempts to uncover ends and purposes. The ontology of medical practice is an investigatory pursuit of human autonomy and thus demands philosophical attention from medical professionals.<sup>35</sup> While autonomous human beings pursue their own ends as ends in themselves, the ontological aspect of medicine seeks the moral ends of medicine.<sup>36</sup>

The key point of the ontological investigation of human beings and medicine rests upon medicine's inability to account for the value of health purely on mechanical and quantifiable terms.<sup>37</sup> In this respect, human life cannot be merely quantified and thus requires philosophical import in order to understand the complexities and difficulties that accompany autonomy and life-determining decisions of autonomous individuals.<sup>38</sup> This ontological investigation of the human body and the practice of medicine shows that medicine, as a philosophy, practices methods of uniting autonomy with personhood and that these aspects are implicit facets of the human body. These aspects further bolster the need for ethics groups that can both consult and advise individuals on how their autonomy may be upheld when issues of consent arise.<sup>39</sup>

### 2.1.3. The Process of Informed Consent

Now that the divide between the philosopher and the physician has been reconciled, the common morality has been established as a foundational grounding of medical ethics, and the importance of autonomy and ontology have been established as focal points of ethical practice in medicine, the practice of obtaining consent for medical intervention in an ethical and moral manner may be addressed. The following section explains the importance of providing patients

with ample written information regarding their course of treatment. In doing so, patients become fully informed before they may exercise their autonomy and thus provide clinical consent.

#### 2.1.3.1 History and Normative Methods: Written Consent and Information Disclosure

Historically, informed consent derives from medicine and biomedical research.<sup>40</sup> Issues of information disclosure, justice, and nondisclosure had been important aspects of biomedical research. However, the concept of informed consent only became prevalent in the early to mid-1970's when medical research and ethics began to focus on the physician's role as an informant for patients and research participants.<sup>41</sup> The informational role physicians were expected to serve came on suddenly during this time and consequently demanded a tremendous amount from them.<sup>42</sup> However, the physician's responsibility and obligation to disclose information and emphasize the quality of a patient's understanding of information opened the pathway to individual's rights to act autonomously and choose to not partake in treatment.<sup>43</sup>

During the 1950's and 1960's, the responsibility of physicians to obtain informed consent from patients was not yet formidably established due to the lack of information given to patients before obtaining consent.<sup>44</sup> Physicians typically performed operations or other medical interventions on human beings without asking nor obtaining their consent. In this respect, there was no appreciation or recognition of a patient's right to consent.<sup>45</sup> The physician-patient dichotomy was largely paternalistic due to the revered expertise of medical professionals. Due to federal intervention, physicians were required to inform and obtain consent from patients in both practice and research. However, the term "informed" was not defined formally and thus left the term and practice superfluously founded.<sup>46</sup>

Finally, in the 1970's the issue of individual liberty and autonomy became a philosophically relevant topic that directly pertained to patient rights and medically ethical

decision-making.<sup>47</sup> Without coincidence, the concern for autonomy, the foundation of informed consent, and the inception of bioethics occurred simultaneously.<sup>48</sup> Although the history and inception of informed consent is relevant to this analysis of autonomy, ethics committees, and ethics consultation, these facets of the discussion do not lend specific details to the philosophical role of the physician and the methods in which consent was historically obtained.<sup>49</sup> The conversational paradigm between patients and physicians accompanied various difficulties in modern medicine. While the weight of conversation originally resided on behalf of the medical professional, modern requirements of clinical consent in medical practice has resulted in instances of unruly demands from patient populations. This phenomenon can be articulated further by philosophically examining the concept of informed consent. Furthermore, an examination of contemporary informed consent will yield a beneficial link between autonomy and authorization- a divide in moral conversation that is partially responsible for communication disparities in health care.<sup>50</sup>

Signed consent exemplifies the lack of information that must be provided for individuals seeking medical intervention. Prior to uncovering what informed consent is, the *telos* of informed consent must be uncovered.<sup>51</sup> Realistically, full disclosure and uncovering every detail of a procedure is impossible and overwhelming for a patient. Instead, the individual must exercise his autonomy in order to discern what elements of a procedure or medical intervention are necessary and relevant.<sup>52</sup> An individual who is not coerced by outside influences and has ample understanding of the proposed intervention may authorize a health professional to perform a medical act upon them.<sup>53</sup> In this respect, the individual who consents is exercising his right as an autonomous decision maker by presenting a self-determining choice.<sup>54</sup> As this analysis demonstrated earlier, informed consent must be grounded in human autonomy if its practice can

be determined as an ethical practice. Truly informed consent cannot take place unless the patient makes an autonomous choice.<sup>55</sup>

The autonomous nature of a human being is certainly the focal point of informed consent and the bases upon which medical practice must abide by, yet relying solely on the autonomy of a human being is not enough. While autonomy justifies the philosophical bases of consent, the information that a human being must obtain prior to making an autonomous choice must be provided. The clarification of information regarding medical treatment stretches far beyond legality and into the realm of respect.

Healthcare professionals must provide information to patients in ways that are accessible and easy to understand.<sup>56</sup> Additionally, communicating with patients to understand their concerns and questions aids in understanding whether a patient wants to receive medical treatment or not.<sup>57</sup> Thankfully, various methods exist that can aid the difficulties that accompany the disclosure of proper information to patients before consent is obtained. These methods involve both oral and written information. The physician or medical liaison involved in a patient's course of treatment must relay information in a way that spends ample time explaining the details of a treatment objectively and in a manner, that reduces stress or notions of obligation.<sup>58</sup> The information should be delivered in oral form and also a written document that explains all relevant and necessary information regarding a course of treatment.<sup>59</sup>

Oral information is important to deliver to patients because a verbal depiction of a course of treatment allows the patient to hear a plan of action from a medical authority. However, the oral information is only as beneficial as the clarity of the written information. The written information should be a document that contains consistent language throughout and is easy to understand.<sup>60</sup> The accuracy and clarity of the written information ensures understanding for all

parties involved and avoids ambiguity when patients exercise their right as autonomous individuals by asking questions about the course of treatment.<sup>61</sup> The clarity of written information regarding treatment respects the rights of patients and promotes their freedom to voice their concerns and opinions about a course of treatment.<sup>62</sup>

Written information regarding a course of treatment must be composed in a way that is accessible and comprehensive, but not too overwhelming. Over-informing a patient can be overwhelming and provoke anxiety concerning the treatment.<sup>63</sup> In order to avoid issues of overwhelming patients, treatment information should provide essential points and suggest further information, questions, topics, or concerns.<sup>64</sup> Synonymous with substitutive judgments that are often used in clinical decision-making, the physician or research liaison that composes the written treatment information should include information that, in their eyes, a reasonable and responsible person would want to know.<sup>65</sup> In this respect, informing patients about treatments must be performed in a balanced manner that reconciles information with a manageable risk and benefit analysis.

#### 2.1.3.2 Upholding Autonomy in Informed Consent: Normative Methods in Practice

Despite the numerous standards and practices that justify the ethics of medical practice, the standard that promotes ethical practice is the acquisition of consent. Although informed consent is an ethical means of treating patients with dignity and respect, the process of disclosure and truly informed consent is achieved by maintaining the personal autonomy of an individual. By examining the instantiation and practice of upholding individual autonomy, one achieves a greater understanding of the importance and practice of informed consent.

Informed consent serves as a medium that reconciles the relationship between healthcare professionals and patients. Furthermore, bolstering this medium invests trust between involved

stakeholders. Trust, albeit a virtue in some circles, serves as a commodity that is expendable, earned, squandered, and invested. While not exclusively viewed as a resource, trust can serve as a currency that must become delicately balanced.<sup>66</sup> Upholding autonomy in medical practice requires the acquisition of informed consent, and this acquisition must abide by specific standards. These standards not only aid in promoting the proper ethical practice but also provide a stronger foundation upon which a trustworthy relationship between physicians and patients may form. First, the practices of a community or sect of individuals must exercise their rights as autonomous human beings who partake in the common morality and mutually agree on the beneficial standards of ethical practice.<sup>67</sup>

These standards, also known as the professional practice standards, may be difficult to uphold due to community disagreement or customary norms that do not abide by ethical norms.<sup>68</sup> Second, autonomous individuals must possess capacity in order to evaluate information objectively.<sup>69</sup> This standard is pertinent to individual autonomy because the respect for the decisional capacity of an individual upholds the self-care aspect of autonomy.<sup>70</sup> Patients must also determine if they have received an appropriate amount of information regarding a course of treatment.<sup>71</sup> Since patients require different forms of care, the adequate amount of information regarding treatment may fluctuate and may not even be quantifiable.<sup>72</sup>

Although the standards for informed consent listed above are effective, they still contain various issues. Informed consent is important and necessary for aiding ethical practice in medicine. Furthermore, informed individuals have the capacity to make decisions for themselves, direct their lives according to their will, and not allow the influence of others to persuade them to partake in practices contrary to their morals.<sup>73</sup> However, three vital components of informed consent must be addressed in order to fully appreciate the need for the acquisition of consent and

the role autonomy plays in this process. These components include informing the individual of the details of a course of treatment, informing the individual that they have the right to voluntarily choose to accept or decline treatment, and performing a comprehensive assessment of the individual's capacity.<sup>74</sup>

The autonomy of a patient may be upheld if he is able to rationally deduce his circumstances and voluntarily decide for himself. However, excessive information about a course of treatment may be detrimental and burdensome to one's self-care. For this reason, it is important to establish a method in which a detailed, yet accessible explanation of a course of treatment can be effectively described to an individual.<sup>75</sup> Naturally, this analysis attempts to show that the method of presenting detailed information to an individual about a course of treatment and allowing their autonomous nature to decide is based on the role of ethics committees and ethics consultants. In this respect, the proper presentation of information both upholds autonomy and solidifies the necessity of ethics consultation.<sup>76</sup>

#### 2.1.4. Threats to Consent: Exploitation of Vulnerable Individuals and Coercion

The discussion has outlined the history and formal structure of informed consent, described the steps informed consent takes to uphold human autonomy, and performed an ontological assessment of the human body and how the ontological status of the body pertains to autonomy. With the above points in mind, instances in which ethical intervention through ethics consultation and committees is addressed. However, before the responsibilities of a committee are demonstrated, the challenges to informed consent require attention.

##### 2.1.4.1 Informed Consent and its Challenges: Threats to Autonomy

To uphold the ethical practice of medicine, certain issues must be accounted for and addressed. Specifically, medical professionals and ethical authorities must take efforts to avoid



the exploitation of patients.<sup>77</sup> Exploitation, as well as various other threats to autonomy, violate the common morality by not abiding by the ontological justifications of the body discussed above. Synonymous to Kant's moral theory and the *telos* principles of autonomy, treating human beings as means to an end rather than ends in themselves does not adhere to the canonical principles of bioethics.<sup>78</sup> Exploitation in medicine may be identified in medical practice if certain criteria are met. First, patients are in jeopardy of succumbing to unethical practices if the treatment proposed to them mutually benefits the healthcare professional.<sup>79</sup> Second, exploitation takes place if the mutual benefits of a treatment violates the integrity or authenticity of the acquisition of consent.<sup>80</sup> These two criteria demonstrate the exploitation of patients by treating them as means to ends rather than ends in themselves.

Obtaining consent from patients can certainly serve as a medium for exploitation via its improper acquisition. This analysis discussed how proper methods of informing participants allows individuals to exercise their autonomy by allowing individuals to make informed decisions about their course of treatment.<sup>81</sup> However, despite the autonomy human beings possess, various individuals are especially susceptible to exploitation. These individuals include the economically disadvantaged, the disabled, and the elderly.<sup>82</sup> These individuals are especially susceptible to exploitation because of their economic, physical, and socially discriminated situations.<sup>83</sup> Furthermore, these individuals may lack access to ample health care and may have never received adequate treatment.<sup>84</sup> These individuals are susceptible to exploitation in both research and in clinical care primarily because these individuals may not have access to proper information before giving consent.<sup>85</sup> For instance, the written information that ought to be provided to the patient before treatment begins is an essential part of informed consent, but this information is useless if the patient is illiterate or unable to comprehend the information orally.

These individuals are autonomous but are unable to exercise their right to their own autonomy in healthcare due to inhibiting factors. Simply excluding these groups from medical treatment is not an option because it would be unjust and discriminatory.<sup>86</sup> Furthermore, exclusion or coercing these individuals into a treatment plan that they may not understand or agree to violate their autonomy and violates the physician's role as a healer and philosopher.<sup>87</sup> Aiding these groups by ensuring proper understanding before treatment commences is of the utmost importance. While competent patients in vulnerable groups can be educated on their course of treatment, patients who lack capacity and a proxy must have access to a group of individuals who will make decisions in their best interest. The role of an ethics committee or ethics consultation is extremely important regarding the prevention of exploitation of individuals in vulnerable situations.<sup>88</sup>

#### 2.1.4.2 Coercion

Although a form of exploitation, coercion presents itself as a unique violation of autonomy and a detriment to the process of informed consent. If a physician coerces a patient into consenting to a treatment, then the consent is not valid.<sup>89</sup> Barring occasional exceptions regarding paternalistic determinations by physicians as a necessary action, coercion is often addressed as a detrimental element to autonomy and a violation of informed consent.<sup>90</sup>

Coercion, along with other issues mentioned in this discussion, is an issue that requires the implementation of normative methods in healthcare ethics through the medium of ethics committees and ethics consultation.<sup>91</sup>

Although physicians are at times praised for putting some pressure on a patient to consent to a life-saving treatment, a fine line is drawn when dealing with coercion.<sup>92</sup> Coercion is unique because it involves the dangers of sufficient harms that may befall a patient and thus strips away

their freedoms and right to choose.<sup>93</sup> Understood in this way, it is clear how coercion in healthcare violates autonomy. The pressures a physician or healthcare professional may put on a patient must be limited to the benefits and harms that are involved in a course of treatment and must not include threats to discontinue treatment.<sup>94</sup> The above section on proper written consent is of the utmost importance when addressing the issue of coercion. If consent solely relies on the oral delivery of information, coercion is certainly more likely to occur. However, uniform literature composed by various individuals aid in clarifying the medical processes in question and encourage patients to decide as they wish.<sup>95</sup>

#### 2.1.5. Institutional Paternalism

Although brief, the discussion of exploitation and coercion above paves an argumentative pathway to one of the most pressing issues surrounding healthcare ethics and the need for ethics consultation. Paternalism in healthcare stands out as one of the more pressing issues that require ethical solutions due to its pervasive nature.<sup>96</sup> Although paternalism was at one time the common practice of physicians and healthcare providers, the contemporary understanding of paternalism is often condemned for being a direct violation of human autonomy and rights.<sup>97</sup> Although paternalism is no longer a default attitude in healthcare, confusion exists surrounding its status and when, if at all, its practice should be initiated. Furthermore, many healthcare professionals are unaware of what instances qualify as instances of paternalism. This section attempts to examine the harms and benefits of paternalism and the role ethics committees can play to regulate this practice.<sup>98</sup>

##### 2.1.5.1 Paternalism: Definitions and Application

Paternalism asserts itself into medical practice as a controversial method. Paternalism is done to benefit another human being, yet its practice still needs moral justification. The act of

paternalism still needs moral justification despite the good intentions of its end because a value judgment, process, or procedure is imposed upon a human being who may not have necessarily request nor agree to a proposal.<sup>99</sup> Paternalism is an example of a practice that shows that good intentions or motives are not sufficient conditions for acting morally.<sup>100</sup> This point asserts that good intentions are not the only element needed for moral decision-making and thus additional elements must be assessed before a moral judgment or action may take place.<sup>101</sup> However, paternalism must be acknowledged as an act that values its desired action embodies the Good and as an end in itself. Defining paternalism is difficult when the concept of the Good is assessed because the kind of good paternalism attempts to reach is a philosophical notion. In this respect, the amalgam of the physician and philosopher plays a key role in paternal decision-making. Providing a comprehensive definition of paternalism also justifies the autonomous nature of informed consent and the need for ethics consultation because regulatory standards of justification must be adjudicated by a team of individuals who understand normative ethical principles.<sup>102</sup>

To determine a paternalistic act, the act must be directed or intended toward a positive end for the affected individual.<sup>103</sup> To develop a comprehensive definition of paternalism, the definition must include language that recognizes the positive and negative implications of paternalism. In this respect, paternalism can be recognized by four criteria: (i) The paternalistic agent truly believes that his action benefits the recipient, (ii) the paternalistic agent recognizes that his actions require moral justification, (iii) the paternalistic agent believes obtaining consent from the recipient is not possible or assumed, and (iv) the paternalistic agent believes the recipient has the utmost confidence in the paternalistic agent's decision.<sup>104</sup>

If paternalism is recognized under these four criteria, paternalistic attitudes that are

justified can be identified and morally acceptable in their application. The first criteria justifies the act as a paternalistic act because the benefit is directed toward an individual other than the recipient.<sup>105</sup> The second criteria is synonymous with parents performing certain actions to benefit their children. If an act is defined as a paternalistic act, the act is morally justified because a moral act aims at benefiting an individual. Although paternalism arguably violates some moral standards, it still must become normatively justified.<sup>106</sup>

The third criteria is especially relevant to the nature of this analysis due to its relevance to autonomy and informed consent. The paternalistic agent must believe his actions do not require the recipient's consent. For instance, if person X collapses on the floor of a shopping mall and person Y is CPR certified, person Y will start performing CPR on person X because person Y assumes this is in the best interest of person X. Regardless of whether or not person X has an advance directive, tattoo, or other documentation stating they do not want to be resuscitated, person Y acts accordingly because he believes this action is a reasonable means of aiding someone in need of medical attention.<sup>107</sup> The last criteria implies a level of dominance or dominion over the recipient because the paternalistic agent believes the recipient can still make their own decision on a specific matter. However, the paternalistic agent believes their decision is the correct and beneficial choice for the recipient and is thus imposed on the recipient.<sup>108</sup>

#### 2.1.5.2 Paternalism and Autonomy

Now that the definition of paternalism and the criteria that must be met for its formal justification has been established, the analysis addresses a formal analysis of paternalism's effect on autonomy. The issue of autonomy and paternalism is difficult because if one is hindered, the other is augmented. For paternalism and autonomy to coexist in a beneficial union, a medium

between these two elements must exist.

Patients indeed have the right to receive information about their treatment plan and make judgments or decisions based on the information they receive.<sup>109</sup> However, since autonomy remains the focal reason why patients are able to make decisions for themselves, the authority of healthcare professionals is hindered and thus provokes their need to exercise paternalistic notions.<sup>110</sup> For instance, if an individual refuses a blood transfusion and a doctor uses methods of deception, lying, manipulation of information, nondisclosure of information, or coercion, the doctor is engaging in some form of paternalism, albeit an immoral use of the practice.<sup>111</sup> Regardless of how paternalism manifests, paternalism always includes a hindering of one's autonomous choices.<sup>112</sup> This becomes a problem in medical practice when examining principles of nonmaleficence and beneficence.

Historically, these two principles have been used as the foundations for paternalistic decisions. However, imposing ideals, procedures, and treatments upon an individual that still has the capacity to make decisions for himself render their autonomy valueless.<sup>113</sup> Still, many theorists argue that there exist various instances where paternalism is warranted and thus undermining human autonomy is warranted. For instance, a drug addict who is unable to make rational decisions for himself and continually harms himself with his drug use may require the intervention of a paternalistic agent.<sup>114</sup> In this instance, the drug addict's autonomy is undermined, but it may be reasonable to deem the autonomy of the drug addict as afflicted or diminished. Since the drug addict is incapable of exercising his autonomy in a way that promotes his flourishing as a human being, paternalistic means of reconciling his behaviors are warranted.<sup>115</sup>

Another example where personal autonomy is hindered in the name of paternalism

pertains to the decisions of parents who are Jehovah's Witnesses. If the infant child of a Jehovah's Witness requires blood and the parent refuses based on their faith, it is morally justifiable to disregard the decision of the parent to save the life of the child. This instance is justified because the child has not yet developed semblance of their own autonomy and thus cannot make an informed decision that reconciles faith with medical practice.

With the above considerations in mind, the necessity of ethics committees and consultants becomes clearer. The morally complicated issues that surround paternalism arise from the difficulties of determining whether a patient's actions are autonomous or not and who and what judgments can be made on their behalf.<sup>116</sup> While paternalistic notions from physicians and other caregivers may be asserted upon patients, it is the job of ethics committees and consultants to identify and analyze situations objectively, facilitate parties involved, and aid individuals on morally acceptable options of treatment and care.<sup>117</sup>

#### 2.1.6. The Development of Ethics Committees and Consultation: Solutions to the Challenges

This analysis has demonstrated the important role physicians must take up to become moral agents in clinical settings. The ontological justification for autonomy and the importance of informed consent has also described what is expected of healthcare providers and what challenges arise in clinical situations when attempting to uphold an individual's autonomy. The specific problems that result from morally questionable situations involving autonomy and informed consent include exploitation, coercion, and paternalism. With these issues in mind, it is important to understand how normative methods in ethics manifest and remain enforced in contemporary clinical situations. The following section discusses the manifestation of ethics committees and ethics consultation and their pertinence in contemporary medical practice. Furthermore, analyzing various issues surrounding ethics consultation justifies their practice.

This analysis attempts to demonstrate that these practices are rooted in a philosophical basis of medical practice and are instantiated to uphold moral excellence.

#### 2.1.6.1 The Necessity of Ethical Consultation and Review: Resolving Moral Disagreement

Due to the results of the Karen Ann Quinlan case of 1976, the New Jersey Supreme Court concluded that ethics consultation must become a necessary component in ethically or morally questionable situations in hospital settings.<sup>118</sup> This event prompted these committees and individuals within these committees to partake in decision-making processes. These decisions are made alongside physicians, family members, patients, and hospital administration.<sup>119</sup> Due to the Quinlan case, the initial role of ethics committees involved substitutive judgments with patients who were incompetent or incapacitated in some way. This was a monumental case because ethics committees were no longer viewed as advisory panels that were commonly cast aside during decision-making processes.<sup>120</sup> Following the Quinlan case, the role and legitimacy of ethics committees were still questioned. However, the novelty behind the integral decisional involvement of ethics committees led to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to make ethics committees a mandatory component for healthcare institution accreditation.<sup>121</sup>

Although the Quinlan case granted tremendous priority to ethics committees and partially relieved physicians of the burden of decision-making, the instantiation of ethics committees aided patients by granting them a panel of advocates that would advise and aid these individuals during treatment.<sup>122</sup> Understandably, the integral priority ethics committees were granted sparked controversy among the medical and philosophical community. One of the primary issues surrounding contemporary clinical ethics committees involves the permissibility of involving medical professionals as members of the ethics team.<sup>123</sup>



While various theorists believe only philosophers should be members of the ethics team, other individuals believe medical professionals ought to be involved. Conversely, many individuals suggest philosophers have no business in medicine.<sup>124</sup> For example, a profession like neurosurgery is a high-risk specialty that involves various issues that may accompany certain procedures and treatments that leave patients in physical and mental states that are emotionally taxing for families.<sup>125</sup> With this point in mind, should neurosurgeon-bioethicists partake in consultation? This question is especially relevant when addressing the issue of amalgamating the roles of medical professionals and philosophers. This analysis argues that the amalgamation of these roles aids the moral fortitude of maintaining personal autonomy, respect, and patient advocacy in and through ethics consultation and ethics committees. However, the role of a physician in ethics consultation is an extremely beneficial asset to decision-making processes by providing ample information about specific cases that involve knowledge that is out of the scope of the philosopher.<sup>126</sup> Since the medical professional has far more advanced knowledge about the specifics of a medical case and the philosopher has ample knowledge of ethics and the normative theories that accompany medical practice, a method of case-by-case evaluation with both professions involved would be a relationship that could combat the complexity of medical situations and aid in viewing medical issues more clearly.<sup>127</sup>

#### 2.1.6.2 Merging the Physician-Philosopher dichotomy with Situational Ethics

Ethical issues in medical practice range from the violation of human autonomy, to the assessment of capacity. This analysis has primarily examined the issues that surround informed consent and the ethical demand for a philosophical basis for medical decision-making. The above analysis describes the necessity of ethics committees and consultation due to the demand for a medium for upholding philosophical assessments in medical practice. Furthermore, the union of

physicians and philosophers serve to justify and bolster the effectiveness of ethical practice in medicine. Although there exist various issues that surround informed consent, its basis, and the philosophical implications of its acquisition, medical professionals are making significant efforts in suturing the divide between medicine and philosophy by upholding new standards of care and practice. Specifically, the future of ethics consultation is promising if it accepts the amalgam of disciplines and works to implement case-by-case practices.<sup>128</sup>

One of the primary issues surrounding ethics committees involves a lack of expertise from the various members that comprise the committee. The key components this dissertation presents has the potential to aid this knowledge discrepancy by implementing the expertise of professionally trained ethicists. While an ethics committee's responsibilities are important, it should not be the responsibility of the committee to conduct ethics consultations, nor should it be the committee's responsibility to hold family meetings when addressing contentious conversations.<sup>129</sup> Tasks involving alleviating moral quandaries, facilitating dialogue, and using philosophically relevant literature to justify ethical recommendations should be left to the professional ethicist. However, these assigned responsibilities should not discredit the role of an ethics committee. Instead, modern ethics committees should serve two functions. First, ethics committees should become venues of education that teach ethical lessons and disseminate this information to departments throughout a health care system. Second, ethics committees should serve as venues for quality improvement projects.

These projects identify an issue that the committee deems a necessary point of correction within the health system. The committee subsequently takes ownership of the project and tracks quality improvement through a longitudinal study. While these tasks are uncommonly associated with ethics committees, the redistribution of roles and responsibilities within ethics committee

structures bolster the effectiveness of disseminating ethics throughout a health care system and aid in utilizing professional resources in ethics.<sup>130</sup>

Although methods for bolstering the practice and acquisition of consent have been reevaluated and assessed, issues are still present when attempting to obtaining consent in a morally stringent manner. No unifying rule exists that resolves ethical issues in medical practice.<sup>131</sup> However, rather than attempting to develop a single rule, amalgamating medical practice and philosophy into an instantiation of a set of rules and formulations that aid in ethical theory is a viewpoint that is more tangible and accessible to ethicists and healthcare professionals.<sup>132</sup> This process aids the above-mentioned process for ethics committee development and promotes a union between a practical field and an otherwise theoretical endeavor.

In accordance with Kantian deontology, various ethical maxims develop to make ethical decisions.<sup>133</sup> However, deontological maxims are rigid and have a propensity for stagnancy when dealing with multi-faceted ethical situations. Since ethical dilemmas manifest in many different forms and entail various factors that contain several variables, each ethical situation must be addressed differently. A possible remedy for the unpredictability and lack of uniformity in ethical situations involves an approach known as situational ethics. Situational ethics is an ethical approach that recognizes the vast differences in ethical situations and addresses them accordingly.<sup>134</sup> This approach is beneficial if the philosophical basis for informed consent is rooted in autonomy.

Situational ethics is unique because it does not limit its practice to a singularity and thus does not apply standards and ethical norms to all situations.<sup>135</sup> Since this method relies on a philosophical basis for medical decision-making, situational ethics works out of affection and

empathy for individual plights.<sup>136</sup> Concerning the relationship between philosophers and physicians and their co-existing role in ethics committees, normative theories and methods of bioethics in contemporary situations become applicable when situational ethics demands a proper union of these disciplines.<sup>137</sup>

Situational ethics is one of many novel approaches to ethical decision-making in healthcare. If individual attention is granted to each ethical case rather than the mere application and reinforcement of ethical norms, further care and concern for human autonomy will occur. Situational ethics can further aid in future medical pursuits by protecting a patient's rights by developing a more comprehensive method for informed consent, anonymity, and confidentiality.<sup>138</sup>

By including trained medical professionals who possess knowledge of both their area of specialty and bioethics, useful information contributes to ethical discussions when attempting to resolve moral disagreements, family disagreements, treatment plans, and hospital protocols.<sup>139</sup> Furthermore, physicians who are trained in bioethics, or, succeed in amalgamating the disciplines of medicine and philosophy, bolster the consultation process in their specific specialty and thus could be used on case-by-case situational ethics issues.<sup>140</sup>

## 2.2. Technology and Clinical Consent

The various issues that surround informed consent and autonomy can certainly be approached in productive and manageable ways by forming ethics committees with individuals who both exemplify knowledge in their specialized field of medicine and are informed about the various bioethical issues in healthcare. The goal of this portion of the analysis is to show the important role philosophical analysis plays in ethical decision-making in medicine and the pivotal role ethics committees and consultation play in upholding ethical norms and theories.

However, the application of the theoretical and historical framework outlined in this discussion is only relevant if these themes are applied to ethically relevant areas of medical practice. The analysis bolsters the implementation of bioethical theories by addressing the issues surrounding biomedical technologies and modern technology in contemporary health care. In doing so, the analysis demonstrates the effectiveness of ethical interventions and the relevance these interventions possess among various curriculum components for ethicists.

### 2.2.1. Practice and Procedure in Contemporary Medical and Clinical Genetics

To address the issues that surround autonomy, informed consent, and paternalism, the discussion turns to the ethics of medical genetics, clinical genetics, and the technologies entailed in both fields. Giving these contemporary practices attention provides a medium in which the ethical themes discussed in this chapter may apply. Additionally, the discussion distinguishes between medical and clinical genetics. Addressing contemporary practices in medical and clinical genetics elucidates the appeal and benefits of modern medical procedures and clarifies the boundaries that modern technology may or may not ethically permeate. Addressing genetic procedure, in turn, yields a preliminary discussion of ethical permissibility which provides a foundation and demand for healthcare ethics consultation. Furthermore, this discussion further supports the need for additional curriculum components for clinical ethics consultants.

#### 2.2.1.1 Contemporary Medical and Clinical Genetics: The Human Genome Project

Despite the literally billions of variances of genome patterns in humans, the similarities of human genomic structures are remarkably close. In 1990, geneticists and scientists alike began to map, sequence, and store genetic information of a complete human genome.<sup>141</sup> In 2003 the Human Genome Project (HGP) succeeded in accomplishing its task by mapping approximately three billion nucleotides and identifying all protein-coding genes within these nucleotides.<sup>142</sup>

This accomplishment opened various doors in the diagnostic world by providing possibilities for specializing diagnostic treatments for patients and prenatal health.<sup>143</sup>

From diagnostic options to treatments and prevention, the mapping of the human genome is an accomplishment that redefined and bolstered the field of clinical genetics. Although the reserve of tools unveiled by the HGP is one that holds relevance for both medical and clinical genetics, it is important to make a professional distinction between these two fields. While medical genetics focuses on the history and prevention of genetically-based diseases, clinical genetics pertains to the application of medical genetics to diagnostic procedures, prognoses, and hands-on treatments of genetically inherited diseases.<sup>144</sup> With the discovery of these useful tools, clinical geneticists are now able to use personalized maps of a patient's genome to aid in diagnostic ventures.<sup>145</sup> The HGP not only provides interesting insights into the composition and pedigree of human beings but also aids in customizing therapies for human beings which subsequently expedite effective treatments. With the information gathered from the HGP, clinicians are now able to target the unique biology and physiology of patients with the goal of enhancing patient care.<sup>146</sup>

Personalizing patient care with the aid of genome mapping may prevent or delay diseases, reduce mortality, reduce the incidence of disease, and aid in prescribing proper treatments and medications with less trial-and-error.<sup>147</sup> In recent decades, genetic testing has allowed researchers and clinical geneticists to cure and prevent genetically based ailments that were never before possible. However, the same information gathered from the HGP may also be used for effective methods of genetic testing and screening. Genetic testing and screening is perhaps the most widely used medium for clinical geneticists.<sup>148</sup> The analysis examines these tests to elucidate the uses of genetic technologies. Furthermore, examining the variances in

genetic testing demonstrates the effectiveness of detecting diagnostically relevant signs in the human genome.<sup>149</sup>

#### 2.2.1.2 The Pace of Technology: The HGP at Work in Genetic Testing and Screening

One of the tremendous medical benefits derived from the knowledge attained by the completion of the HGP in 2001 is the ability to test and screen for genetic abnormalities within the human genome.<sup>150</sup> Advanced diagnostics has migrated from the realm of science fiction to reality at an alarming pace. In 1956, the chromosome modal number of 46 was established for humans. In 1959, the trisomy 21 imbalance was identified thus uncovering an explanation for Down Syndrome and, in the mid-1980's, genetic molecular techniques were formally developed into a field of professional diagnostics.<sup>151</sup>

The excitement surrounding the fascinating developments in clinical genetics often overshadows the troubling pace at which these discoveries are made. Genetic technologies are no different from other developments in modern technology in that the discoveries and innovations surrounding the field are uncovered and implemented swiftly and often without philosophical review.<sup>152</sup> When dealing with medical advancements as impactful as genetic technologies, the speed at which development takes place often provokes various ethical dilemmas and situations that demand recourse. However, despite the pace at which these technologies are discovered and used, many discoveries in diagnostic genetics have proven to be extraordinarily beneficial.<sup>153</sup>

Genetic testing is the diagnostic evaluation and analysis of DNA.<sup>154</sup> Since DNA possesses a tremendous amount of information, genetic testing with DNA ranges from chromosomal analysis to gene linkage, to *in situ* hybridization, to gene sequencing.<sup>155</sup> The variances in genetic testing share a common goal in clinical genetics, namely, the goal of identifying a specific genetic cause, etiology, medical malady, or condition. These tests differ

based on the genetic variance of a specific abnormality.<sup>156</sup> For instance, carrier testing involves the genetic testing of an individual who is not affected by a genetic condition but still possesses the genetic abnormality in their DNA which can be subsequently transferred to their offspring, while prenatal testing pertains to the identification of genetic abnormalities and changes in an unborn fetus.<sup>157</sup> For individuals who are asymptomatic but are at risk for developing a genetic issue in the future, there is pre-symptomatic testing.<sup>158</sup>

The above-mentioned tests yield tremendous benefits for patients and would have been impossible had it not been for the discoveries uncovered in the HGP. The discussion previously mentioned the profound rate of technological development in health care. Although the benefits of genetic testing are apparent, the pace at which these tests are implemented prompt a high risk of ethical questionability. For instance, prenatal testing requires access to cells that must be removed from the developing embryo while cells from amniotic fluid must be obtained during amniocentesis.<sup>159</sup> The practical issues involved in genetic testing are of the utmost importance concerning their use in clinical medicine. Issues like cost, ethical considerations, and details of test completion are all integral parts of genetic permissibility.<sup>160</sup> Furthermore, genetic testing may not yield the desired answer for clinicians and patients. This issue becomes especially problematic when certain boundaries are crossed to perform a genetic test in the first place.<sup>161</sup> In terms of genetic screening, or the process of genetically searching for predisposed ailments in patients, tremendous ethical issues arise in patient discrimination. While one group of individuals may not be predisposed to a genetic ailment, another group may be unjustly discriminated for abnormalities in their genetic makeup.<sup>162</sup>

The issues surrounding genetic testing and screening are overlooked due to the rate at which genetic technologies are developed.<sup>163</sup> Simply because human beings can perform an



action does not necessarily mean they should perform that action. It is also important to note that the rapid expansion of modern technology is not an issue isolated to genetic technologies. In recent decades, technology has developed so quickly that it has replaced itself in nearly every facet of its existence. To discuss the issues of genetic technologies further, the following section implements the philosophy of Martin Heidegger in his essay *The Question Concerning Technology*, (*Die Frage nach der Technik*).<sup>164</sup> To uncover man's relationship with technology, Heidegger reveals the dangers associated with technology. For the purposes of this investigation into genetic testing, screening, and the necessity of ethics consultation, Heidegger's philosophy will aid as a medium that uncovers the causes and dangers of rapidly expanding genetic technologies.

#### 2.2.2. Philosophy of Technology: Heidegger and Transhumanism

The section above discusses the impact genetic technologies have had in recent years. The tremendous strides genetic technology has made on genetic testing and screening seemingly yields fruitful benefits for human beings. Testing for genetic abnormalities and subsequently providing useful treatments aids in customizing personalized diagnostic treatments while genetic screening bolsters the effectiveness of preventative medicine.<sup>165</sup> Although genetic testing and screening share common benefits, the ethical implications of their practice are highlighted by the philosophy of Martin Heidegger in his essay *The Question Concerning Technology*.

Heidegger's philosophy is used as a medium to uncover the underlying ethical issues of genetic testing and screening. Furthermore, Heidegger's essay aids the discussion by emphasizing the dangers of genetic modification and the future of genetic technologies. Primarily, the discussion surrounding Heidegger serves as a demonstration of the implementation of philosophical aids for contemporary curriculum components and shows the benefits of

combining rolls of physicians and philosophers. The following section details the ethical impact of modern technology on nature by examining the relationship between nature and modern technology, the imposition of modern technology has on nature, and the danger modern technology places on nature.<sup>166</sup>

#### 2.2.2.1 Modern Technology and the Rape of Nature

Modern technology is rarely regarded or discussed in a negative light, especially when referring to modern medical technologies. Devices like the MRI that revolutionized diagnostic medicine are viewed as tremendous benefits to human health, yet the power of modern technology shifts from its practical use to a tool of abuse quickly when technologies are implemented into actions that manipulate human makeup.<sup>167</sup> Since genetics involves the natural molecular composition of human beings, the modification and tampering with genetic structures raises various ethical issues. Although Heidegger does not refer to medical technologies in his philosophy, he does give a detailed analysis of man's abuse of nature when developing and using modern technologies. If addressed appropriately, Heidegger's philosophy and the caution he provides within his technological assessment yields fruitful insights into the dangers of tampering with human genetics in contemporary practices.<sup>168</sup>

In his description of modern technology, Heidegger does not hesitate to use abrasive terms to describe technology's imposition on nature. Heidegger describes modern technology's relationship with nature as one that is dominating, imposing, exploitative, and forced.<sup>169</sup> However, the term that Heidegger stresses the most during his assessment of modern technology is the term "challenging" (*Herausfordern*).<sup>170</sup> It is this term that separates two kinds of technology, handicraft technology and modern technology. While handicraft technology is a form of development and enhancement that involves man's cooperative conjunction with nature,

modern technology demands satisfaction and forces and challenges nature to yield to the demands of man.<sup>171</sup> In this respect, nature works *for* instead of *with* humankind.<sup>172</sup> This is especially problematic when referring to man's relationship with nature since man is inherently part of nature.<sup>173</sup>

Once the dichotomy between man and nature is broken by a demand for nature's submissiveness, man's relationship with nature is enframed (*Gestell*) as a standing reserve that is forced to provide for human needs, whims, and satisfaction.<sup>174</sup> Heidegger considers man's relationship with modern technology as a dishonorable challenge since nature has no means of protecting or defending itself from the violent demands of modern technology.<sup>175</sup>

The imposition modern technology places on nature is of the utmost importance when attempting to examine the ethical permissibility of modern technology in genetic alteration. Heidegger describes modern technology's imposition on nature as an unwarranted advantage.<sup>176</sup> When man attempts to reap unnatural bounties from nature deliberately and forcefully, man begins to impose himself upon what is natural. In the Heideggerian sense of the term impose, man's relationship with nature is synonymous with playing God.<sup>177</sup> Heideggerian imposition is especially relevant when discussing the ethical permissibility of genetic alteration. While the genetic makeup of a human being is determined by nature, the modification and tampering with genetic makeup is an example of man's unwarranted and forceful demand from nature. Rather than working with the naturally occurring biology of human beings, genetic alteration and modification exemplifies the unwarranted demand and imposition that modern technology places upon nature.<sup>178</sup> For instance, when traditionally farmed crops are reaped from the land it is not uncommon to pray before consuming the bounty. However, if the same crops are genetically

altered and modified, a prayer to God before their consumption is almost unwarranted due to the imposition man places upon nature.<sup>179</sup>

To discuss the dangers and details of genetic alteration and modification, a final point of Heidegger's philosophy must be addressed. In respect to the dangers associated with modern technology, Heidegger notes that the primary danger inherent in modern technology lies in the possibility of the loss of human freedom.<sup>180</sup> Since the abuse of nature stems from the dependence and imposition of modern technology, there lies a very real possibility of human enslavement to a dependence on modern technological advancements. If man's relationship with modern technology is one that continues to rape nature of its resources by forcefully modifying and disrupting its homeostasis, human beings may relinquish their former free-standing relationship with nature by becoming inherently dependent on the newly fostered unnatural rather than the inherent natural.<sup>181</sup> In order to consider this philosophical assessment properly, consider the following example: If human genetic alteration becomes a common practice and most human beings become genetically altered, nature no longer co-exists with man and instead works *for* man. In this respect, man becomes enslaved to his own creation since the survival of humankind cannot thrive without the newly-modified unnatural state of human biology.<sup>182</sup>

The lengthy discussion of Heidegger's philosophy and its relationship with modern genetic technology is intended to caution against the manipulation of the natural. While genetic modification and alteration may be categorized as modern technology, in the sense that its practice inherently abuses nature, genetic screening and testing may be viewed as handicraft technology or, a technology that works in accordance with nature. However, benefits of genetic alteration, *i.e.* therapeutic modifications to prevent inherited diseases or abnormalities, are still categorized as modern technology. prior to investigating the permissibility of genetic testing and

screening, a brief consideration the philosophy of transhumanism and transhumanism's effects on modification technologies must be examined.

#### 2.2.2.2 The Philosophy of Enhancement: Misconceptions and Responses

There exist schools of thought that both advocate for and caution against the modification of human beings. Yet the philosophy of modification may easily be classified as a school of thought that aims to bolster the varying perspectives entailed within the realm of human modification. While the philosophy of Martin Heidegger serves as a medium that explicitly cautions against the manipulation of nature or, for the purposes of this investigation, the manipulation of human genomics, the philosophy of transhumanism attempts to seek out the enhancement of human intelligence, physical performance, and biological resistance their current limitations.<sup>183</sup>

It is important to note misconceptions that transhumanist philosophers attempt to rebut. Philosophy tends to explain the nature of its practice by explaining what it is not rather than what it is and transhumanism is no different in this respect. First, transhumanist philosophers argue that it is not the goal of a transhumanist philosophy to achieve a perfect human subject. Instead, transhumanism seeks to perpetually improve what they consider to be a flawed piece of biological engineering. Contemporary phenomenologist and philosopher of technology Don Ihde counters this argument by stating that transhumanism seeks to develop a futuristic utopia of human beings. However, transhumanist literature combats this criticism by explaining that the actions entailed in transhumanism, synonymous with an *energia* (ἐνέργεια), seek to perpetually improve and engage in an act that inherently entails an end within itself.<sup>184</sup> Despite the transhumanist response to critic's utopian claims about the philosophy of transhumanism, this misconception is still warranted due to the very nature of transhumanism. Although it is most

likely impossible to achieve human perfection, the very act of attempting human perfection by expediting the natural model and construction of human beings is first, a bold and arrogant claim against the natural, and second, a dangerous step in segregating different types of modified and non-modified human beings.<sup>185</sup>

A second misconception regarding the philosophy of transhumanism involves the notion of transhumanist philosophers despising or loathing their bodies and the current biological makeup of human beings. Furthermore, this criticism serves as a primary reason why transhumanist philosophy seeks to expand the current state of human composition. Although this criticism is argumentatively fallacious, the dangers entailed in what the transhumanist movement seeks may very well skew the human perspective on what is natural.<sup>186</sup> This point is especially relevant to the dangers Heidegger presents in his philosophy in that the disruption of, rather than a cooperation with, that which is natural yields dangerous and unethical results. Although advocates of transhumanism may not loathe their bodies, they do believe improvements must be made to an otherwise flawed piece of engineering. By developing a human body that is resistant to aging, disease, and capable of inhabiting different bodies, *i.e.* virtual bodies, transhumanist advocates seek to manipulate an inherently natural biological structure for subjective improvements.<sup>187</sup>

The kind of modification entailed in a philosophy of transhumanism fits directly into Heidegger's philosophy of technology, namely, a technology that is inherently modern. The modern technology discussed by Heidegger and transhumanists alike involves a manipulation and disruption of what is naturally occurring in biological structures. While the biology of human beings is affected by implementing drugs, procedures, and treatments, the direct modification of human genomics may be classified as an unwarranted and unethical

manipulation of a natural creation. While modern medicine pertains to handicraft technology, in that a skill is amalgamated with an art form to produce beneficial results, the modification of human genomics for the “betterment” of humanity is a direct manipulation of the natural and thus deemed, in the Heideggerian sense, as modern technology.<sup>188</sup>

Despite the pervasiveness of human enhancement and the editing of human genomics for biological improvement, it is not unreasonable to examine the modification of human genomics as a beneficial tool for human therapy. While this form of editing human genomics is still ethically questionable, it is a necessary component of discussion when addressing the necessity of genetic ethics consultation.

### 2.2.3. Therapeutic Genetics: Newborn Screening and Ethical Management

While modern technology reflects a deliberate and pervasive kind of manipulation to that which is deemed natural, handicraft technology is a medium that attempts to uphold a legitimate relationship with that which is deemed natural.<sup>189</sup> In terms of genomics, handicraft technology may be categorized as the various methods and technologies associated with therapeutic genetic testing, screening, and prevention. To investigate the intricacies of ethics consultation surrounding therapeutic genetic testing and screening, the analysis presents a brief consideration into the methods and procedures of therapeutic screening and testing.<sup>190</sup>

#### 2.2.3.1 Ethics of Newborn Screening: Handicraft Technology in Practice

Arguments and policies surrounding the promotion and use of genetic screening for newborns may be traced back to a case in 2000 involving a child named Ben Haygood who died due to a rare metabolic disorder is known as medium chain acyl-coenzyme (MCADD). MCADD requires those afflicted to avoid long-term fasting due to increased risk of disease and death.<sup>191</sup> Advocates for genetic screening in newborns argue that a simple genetic test that Haygood did

not receive could have prevented his death. Furthermore, the same advocates argue that various alternatives for improving the health of children are rooted in genetic screening and these tests must become systematized in healthcare as policy standards.<sup>192</sup> However, in relation to the philosophical justification for technological use in healthcare discussed above, the ethical implications of genetic screening must be determined by its relationship with nature. Although there is a push for the policy-mandated screening of newborns for all possible genetic abnormalities, only some ailments are mandated for testing.<sup>193</sup>

Despite the promotion of comprehensive genetic screening in newborns, some screening methods for ailments and their treatments may not coincide with the ethical permissibility of handicraft technology and thus work against the naturally occurring structures in the human body. In the case of Ben Haygood, the screening method for MCADD involves a simple blood test that does not manipulate, nor disrupt the structural integrity of his genome. Furthermore, the treatment for MCADD simply involves eating a scheduled diet to ensure the body's proper production of glucose; a process that also does not disrupt or interfere with the genomics of the human body.<sup>194</sup> In Haygood's case, both the method of screening and resolution to his ailment would qualify as quintessential examples of diagnostic medical interventions, despite the involvement of human genomics. However, state law mandates only certain genetic screening methods, including PKU, sickle cell anemia, congenital hypothyroidism, and glucosemia, while other screening procedures are either not available or not required.<sup>195</sup>

The primary screening method for newborns involves a heel-stick blood sample that is drawn 24-48 hours after an infant is born. However, tandem mass spectrometry, a technology discovered in the 1990's, has become a far more efficient and effective way of screening newborns for diseases like PKU, cystic fibrosis, and even MCADD. Despite its effectiveness,



this technology must be viewed under ethical scrutiny and supervision regarding the effects these interventions may have on human beings.<sup>196</sup> Tandem mass spectrometry measures the levels of metabolites in human blood. From this measurement, scientists may determine what kind of metabolic disorders are present.<sup>197</sup> Since tandem mass spectrometry uncovers a result and presents physiological options for treatment, one can argue that this form of screening is ethically permissible. Conversely, microchip technology that is currently in the process of development possesses the capability of perpetually detecting genetic ailments of a human being after the chip is implanted.<sup>198</sup> In respect to this latter technological development, chip-technology boards on the transhuman due to the extent of its modification.

While the human body lacks the capability to detect ailments that may dwell within, the addition of a microchip that detects human genetic ailments qualifies as a human modification. In this respect, the delineation between modern technology and handicraft technology in healthcare becomes clear. The effectiveness of chip technology does not yield more fruitful results than current tests except for occasional instances of early detection. While the heel-stick method and tandem mass spectrometry detect genetic ailments via medical tests, augmentation through chip-technology skews both the intent and agency of medical procedure. Additionally, this kind of modification has a propensity to yield unfair advantages to individuals who have access to this kind of human modification.<sup>199</sup>

The section above demonstrates the philosophical differences between screening technologies and augmentation and preventative screening. Naturally, these aspects of genetic screening and testing possibilities are fundamental considerations when receiving genetic counseling. However, these considerations often go wanting due to the contemporary demand for practicality. While philosophical considerations regarding ontology and the permissibility of

procedures and technology are definitive points of argumentation in contemporary health care ethics, a good clinical ethics consultation must be tailored to the concerns and situations of the parties involved. Before delving into the various theoretical approaches to genetic counseling that aid decision-making and ethical facilitation, some final practical considerations that must go into the counseling conversation must be addressed.

#### 2.2.3.2 Policy and Management: Practical Considerations for Ethics Consultants

Various issues surrounding genetic testing and screening must be considered when performing an effective ethics consultation. Genetic testing and screening are especially unique consultation topics due to the inherent necessity of performing these procedures, typically, during early stages of life. However, due to this necessity, many individuals are faced with onerous predicaments including cost, fair use, confidentiality, and consent. An examination of these issues provides insight into the conversational and counseling components of an effective genetics consultation.

Although cost is a primary issue concerning genetic testing, various public screening policies attempt to alleviate financial burdens. Furthermore, various state legislations require mandatory minimum genetic screening for all newborns. State-mandated required screenings involve screenings for standard diseases like PKU and sickle cell disease but do not necessarily cover all genetic diseases.<sup>200</sup> In the case of *Bed Haygood*, MCADD was not a disease that mandated required screening and thus cost more to voluntarily perform this procedure.<sup>201</sup> Although the procedure is simple, screening for genetic diseases other than state-mandated screenings is costly.

Due to the increased cost of non-state mandated screenings, parents often do not opt for voluntary screenings. This is not an unreasonable decision from parents. Most genetic diseases,

unless otherwise specified in family history, present no motivation for preemptive screening. Although families have the right to choose what screening procedures are performed on their newborns, many life-threatening or life-altering diseases go undetected and untreated. Rather than risk usurping a family's autonomous decisions for their kin by imposing more state-mandated screenings, a well-comprised, comprehensive ethics consultation that presents all relevant genetic screening options to a family is a far more formidable option. In doing so, viable options that coincide with a hospital's mission and goals and values of a family may be properly facilitated.<sup>202</sup>

The massive amount of information genetic screening and testing provides is not limited to the individual undergoing the screen or test. Since genetic science specifically pertains to genomic lines of pedigree and familial traits, it is possible for multiple family members in the same genomic line to receive the same genetic diagnosis. For this reason, understanding one's family history is extremely important. In 2004, the U.S. Surgeon General's Family History Initiative urged families to become familiar with diseases that are prone to inflicting their family line. However, family history is a difficult facet of information to regulate on an individual basis. One family member's provision of their family's history is also shared information with all members of the same genomic line. In this respect, issues of privacy and fair use in interpreting genetic information become problematic. While one family member may want to provide their history with their families' history for diagnostic purposes, the same family member is inherently disclosing information that may not be theirs to distribute.<sup>203</sup>

A patient who receives a genetic diagnosis may also learn that their disease is present in another family member that did not request a genetic screen. Breaching confidentiality for the sake of preventing harm becomes a serious ethical concern when performing genetic screening

and testing. This point is especially relevant for ethics consultations regarding genetic screening. Since genetic screening affects more than just the one patient undergoing the screen, ethics consultants must serve their purpose as facilitators to bridge communication gaps between previously uninvolved party members. Since no U.S. authority exists that mandates the disclosure of information in genetic incidents, ethics consultants must aid in providing options and encouragement for patients who are afflicted with this onerous task.<sup>204</sup>

A final practical consideration regarding genetic ethics consultation pertains to decision-making capacity. Many health care procedures may require the consent from an individual who is unable to do so, and genetic testing and screening are no different. Among this population of patients are children who are unable to understand the purposes and outcomes of genetic screens and tests and adults who are afflicted with a mental or learning disability. For these populations, gaining informed consent is impossible.<sup>205</sup> In this respect, ethical consultation can play an extremely important role in aiding decision-making processes. Ethics consultants provide a forum for an open conversation that may dictate the importance of not presuming a patient's inability to communicate.

Instead, ethics consultation meetings may perpetuate the need for thorough capacity assessments of patients before surrogacy or a similar substitutive method is enacted. Patients who are deemed to lack capacity or are unable to communicate must be held in a regard that does not cause harm, nor sacrifice their integrity by, for example, breaching their right to privacy.<sup>206</sup> A difficult population of individuals include patients who cannot communicate or give consent and those who may not benefit from a test or screen. However, the screen or test performed on this specific individual may very well aid in the diagnostic efforts of another family member that shares the same genomic line. According to the Joint Committee on Medical Genetics,

individuals who have hindered communication or decisional capacities should not be less altruistic than other patients and should thus partake in procedures as long as the procedure does not inflict harm to the agent.<sup>207</sup>

Another primary issue regarding decision-making capacity or inhibited communication involves children who may not understand the implications of a genetic test or screen. While studies indicate that testing and screening may be performed in the best interest of the child, the child should still be informed in a way that may perpetuate their understanding.<sup>208</sup> Ethically, it is quite clear if the test yields useful medical knowledge and management for the child, *i.e.* learning that regular colonoscopies are necessary for a child who is diagnosed with familial adenomatous polyposis or, in the case of Bed Haygood, scheduling frequent meals for a child diagnosed with MCADD. However, performing tests and screens for children who may be susceptible to adult-onset diseases becomes more problematic due to the scope and nature of these illnesses. Rather than implementing a test or screen while the child is still unaware of his or her circumstances, many decisions regarding testing and screening for adult-onset genetic abnormalities are deferred until a child can fully grasp the importance of their medical situation. In this respect, the child's autonomy is exercised once the child is developed enough to do so. Conversely, many parents attempt to make these decisions for their child out of standards of best interest, regardless of the results of the test or if the screen will have immediate results.<sup>209</sup>

Although the above-mentioned issues of genetic testing and screening have their ethical roots in philosophical justification, it is important to note the practicality and relevance of information that must be provided to families and patients during a clinical consultation. While it is important not to avoid the philosophical implications of genetic testing, screening, and modern technologies, it is imperative that families and patients are counseled on their options and

implications of their options.

### 2.3 Conclusion

This chapter began by first addressing the importance of a philosophical education and background for medical professionals. This point opened a gateway to the shared idea of the common morality and aiming at a *telos* in medical practice. The discussion addressed the important role autonomy plays in informed consent by conducting an ontological analysis of the body. This analysis both justifies the role of the physician-philosopher and aids in developing a more formidable model for ethics committees and consultants. The problems of medical ethics and consultation were thoroughly addressed by first outlining the details of informed consent and subsequently discussing the issues of exploitation, coercion, and the improper uses of paternalism in medical practice. By specifically examining paternalism and its abuse, the demand and necessity of ethics consultation and committees are made clear. By justifying the amalgamation of roles between philosophers and physicians, an inherent need for philosophical interventions in human health becomes apparent.

Investigating the pervasiveness of genetic and modern technologies in health care aids the need for philosophical interventions in health care. While this assessment does not discourage technological advancements, the discussion does encourage ethical evaluations of technologies before their premier in communities. The chapter addresses the philosophically associated problems of pervasive technologies in genetic medical science and emphasizes the development of a comprehensive clinical ethics consultation method for genetic issues by evaluating the case of Benjamin Haygood. By juxtaposing this clinical case with the issues surrounding the therapeutic and experimental aspects of clinical testing and screening for genetic diseases, the discussion demonstrates that the screening and testing of individuals is far more

ethically permissible than the alteration of human beings; a task that is only taken seriously if philosophical paradigms are merged with modern medical practice. The reasons for this result lie in the dangers of natural modification.

While genetic testing and screening do not permeate the natural order of human genomics, human modification has shown that it is in the very nature of these technologies to treat human biology as a standing reserve that is waiting to become modified. To assess the most effective means of genetics consultation, chapter three dissects three popular methods of ethics consultation, the Four Topics Method, CASES, and Process and Format. Additionally, the discussion addresses the foremost efforts in establishing clinical ethics as a professional discipline. In doing so, the discussion attempts to extract effective components of these consultation methods and subsequently apply them to a comprehensive consultation method.

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### Chapter 3: Methods & Standards of Clinical Ethics Consultation

Since the 1970's, health care has made tremendous steps toward formalization and the development of professional policies regarding ethical reinforcement in health care. However, certain pivotal facets of health care ethics are still in need of tremendous revision and review. The issues surrounding clinical care are immense. However, an overarching resolution that connects the clear majority of these and other issues surrounding clinical care involves effective clinical ethics consultation methods. Health care ethics consultations (HCEC) range from conversations with patients, to families, attorneys, chaplains, social workers, and case management officials. Furthermore, HCEC aims to facilitate discussion and resolution between different party members that have difficulty resolving an ethical dispute or dilemma by bolstering means of communication between health care professionals, patients, and team members.<sup>1</sup>

The chapter begins with a definition of clinical ethics, followed by a description of a clinical case that is presented thematically throughout the first half of the discussion. The chapter then discusses the foremost contemporary clinical consultation approaches. To develop a consultation method that weds the most beneficial aspects of existing consultation methods, the analysis presents thematic qualities that are traced through each clinical consultation method. In doing so, the discussion attempts to develop a comprehensive consultation method from the fragments of contemporary methods. The second half of the chapter presents a detailed description of the ASBH's efforts to standardize a credentialing process for clinical ethics consultants. This description identifies components of an ethics curriculum that is broad enough to accommodate various levels of expertise while simultaneously identifying necessary facets of

professional ethics. In doing so, the chapter attempts to demonstrate the benefits and defects of the ASBH's efforts to develop standards that reflect existing consultation methods.

### 3.1. The Variety of Clinical Ethics Consultation Methods

Bolstering communication between care team members avoids unfavorable outcomes. These unfavorable outcomes usually emerge due to incorrect data, patient information, and a disregard for patient values, beliefs and preferences.<sup>2</sup> In an effort to address the issues of ethics facilitation and communication amongst health care professionals, this chapter analyzes and amalgamates the beneficial aspects of various clinical consultation methods in ethics while simultaneously establishing a philosophical basis upon which these methods of consultation may act. Subsequently, the chapter demonstrates the contemporary efforts made by the ASBH and the methods in which the ASBH has attempted to formalize standards of consultation, accreditation, and professionalism in clinical ethics.

#### 3.1.1. Defining Clinical Ethics Consultation

Despite the array of consultation methods that are implemented and used throughout various ethical issues, only a few methods are addressed in this chapter. This discussion limits the scope of consultation methods in this chapter because not all consultation methods are credible or relevant. The mentioned consultation methods are frequently used in contemporary methods and the methods selected for this analysis aid in developing a pragmatic amalgamation of theories. However, prior to introducing these methods, it is imperative that a definition of clinical ethics is addressed. By introducing a formal definition of clinical ethics, the discussion's attempt at amalgamating relevant theories of clinical ethics consultation is provided with direction and a clearly delineated standard for forming a theory.

### 3.1.1.1 Defining Clinical Ethics: Bernard Lo

Currently, interpretations and definitions of clinical ethics attempt to demonstrate morally acceptable practices in clinical medicine. However, contemporary defining factors of clinical ethics are inadequate due to their stagnancy in ethical principlism. Although principlism is substantive and possesses virtuous qualities that should be considered in ethical decision-making, there lie inherent dangers that accompany principlism. For instance, principlism, if followed dogmatically, provokes relativistic actions in ethical decision-making. This is an especially precarious issue due to the limitations ethical relativism places on conflict resolution in clinical care. For instance, while one group believes they are acting ethically by exercising a patient's autonomous rights, another group may insist that justice is the principle that trumps all others and therefore must supersede autonomous rights of individuals.<sup>3</sup> In situations like this, principlism becomes deadlocked in a discussion that begs questions of ethical priority. This analysis attempts to demonstrate the effectiveness of various ethical theories by a method of amalgamation and theoretical extraction. In doing so, this discussion demonstrates the effectiveness of comparative theories in health care ethics.

Although the definitions of clinical ethics that are rooted in principlism aim to benefit patients in ethically doubtful situations, a far more appropriate and beneficial definition of clinical ethics may be uncovered by amalgamating the ASBH's goals and definition of healthcare ethics consultation with Bernard Lo's definition in his text, *Resolving Ethical Dilemmas: A Guide for Clinicians*. Lo's approach begins by addressing clinical ethics within the first few pages of his analysis. Although Lo does not give a strict and concrete definition of clinical ethics, he provides a robust description of clinical ethics and the intricacies that accompany its practice. According to Lo, clinical ethics differentiates itself from traditional

bioethics by honing interactive dichotomies and relationships in clinical care.<sup>4</sup> In clinical settings, patients are inevitably associated with physicians, nurses, and other medical staff. This facet of clinical care does not necessarily mean that patients foster a relationship with health care professionals or vice versa. However, the ethical aspect in a clinical setting that involve a patient-physician relationship concerns issues of value-judgments, the differences between right and wrong actions, and decisions about effective or safe treatments.<sup>5</sup> Lo's description of clinical ethics presents insights into the definition of clinical ethics. While various relationships in clinical medicine may pertain to action, the relationship clinical ethics forges result in a dichotomy that answers questions of action and inaction.<sup>6</sup>

Lo expands his description of clinical ethics by investigating the differences between morality and ethics.<sup>7</sup> Lo notes that, although these terms are used interchangeably, tremendous differences exist between these concepts.<sup>8</sup> In clinical ethics, distinguishing these terms are of the utmost importance. If a clinical ethicist exercises the ethics facilitation approach, he must adhere and respect the wishes of parties involved while simultaneously upholding ethical norms.<sup>9</sup> Morality entails values and beliefs that have no empirical evidence for their existence.<sup>10</sup> While morality possesses subjective elements, ethics pertains to a formal area of philosophical reasoning that demands argumentative justifications for its import.<sup>11</sup> The distinction between morality and ethics aids in uncovering a definition of clinical ethics by juxtaposing two themes that are mutually inclusive. While morality pertains to individual values and concerns, ethics refers to the formal, argumentative process of identifying the *why* and *how* of value-based questions.<sup>12</sup>

### 3.1.1.2 Defining Clinical Ethics: ASBH Core Competencies

Now that Lo's definition of clinical ethics consultation has been elaborated, the analysis

presents a brief consideration of the defining factors of clinical ethics consultation from the standpoint of the ASBH core competencies. According to the ASBH core competencies, healthcare ethics consultation is first and foremost a service that aids relevant members involved in a health care related discrepancy.<sup>13</sup> Furthermore, the ASBH stipulates that the discrepancies that arise in healthcare generally concern value-laden concerns of right and wrong.<sup>14</sup> The responsibilities of an ethics consultant differ from the roles and responsibilities of other healthcare professionals due to the consultant's interest in the ethical permissibility of medical practices.<sup>15</sup>

While a physician may conclude that their knowledge grants them the ability to perform a medical function or intervention on another human being, an ethicist asserts his role by investigating the moral permissibility of the physician's actions.<sup>16</sup> In this respect, the ethical questions that arise in healthcare require a definition that answer questions of permissibility.<sup>17</sup> Although the ASBH core competencies delineate specific areas of bioethics, *i.e.*, organizational ethics, professional ethics, etc., the role of healthcare ethics consultation pays homage to the roles and responsibilities entailed in clinical ethics.<sup>18</sup> This point specifies the uniqueness and inherent differences between bioethics and clinical ethics. While bioethics houses various disciplines, the ASBH core competencies indicate that clinical ethics is a unique specialty under bioethics that is inherently entailed in clinical ethics consultation.<sup>19</sup>

Comparing and subsequently combining theories proves to be a successful and effective means of uncovering a formal definition of clinical ethics. With Lo and the ASBH's critiques and definitions in mind, a formal definition of clinical ethics may be considered as the professional practice of appropriately listening and responding to patients, families, surrogates, healthcare professionals, and all other involved parties who are in need of conflict resolution

regarding moral or value-based concerns involved in healthcare while simultaneously assessing the risks and benefits of a situation and its outcomes.<sup>20</sup> This definition not only clearly delineates the role of health care ethics in a comprehensive manner, but also demonstrates the effectiveness of combining and filtering through multiple considerations.<sup>21</sup> With the model and procedure of comparative amalgamation explained, the analysis now tends to various ethical consultation theories. Furthermore, by applying these theories to a clinical case, both the theoretical and practical aspects of ethics consultation methods may become elucidated.

### 3.1.2. Clinical Case Analysis and Review

To discuss the effectiveness of various clinical ethics consultation methods and subsequently the various beneficial aspects of these methods, this analysis first presents a clinical ethics case that occurred at the Atlanta Veteran's Association Medical Center (VAMC). Although this specific case does not entail a comprehensive array of ethical issues, it still provides an excellent medium for assessing different models and methods of clinical ethics consultation. While the patient and family in this case did not receive a clinical ethics consultation, the physicians assigned to this patient exercised various elements of consultation tactics that ultimately resulted in a positive outcome. By assessing the details of this case, the discussion may then move into a thorough discussion surrounding popular models of clinical ethics consultation.

In October of 2015, Mr. Smith, a gentleman in his mid-50's, was admitted to his local veteran's associated medical hospital (VA) for respiratory distress and difficulty swallowing. The patient experienced pain and discomfort upon trying to swallow and indicated his pain level to the medical staff. The patient had a history of asthma attacks and was currently undergoing treatment for esophageal cancer. The patient was admitted and monitored. Since the patient's

primary issue resided in a respiratory complication, medical staff remained extremely attentive to his oxygen stats. Upon his admission to the VA, the patient's oxygen stats were in the 30's. After receiving various breathing treatments, the patient's oxygen stats climbed to the 80's. This oxygen stat improvement was a positive outcome of the patient's treatment, but still did not yield curative results for the patient's underlying condition.

During his treatment, the patient's family and friends were constantly bringing various outside food items for his consumption. The patient enjoyed foods like pudding, cake, thick soups, and other dense liquid-based items. These events prompted the patient's physicians to investigate into his cancer diagnosis further. After a series of tests and examinations, physicians determined that an asthma attack did not induce the patient's respiratory distress. Instead, the esophageal cancer that afflicted the patient eroded barrier tissue that originally separated the patient's esophagus and trachea. As a result, the food that the patient was consuming was redirected into his windpipe and subsequently his lungs, causing advanced cases of aspirated pneumonia. Additionally, each time food was redirected into his lungs, the patient's body became weaker and caused his condition to worsen. After the patient was informed that his currently lifestyle, namely, consuming the foods he enjoyed, was expediting his already worsening condition, the patient became saddened and melancholic. It was extremely clear to medical staff that the patient enjoyed eating the very foods that were detrimental to his condition. Upon witnessing the patient's change in demeanor, physicians began discussing treatment and care options with the patient.<sup>22</sup>

The patient was initially a full code, or, requested that in the event his heart was to arrest the medical team would perform all resuscitation efforts necessary to restore normal heart rhythm. Additionally, the patient requested that aggressive interventions are used to prolong his



life if possible. However, after informing the patient about the severity of his current condition, it became clear that the patient and his family did not comprehend the details of maintaining his full code status, nor the burdens that accompany aggressive interventions.<sup>23</sup> Physicians explained the violence that is entailed in resuscitation to the patient and his family. Furthermore, the physicians explained that it was unwise to remain a full code and to continue aggressive interventions if the patient wanted to continue eating the foods he enjoyed. Even though the foods the patient was consuming were exacerbating his respiratory condition, the patient still wanted to enjoy his current life style. Physicians explained that due to the severity of his cancer, it would be wise to pursue palliative and comfort options.<sup>24</sup> Initially, the patient considered this choice of treatment as “giving up” in terms of his illness. However, physicians informed the patient that no curative measures exist for his condition. Physicians continued by explaining the benefits of home hospice care. Since the patient had no chance of curing his cancer and still wanted to enjoy his current life style, the patient agreed to pursue comfort measures and explore hospice options. Furthermore, the patient agreed to change his code status to a do not resuscitate order. The patient died at home one month after his discharge from the VA. He was surrounded by his family, friends, and under the care of hospice personnel that ensured comfort during his passing.

The above case primarily deals with issues surrounding end of life care, code status, and palliative options for terminally ill patients. However, one of the most pressing issues that surrounds this case involves the role and authority of health professionals and their abilities to coerce or convince a patient into a certain course of medical action. Typically, the ethical issues that surround coercion or manipulation pertain to treatment options. These options usually entail a course of medication or surgical intervention. In this case, physicians attempted to demonstrate

to the patient that suspending curative treatment efforts would yield a more comfortable, fruitful, and enjoyable remainder of life. Although the medical staff were imposing a course of action that was contrary to the preferences of the patient, the staff still acted in the name of beneficence.<sup>25</sup> Specifically, the medical staff believed the patient, although competent, did not fathom the gravity of his illness and thus needed information about comfort options. This method of presentation served as an educational catalyst that aided in explaining the severity of the patient's situation and the futility involved in continuing curative measures.

The above case aids this discussion's task of amalgamating effective clinical ethics consultation methods by providing a receptacle into which the discussed theories may be placed. By introducing this case, the discussion elucidates themes throughout clinical ethics consultation methods and exposes thematic components of each theory. The following section introduces the main consultation methods used in clinical ethics. Outlining the following theories while simultaneously applying the above clinical case clearly delineates connective concepts and themes in their practice.

### 3.1.3. Methods of Ethics Consultation

The following section investigates three methods of clinical ethics consultation. These approaches to clinical ethics and clinical ethics consultation are used widely and have proven to be extremely effective in contemporary clinical ethics consultation. However, the field has not accepted a universal method into the realm of clinical ethics consultations for various reasons.<sup>26</sup> The most pressing issue in clinical health pertains to the various ethical, moral, and practical factors that accompany a clinical case. Furthermore, the methods and practices involved in clinical ethics consultation perform their duties well enough for a consultant to choose whatever method they see fit. To uncover the key components to an ethics consultation curriculum and an

ethical consultation method that may be used in a universal manner, the following section investigates Process and Format, Four Topics, and the CASES method of clinical ethics consultation.

#### 3.1.3.1 Process and Format and Four Topics

Process and Format, established by Robert Orr and Wayne Shelton, places a tremendous emphasis on patient documentation and hands-on communication between ethicists and other involved party members.<sup>27</sup> Orr and Shelton emphasize the need for clinical ethics consultation when value-laden issues create discrepancies among involved parties arise.<sup>28</sup> According to this criteria, Process and Format is extremely useful when addressing cases where family dynamics are not ideal.<sup>29</sup> However, certain cases may not require a tremendous emphasis on patient involvement. While discrepancies often occur when a patient's values conflict with another involved party member's values, situations where the values of the patient are unknown may require ethical facilitation of all party members except the patient.<sup>30</sup> These instances include situations where the patient is a newborn or perhaps cognitively compromised.<sup>31</sup> This issue is problematic because the Process and Format approach does not necessarily address issues of substitutive judgment thoroughly, nor does Process and Format regulate options for situations of this magnitude.<sup>32</sup> Despite this shortcoming, Orr and Shelton give detailed and useful information regarding interactions between patients and family members.<sup>33</sup> Although Process and Format states that it is almost always appropriate to visit a patient that is involved in an ethics consultation, there are instances where patient involvement would not be appropriate, *i.e.* a child that does not understand the severity of their situation and, without undergoing a specific intervention, the child is at serious risk of harm or death. Another instance may involve a patient whose team requested an ethics consult and did not personally desire the involvement of

additional individuals. In this respect the consultant is performing their duties for the team rather than the patient.<sup>34</sup>

Process and Format does an excellent job insisting that the ethics consultant properly introduce themselves and clearly state their role in the hospital.<sup>35</sup> In order to uphold this aspect of Process and Format, cases where the patient is incapacitated require the consultant to speak with family members and ask questions about the patient, *i.e.*, what their personality is like, what they like to do, specific hobbies, sports they enjoy playing, *etc.*<sup>36</sup> These questions not only present the family with a sense of familiarity, but also aid in ethics facilitation by gaining a better understanding about the patient, including insight into the patient's baseline status.<sup>37</sup> In the case of Mr. Smith, there exists a clear divide between what lifestyle the patient wants to live and the limitations his illness places on his wishes. Mr. Smith enjoyed eating certain kinds of foods. He was a tremendous cooking enthusiast and lover of world foods. Naturally, this aspect of his life was a facet that he did not want to compromise, despite his illness.<sup>38</sup>

Typically, esophageal cancer manifests in a manner that still allows patients to eat normally. However, due to the erosion of the tissue that separates Mr. Smith's trachea from his esophagus, eating by normal means expedited the degradation and death of his lungs and respiratory system. It is important to note that Mr. Smith's specific condition did not make it impossible for him to consume foods in a normal fashion. Instead, eating foods in a normal fashion was expediting Mr. Smith's death. Since Mr. Smith was inevitably going to die from his cancer and enjoyed partaking in an activity that was actively killing him, Mr. Smith was left with a qualitative choice about his lifestyle. On the one hand, Mr. Smith could continue his course of medical treatment that, although was not curing his disease, was thwarting the disease's progression. This choice also entailed a full code status and placed a responsibility on Mr.

Smith's care team to advise him about the dangers of his dietary lifestyle. Furthermore, this responsibility of the care team also prompted health care professionals to prevent Mr. Smith from harming himself further which aligned with his treatment plan. On the other hand, Mr. Smith could choose to pursue comfort options and receive at-home palliative/Hospice care for the remainder of his short life. Since this option is not a curative one, Mr. Smith's care could be tailored in a way that allows him to live a lifestyle of his choosing. In other words, Mr. Smith would be able to consume the foods he enjoyed without a concern for the degradation of his health.<sup>39</sup>

By implementing the Process and Format approach to Mr. Smith's case, various qualitative details about Mr. Smith's wishes have a venue in which they receive consideration. This point about Process and Format is especially relevant for cases that involve a patient that is apprehensive to the suggestion of comfort measures. Naturally, the decision to cease aggressive treatments and pursue comfort measures only is difficult and a sensitive subject. After all, patients who are enrolled in services like hospice are individuals who inevitably must come to terms with the last stages life. However, Process and Format proves useful by asserting that this consultation method does not need to present itself as a method that imposes treatment or forces beneficence. Rather, Process and Format investigates multiple options for patients in an autonomous fashion. Rather than granting decisional priority to a health care professional, this module of consultation allows patients to review qualitative options and decide accordingly. However, in cases like Mr. Smith's, autonomous choices become difficult when determining comfort measures. While Mr. Smith knew what he enjoyed, he did not know what he wanted to do in terms of his treatment.<sup>40</sup> Although Process and Format is an excellent module for

determining options, it still falls short when attempting to educate patients about their current clinical situation.

Another beneficial aspect of Process and Format involves its ability to give detailed and useful information regarding interactions between patients and family members.<sup>41</sup> Although Process and Format states that it is almost always appropriate to visit a patient that is involved in an ethics consultation, there are instances where patient involvement would not be appropriate.<sup>42</sup> However in Mr. Smith's case, direct communication is, and proved to be, extremely valuable. Fortunately, Mr. Smith was competent and able to communicate throughout his stay at the V.A. However, had Mr. Smith been unconscious, Process and Format is still an excellent option for his treatment due to its ability to incorporate facilitation approaches regarding advanced directives, wishes and values, and the concerns of family members. Additionally, Mr. Smith's son had a continuous and important role throughout the decision-making process. Synonymous with Mr. Smith's decisions and preconceived notions of what a full code entailed, Mr. Smith's son supported his father's initial decision regarding his code status and course of treatment. However, once the severity of his situation was elaborated by medical staff, both Mr. Smith and his son were willing to adjust their opinions about the clinical situation. This phenomenon in Mr. Smith's case is a testament to the malleability of Process and Format. Despite the tremendous emphasis that is placed on the autonomous decisions of the patient, Process and Format permits the involvement of many individuals involved in a clinical situation. Despite the decisional priority of the patient, Mr. Smith made it extremely clear that his son must have an equal say and participatory role in his clinical decisions. Although this situation is not ideal from a facilitation stand point, the Process and Format approach yields successful results when assessing joint decision-making.

Process and format insists that the ethics consultant properly introduce themselves and clearly state their role in the hospital.<sup>43</sup> Furthermore, in cases like Mr. Smith's, the consultant should speak with the family members and ask questions about the patient, *i.e.*, what his personality is like, what he likes to do, specific hobbies, sports he enjoy playing, etc.<sup>44</sup> In Mr. Smith's case, it was clear that his passion for food directly influenced his decision to move to a palliative plan. These questions not only present the family with a sense of familiarity, but also aid in ethics facilitation by gaining a further understanding about the patient's wishes.<sup>45</sup>

Due to this method's rootedness in principlism, the Four Topics method an especially beneficial method for addressing value-laden discrepancies amongst stakeholders. However, a difficulty that lies in a method that is heavily rooted in principlism involves the argumentative preference of the party whose reasoning is not based in biomedical principles. For instance, if Mr. Smith was obtunded and one of Mr. Smith's surrogates chose an action that abided by his wishes but was contrary to the choice of another surrogate decision maker, the surrogate who is abiding by biomedical principles is honored since this individual is supported by an arsenal of accepted ethical norms. However, the voice of the other surrogate decision-maker is left unattended and disregarded due to their lack of clout in ethical norms. This issue begs the question of justice between stakeholders and demonstrates the difficulties associated with dogmatic subscriptions to principlism.<sup>46</sup> To further assess the strengths of Four Topics and its shortcomings further, each quadrant is examined:

(1) Medical Indications: The quadrant of medical indications in the Four Topics method bases itself off of the principles of beneficence and nonmaleficence.<sup>47</sup> Typically, the medical indications of a case are assessed in terms of a patient's medical problem, the goals of their treatment, and the risks and benefits involved in the patient's course of treatment.<sup>48</sup> Concerning a

patient's available treatment options—curative or otherwise—the goals of these procedures and examinations require clear delineation for patients.<sup>49</sup> In doing so, determinations about the risks and benefits of a procedure become elaborated. For instance, if the goal for a terminally ill patient is to extend their life as long as possible, then strictly adhering to comfort options or options involving terminal weaning are not appropriate. Alternatively, if the goals of the patient involve enjoying their remaining years without the difficulties of low-yield high-burden treatments, comfort options and palliative efforts become appropriate.<sup>50</sup>

In Mr. Smith's case, the patient is assessed in terms of his medical problem, the goals of his treatment, and the risks and benefits involved in his course of treatment.<sup>51</sup> However, Mr. Smith's case presents a quintessential conundrum in clinical ethics. Specifically, Mr. Smith's case presents a conflict between the autonomous decision-making of the patient and medical beneficence. On the one hand, the care team could allow Mr. Smith to exercise his autonomy by not questioning or inquiring about his full code status and treatment wishes. However, this option also would cause the most harm to Mr. Smith due to the violence entailed in a resuscitation procedure. On the other hand, imposing a course of action like comfort measures on Mr. Smith, although contrary to his initial wishes, proves to be a far more formidable plan for both Mr. Smith and his family. The difficulty surrounding this option involves usurping Mr. Smith's autonomy in the name of beneficence.<sup>52</sup> The physicians in charge of Mr. Smith's care asserted what they believed to be a better course of action considering Mr. Smith's diagnostic situation.

Finally, one of the more pressing points that specifically pertain the medical indications surrounding Mr. Smith's case involve the educational and informative aspects surrounding the risks and benefits of Mr. Smith's options.<sup>53</sup> Identifying Mr. Smith's son as his surrogate decision maker is a relatively simple task due to the fact that Mr. Smith clearly stated to hospital staff that



his son was the individual responsible for making his decisions in the event of his incapacitation.<sup>54</sup> However, Four Topics only asks what standards should govern the surrogate's decisions and does not aid in facilitating discussions between a surrogate decision maker and patient who do not understand the gravity of their treatment decisions.<sup>55</sup>

Although stated in a subtle manner, the second quadrant of Four Topics notes two standards for surrogate decision-making: substitutive judgment and best interest.<sup>56</sup> However, unlike Process and Format, Four Topics appears to deem surrogate decision-making as a formal indication by a consultant rather than a constructive conversation that may occur between a consultant and a family member.<sup>57</sup> Both consultation methods contain beneficial aspects in their application. While allocating patient decision-making to surrogates and obtaining proper information regarding a patient's wishes are well represented in both approaches, it is still unclear how educational and informative aspects regarding treatment manifest. The next quadrant of Four Topics is especially pertinent to Mr. Smith's case and provides insights into the informative aspects of comfort measures.

(2) Preferences of Patients: The second quadrant of Four Topics, preferences of patients, is rooted in the principle of autonomy for obvious reasons. The preferences and beliefs of patients are inherent indications of autonomy and exercise one's personal autonomy through the medium of choice.<sup>58</sup> The second quadrant first addresses whether the patient has been informed about the benefits and risks of their diagnosis and treatment.<sup>59</sup> In respect to clinical ethics consultations surrounding terminally ill patients, the second quadrant of Four Topics may apply to the relevant information concerning the possible outcomes and expectations of curative or comfort options. However, the mental capacity of patients who face decisions at the end of life are often misrepresented. Understanding a patient's preferences prior to incapacitation is a

crucial step in the advance care planning process. The appointment of an appropriate surrogate is also crucial if the patient's wishes are upheld with some semblance of accuracy.<sup>60</sup> Identifying a surrogate decision maker is a relatively simple task, yet Four Topics only asks what standards should govern the surrogate's decisions and does not aid in facilitating discussions with a disgruntled or unreasonable surrogate decision maker.<sup>61</sup>

Suppose the patient in the above-mentioned case is obtunded and their surrogate asks for interventions that are considered harmful or simply not medically indicated. While the surrogate wants what is best for the patient, unreasonable requests are often viewed as futile interventions and commonly perpetuate misconceptions about decision-making capacity.<sup>62</sup> While it is impossible to determine the preferences of the patient with certainty, items like advance directives aid this process. Unfortunately, while most Americans do not possess an advance directive, the decision-making process is left to surrogates who are determined by state laws surrounding next of kin statutes. Since this process is an onerous one, ethical involvement through a method like Four Topics aids the overall development of conversation and facilitates dialogue effectively. Although stated in a subtle manner, the second quadrant of Four Topics notes two standards for surrogate decision-making: substitutive judgment and best interest. Unlike Process and Format, Four Topics appears to deem surrogate decision-making as a formal indication by a consultation rather than a constructive conversation that may be had between a consultant and a family member. In this respect, a hybrid combination of both Process and Format and Four Quadrants would be extremely beneficial in clinical ethics cases that involve surrogate decision-making.<sup>63</sup>

Despite the physician's impositions upon Mr. Smith, the result of their actions resulted in a positive outcome. However, the deontological approach of ascribing to maxims or, in respect to

principlism, ascribing to the four principles of health care ethics to Mr. Smith's case, deems the course of action the physicians chose to take for Mr. Smith as unethical.<sup>64</sup> In a commentary on issues of beneficence, autonomy, and their relationship to futility, Dr. Kenneth Prager notes that the goals of treatment for a case like Mr. Smith's require clear delineation.<sup>65</sup> In doing so, determinations about harm, healing, and futility are determined. For instance, if the goal for Mr. Smith was to keep him alive as long as possible, then his original course of treatment is appropriate. However, since Mr. Smith reevaluated his goals and determined that he wanted to live the rest of his life in a comfortable manner of his choosing, the current treatment was not appropriate and even considered futile.<sup>66</sup> In this respect, the first quadrant of Four Topics aids the ethical assessment of Mr. Smith by actively seeking and reevaluating the goals of his treatment. However, the means in which Mr. Smith came to his reevaluation are unethical if viewed from a deontological-principlism approach, but appropriate if viewed from a situation ethics approach. The details and benefits of situation ethics as an alternative approach to this discussion is discussed later. However, it is important to note the difficulties of implementing the consultation methods discussed in this essay while simultaneously abiding by principlism.<sup>67</sup>

(3) Quality of Life: The third quadrant of Four Topics involves quality of life issues that include, but are not limited to the probability of recovery and the functionality of a patient after recovery, biases, and forgoing life-sustaining treatments.<sup>68</sup> Furthermore, the third quadrant is based upon the principles of beneficence and nonmaleficence.<sup>69</sup> Regarding Mr. Smith's case, it is clear that quality of life is a reasonable issue that may aid in implementing comfort decisions, withdrawing treatment, or using palliative sedation. This facet of Four Topics addresses the possible biases and interpretations of life quality, but does not specify who may have these biases and how they become addressed.<sup>70</sup> Both Mr. Smith and his son did not necessarily possess

preconceived notions concerning quality of life, nor a standard for best interest. In this respect, this quadrant of the Four Topics method serves an excellent function in providing informative aspects and options for both Mr. Smith and his son. Although the medical staff did in fact perform this task, it is questionable whether the medical staff fully informed Mr. Smith and his son of the risks and benefits of making a comfort measure decision or if they simply explained the dangers and horrors associated with aggressive resuscitation and continued treatment. Mr. Smith clearly enjoyed a certain life style that he did not want compromised despite his condition.<sup>71</sup> Since this quadrant of the Four Topics method specifically pertains to inquiring and addressing quality of life decisions with patients, an unbiased discussion with Mr. Smith and his son would have provided excellent insights and perhaps a mutually agreeable resolution to his situation.

(4) Contextual Features: The final quadrant entails logistical and professional standards of practice.<sup>72</sup> In respect to Mr. Smith's case, the professional standards that a physician must uphold are extremely relevant. However, the approach of the physician and the permissibility of his actions is still dependent upon the ethical approach to this specific case. While a physician has a duty to protect a patient from harm, the physician still must uphold a standard of autonomy for the patient. However, in the case of Mr. Smith, it is reasonable to claim that the patient's decision for a full code status and aggressive modes of treatment may have led to harm. In this respect, establishing an educational model to Four Topics and other methods of consultation discussed in this essay are extremely beneficial.<sup>73</sup>

### 3.1.3.2 Informed Consent in Ethics Consultation Models

In recent years, informed consent has become a standard of ethical practice in medicine due to its effectiveness in preventing violations of patient autonomy. Informed consent is a

procedure in medical practice that ensures that all necessary information regarding a physician's intervention with a patient is properly and effectively relayed.<sup>74</sup> Furthermore, proper execution of informed consent establishes an agreement that stipulates penalties for physicians or medical professionals that deviate from the plans and interventions discussed with a patient. While the final decisions made by a physician are somewhat authoritative, a patient's involvement in approving a physician's decisions stem into the realm of respect for personhood and uphold communication between the healer and the patient.<sup>75</sup>

Since informed consent is the act of respecting a patient's autonomy by providing relevant information regarding medical treatment, articulating relevant information about a diagnosis and treatment plan is paramount.<sup>76</sup> For Mr. Smith, the risks and negative outcomes of his initial decision to remain a full code patient and receive all and any aggressive treatments were fully articulated to him and his son. However, it is unclear if the benefits of his decision were ever communicated. It could very well be the case that Mr. Smith's initial plan had no feasible benefits and was thus determined as a futile course of action.<sup>77</sup> Communication between the physician and the patient regarding the patient's diagnosis and treatment plan begins with a diagnostic explanation by the physician. Since the patient presented to the V.A. with respiratory issues, Mr. Smith was under the false impression that his asthma was the culprit behind his labored breathing. However, by discussing the issues surrounding Mr. Smith's cancer diagnosis and the subsequent erosion of his esophagus, the first step of obtaining informed consent, namely, properly informing a patient, was properly presented to Mr. Smith and his son.

Obtaining informed consent is a delicate facet of clinical conversation for various reasons. First, the physician must not use conflated medical jargon or attempt to confuse the patient in any way. It is the physician's responsibility to educate the patient on these terms and

their relevance to the patient's diagnosis.<sup>78</sup> This detail also aids in avoiding coercive language or statements.<sup>79</sup> Second, the physician must articulate the relevant information in a way that ensures that the details of the information are presented as recommendations that are coupled with good reasons for their proposal.<sup>80</sup>

While the physician is the foremost authority regarding medical facts of a patient's illness, it is important that he articulates the reasons for his diagnosis and treatment procedures.<sup>81</sup> At the very least, this step in obtaining informed consent aids in establishing a trustworthy relationship between the physician and the patient. Although the patient is often not versed in medical science, the patient is still the sole decision maker regarding what interventions are performed.<sup>82</sup> Finally, proper communication between the physician and the patient yields a mutually beneficial agreement between both parties.<sup>83</sup> The dialogue held between the physicians, Mr. Smith, and his son inevitably leads to an agreement regarding a plan of action. However, it is unclear whether Mr. Smith's convincing was done so in an ethically justifiable manner. By fully informing a patient and subsequently receiving the patient's consent, the physician may use his diagnostic knowledge appropriately and continuously with the patient.<sup>84</sup> However, if the physicians coerced Mr. Smith into choosing an action that, although was appropriate and prevented harm, coincided with the physician's beliefs rather than Mr. Smith's, then the course of treatment is not ethically supportable.

Informed consent at its root is a request for acceptance. Once a physician properly discloses relevant information to a patient, the patient may choose to accept or reject recommendations.<sup>85</sup> Furthermore, the recommendations presented by a physician must also include a weighing of risks and benefits.<sup>86</sup> This aspect of disclosure is important when obtaining informed consent because the risks and benefits of certain procedures may directly influence the

permission of a patient. While diagnostic and procedural information presented to patients may be accurate, the acceptance of the information by the patient is only warranted if the patient understands the physician's recommendations as well as the risks and benefits associated with the recommendations.<sup>87</sup> In order to assess the proper standards for disclosure, a physician may determine what information is appropriate to disclose based on the "reasonable patient standard."<sup>88</sup> In other words, a physician makes a judgment call of how much information should be given to a patient. If the patient is seemingly reasonable and competent, the physician may deliver all necessary information. Mr. Smith presented no signs of being incompetent or an unreasonable patient. The only issue Mr. Smith presented to the physicians was his lack of agreement with their initial proposal of becoming a comfort measure only patient. In this respect, the physicians did not necessarily uphold a proper standard of disclosure.

Despite the issues surrounding the reasonable patient standard, it is one of the most common standards regarding informed consent and is recognized by law.<sup>89</sup> However, a standard of disclosure that is increasing in popularity is the "subjective" standard.<sup>90</sup> This standard is effective due to its ability to work on a patient-to-patient level by assessing individual cases with tailored information based on a patient's needs.<sup>91</sup> The subjective standard is enticing from an ethical perspective because this standard facilitates mutual respect and understanding. This latter approach to assessing a patient's standard of competence is especially relevant to Mr. Smith's case due to the subjective nature of beneficence that Mr. Smith's medical team placed upon him. Although many critics would claim that Mr. Smith's care team acted unethically, it is important to note that the team's decision to act out of beneficence rather than out of concern for the patient's autonomy is simply another approach to ethical facilitation that is not rooted in principlism. To demonstrate this point, a brief consideration into the theory of situation ethics

aids in elucidating alternative methods to principlism when determining end of life care.<sup>92</sup>

### 3.1.3.3 Fletcher's Situation Ethics: Alternatives to Principlism

Despite ethical advancements in clinical practice, there still exist issues that remain unresolved. Specifically, the issues that remain lie in perspective issues rooted in principlism. For instance, Mr. Smith's case may become interpreted as an example of unethical coercion due to its violation of the principle of autonomy. Alternatively, the case is equally viewed as an instance of ethical fortitude on behalf of the care team due to their emphasis on beneficence and situation ethics.<sup>93</sup> Although methods for bolstering, for example, informed consent, have been established, there still exists no unifying rule that resolves ethical issues in clinical care.<sup>94</sup> Rather than attempt to develop a rule that can unify divided standards of ethical responsibilities, there may be an instantiation of a set of rules and formulations that aid in ethical theory.<sup>95</sup>

In accordance with Kantian deontological thinking, various ethical maxims aid in ethical decision-making.<sup>96</sup> However, the problem with deontological maxims lie in their rigidity and stagnancy when dealing with multi-faceted ethical situations. In this respect, ethical principlism becomes a difficult facet of consultation for two reasons. First, ethical principlism mutually excludes facets of itself when attempting to arrive at ethical resolutions.<sup>97</sup> This issue manifests in Mr. Smith's case with a debate between upholding patient autonomy and maintaining the principle of beneficence. Second, the rigidity of the four principles within ethical principlism restrict effective ethics consultation methods by forcing these methods to abide by principles. By addressing ethical situations in a tailored manner, principlism may still be upheld by ideals rather than standards that risk violation.

A possible remedy for accommodating for ethical variance is an approach called situation ethics. Established by moral theologian Joseph Fletcher, Situation ethics is an ethical approach



that understands how ethical situations may manifest differently.<sup>98</sup> Although the vast differences between human beings and their clinical situations serve as a primary example of the beauty of autonomy, an ethical approach that can adapt to the differences of human beings must be established. Situation ethics does not limit its practice to a singularity and thus does not apply standards and ethical norms to all ethical instances.<sup>99</sup> Situation ethics is especially keen to human needs and varying situations because this method responds out of affection and empathy.<sup>100</sup>

Situation ethics bases its practice upon love and care for individuals and their plights.<sup>101</sup> Regarding Mr. Smith's clinical case, one can argue that the physicians' actions and responses to Mr. Smith's ignorance about his clinical situation and the implications that accompany full code procedures are actions that manifest purely out of love for the dignity, safety, and comfort of Mr. Smith.<sup>102</sup> In addition to this point, perhaps the most controversial philosophical claim from a situation ethics perspective is that love is always and everywhere a morally and ethically 'good' determination.<sup>103</sup> This claim is controversial due to the boldness entailed within this claim. However, acting out of love in all situations, provided this claim is true and valid, effectively reduces argumentative conundrums that are faced in principlism.<sup>104</sup> In other words, while principlism combats itself by determining which principle receives priority in ethical decision-making, situation ethics simply decides the most ethical option based off the decision that yields the most care.<sup>105</sup>

If viewed from a situation ethics standpoint, the physicians responsible for Mr. Smith's case acted effectively and appropriately. By effectively implementing a situation ethics approach, the physicians' conversations with Mr. Smith and his son effectively used a standard of care that justified their persuasive and informative tactics to move Mr. Smith into a care plan that emphasizes comfort measures only.<sup>106</sup> Situation ethics is a more effective foundation for

clinical ethics consultation models due to its malleability.<sup>107</sup> If exercised properly, situation ethics may be used as an attitude that effectively bolsters current and future models of consultation.

With the foundational aspects of situation ethics elaborated, the analysis examines a final ethics consultation method. In respect to Mr. Smith's case, both Process and Format and Four Topics have provided excellent methods for accruing ethically relevant information when constructing a clinical ethics consultation. However, the discussion has also demonstrated the issues that accompany these methods when implemented from a principlism model. Ultimately, Mr. Smith's case requires a method that not only articulates ethical discrepancies within a clinical context—a task that is completed rather well via Process and Format and Four Topics—but also aids in perpetuating an effective attitude toward involved party members, namely, Mr. Smith's son. Furthermore, an appropriate consultation method for Mr. Smith's case must also entail a module that perpetuates appropriate educational aspects for patients and their families.

Earlier, the discussion noted that a lack of educational facets for Mr. Smith and his son yields ethically unsupportable approaches on behalf of the medical staff. However, since the medical staff performed their duties out of care and love for the patient through a situation ethics model, their actions were inherently justified. To demonstrate an effective clinical ethics model that reflects the beneficial aspects of situation ethics, a final consideration of the CASES model of clinical ethics consultation is discussed.

#### 3.1.3.4 CASES: A Method for Facilitating Value Discrepancies and Education

Within the clinical context of Mr. Smith's case, the CASES approach is an effective model due to its ability to adapt a situation ethics framework. CASES presents a formal checklist criterion for clinical ethics consultations; a property that is represented well in Process and

Format and Four Topics. Furthermore, CASES, unlike Process and format and Four Topics, presents a general attitude that can be adopted by other clinical consultation methods. In order to illustrate this point, the analysis applies CASES to Mr. Smith's case.<sup>108</sup>

The CASES acronym, clarify, assemble, synthesize, explain, and support, are five elements of clinical ethics consultation that are applicable to all cases and under any consultation approach. The first step, clarify, involves uncovering what kind of consultation request is made, gaining preliminary information about a case, and provides an opportunity to determine what ethics questions are present.<sup>109</sup> This aspect of CASES is synonymous with the medical indication quadrant of Four Topics but differs in that an assessment of a proper consultation method is adopted. CASES is open-ended enough that a vast array of ethical issues may be identified without limiting the scope of the overall goals of conducting a clinical ethics consultation.<sup>110</sup> While Mr. Smith does not necessarily understand his clinical situation, nor what is entailed within clinical ethics for that matter, the CASES approach allows his medical team to determine how and in what capacity the educational aspects surrounding Mr. Smith's clinical case may be dictated to him. The clarification aspect of CASES is also used to justify the underlying goals of Mr. Smith's case and aids in determining the risks and benefits that surround his decisions. Mr. Smith was unaware of the consequences of his decisions, but certainly knew what he wanted out of life. Naturally, it is reasonable that Mr. Smith wanted all possible measures taken to save his life. However, the underlying issue in Mr. Smith's case does not pertain to futility.<sup>111</sup> Rather, Mr. Smith was simply uneducated about his condition, his treatment plan, his options, and the risks and benefits entailed within his options.

The second and third aspect of CASES, assemble and synthesize, aid in gathering all necessary information regarding a case and aid in determining whether or not a formal ethics

meeting is required.<sup>112</sup> These steps include acquiring the types of information needed, sources of information, summary of the ethics questions, and identifying an appropriate decision maker.<sup>113</sup> These steps may appropriately summarize the entirety of what Process and Format and Four Topics attempt to accomplish. Efforts to understand Mr. Smith's preferences, his son's preferences, and the overall goals of treatment are assessed here.<sup>114</sup> From an ethical standpoint, it would have been appropriate to call for an ethics consultation for Mr. Smith.<sup>115</sup> The physicians responsible for Mr. Smith's care decided to take the ethical issue into their own hands by implementing a standard of care. Here, the standard of care the physicians implemented may be categorized as a situation ethics approach. However, a formal ethics consultation may have aided in the elaboration of this case. While the physicians may have acted unethically if their model of ethics was based upon a principlistic model, their standard of care is deemed appropriate if examined through a situation ethics model. A proper ethics consultation may have aided the intention of the physicians' ethical approach to Mr. Smith's case and subsequently facilitated a beneficial result.

The fourth and fifth steps of CASES involve explanation and support.<sup>116</sup> These two facts of CASES set this approach apart from others by insisting on direct steps that specifically pertain to Mr. Smith's case. Within the context of explanation, consultants must communicate the synthesized aspect of the consultation with key participants.<sup>117</sup> In this respect, communication with Mr. Smith's son is bolstered and aids in expediting his son's decisions for his father. Furthermore, this step involves providing additional resources for Mr. Smith's son, including counseling, literature, and information on end of life care, hospice, and details of comfort measures.<sup>118</sup> Since Mr. Smith's son took issue with the comfort option for his father, the explanation aspect of CASES may provide an element of catharsis. The support aspect of

CASES is extremely beneficial for Mr. Smith's son following all clinical decisions made for Mr. Smith due to its requirement to follow-up with involved stakeholders.<sup>119</sup> This step provides additional support for Mr. Smith's son following the clinical decision. This step also aids in improving the consultation process and any other format of clinical ethics consultation that is used along with CASES by reviewing the consultation process and adjusting facets for future application.<sup>120</sup>

While the effectiveness of the above-mentioned consultation methods shines through the varying circumstances that accompany clinical ethics debates, their application and solidification in a structured curriculum is lacking. Although these consultation methods are a standard form of consultation in clinical ethics, a criterion that demonstrates the effectiveness of a consultant's work ought to be in place. The following section of chapter three discusses the current clinical ethics consultation standards that have been developed by the ASBH. The ASBH attempts to uncover the necessary components of a curriculum that must become examined if a clinical ethics consultant is to receive professional credentials through its CECA sub-committee.

### 3.2 The Clinical Ethics Consultation Standards of the ASBH

In 2009, the ASBH formed the Clinical Ethics Consultation Affairs (CECA) standing committee. This committee was formed to address concerns regarding the competency and professional knowledge of individuals responsible for providing clinical ethics consultations to patients, families, and health care professionals. These concerns primarily involve the legitimacy of consultations and consultant competence. Furthermore, this committee formed in an attempt to improve both basic and advanced levels of competency for clinical ethics consultants based on the ASBH's *Competencies for Health Care Ethics Consultation*.<sup>121</sup> The evaluation is broken into two parts. Part I presents the ASBH's pilot program and the CECA sub-committee's

recommendations to the board of directors. Part II discusses appendix B of the CECA report. Appendix B outlines specific skill and knowledge areas that must be met for an individual to receive a sufficient clinical ethics consultation education and accreditation. Appendix C gives examples of certifying bodies that are currently using some facets of the ASBH's pilot program. Although this information is helpful in that accrediting bodies demonstrate the topics listed in this report, this critique examines the details of both the ASBH's pilot program for professional ethics accreditation and the CECA's recommendations for the ASBH's pilot program via the CECA's 2010 report to the ASBH board of directors. In conjunction with one another, this critique demonstrates current methods of evaluating the levels of competence clinical health care ethicists possess by evaluating the ASBH's pilot program.<sup>122</sup>

### 3.2.1. Certification, Credentialing, and Accreditation

The report begins by explaining the inherent demand for qualified clinical ethics consultants. The primary question the report addresses is whether individuals conducting clinical ethics consultation possess adequate qualifications. The report mentions that according to Fox and Colleagues' national survey, only 5% of consultants have completed a fellowship or graduate program in bioethics.<sup>123</sup> Despite this statistic, the ASBH and CECA have placed an emphasis on other means of accreditation and certification for clinical ethics consultants due to the legitimacy of graduate programs. According to the ASBH and CECA, no bioethics graduate or fellowship program is accredited to educate and train clinical ethics consultants. In this respect, the ASBH asserts that there exists no tangible evidence that asserts the competence of clinical ethics consultants.<sup>124</sup>

#### 3.2.1.1 ASBH and CECA Methods of Ethics Consultation: Skills and Competencies

Initially, the ASBH developed a multiple-choice examination that would determine the

competency of clinical ethics consultants and other individuals assisting with ethics consultations. This exam is comprised of multiple choice questions that test a range of topics involved with CEC including, bedside manner, role delineations, and basic skill sets that have been established by the ASBH's *Core Competencies for Healthcare Ethics Consultation and Improving Competencies in Clinical Ethics Consultation*. However, the CECA committee indicates that the multiple-choice examination that the ASBH requires is an insufficient means of testing competencies and skills for clinical ethics consultants.<sup>125</sup>

The CECA in conjunction with the ASBH's requirements suggests further actions involved with an examination process. These actions include a multiple-choice examination that also includes an essay, written case study analysis that involves an example of electronic medical record (EMR) documentation, and an oral interview with, presumably, an experienced and skilled consultant. Additionally, the CECA advocates for five additional methods to measure CEC skills and knowledge competencies. These methods include an evaluation based on mock consultations, evidence of having performed a minimum number of consultations as a lead consultant, a graduate degree in the applicant's field, formal evidence of clinical ethics consultation education and training, *i.e.*, a bioethics degree program, certification program, or continuing education, and a letter of recommendation from a supervisor or colleague who has provided clinical ethics consultation experience and observed the applicant's consultation skills.<sup>126</sup>

### 3.2.1.2 A Five-Point Certification Process

In addition to the above-mentioned modifications to the ASBH's examination process, the CECA subcommittee outlines five points that are necessary components for an individual to receive a standardized accreditation for conducting clinical ethics consultations. The first

certification point involves a written exam. This exam has been discussed in the previous section and involves a much more detailed approach to certification than the previous standing multiple-choice examination composed by the ASBH. This examination not only involves a multiple-choice examination that tests an individual's basic competencies in clinical ethics and clinical ethics consultations, but also requires individuals to demonstrate their writing skills via written essay sections that includes a written case study analysis. Furthermore, the exam also tests the written fortitude of applicants via EMR evaluations.<sup>127</sup>

The second certification point involves a portfolio that applicants must provide. This portfolio must include summaries of a minimum number of ethics consultations that have been conducted in the past year, *i.e.*, anonymous EMR documentation of three case consultations in the prior fiscal year.<sup>128</sup> This aspect of the application process both assess the writing capabilities of the applicant, as well as their ability to curtail their writing specifically for clinical ethics consultation. The third certification point the CECA presents involves an observational element to the certification and application. While this point is undeveloped in the CECA and ASBH's report, this aspect of the application process encourages eye-witness testimony to the effectiveness of an individual's clinical ethics consultation skills. Although it is not specifically outlined in the report, the individual who is performing the evaluation is presumably an experienced consultant who possesses the skills to both perform consultations and evaluate prospective consultants.<sup>129</sup>

The fourth point of certification involves letters of reference with attention to "360-degree reviews" from supervisors, colleagues, and other affiliated stakeholders. A supervisor, for instance, may be a director of a clinical ethics consultation service or an ethics committee chair while a colleague is an individual who has personally observed the applicant during a



consultation. Two other individuals who may conduct a “360-degree review” may entail a subordinate who has observed an applicant provide a consultation or a patient or family member who has been involved with an ethics consultation. If available, the latter individual may present a standardized form that evaluates the level of performance of a specific consultation with a narrative explanation.<sup>130</sup> Finally, the fifth point involves an interview by a panel of experienced clinical ethics consultants. This interview is conducted under the guise of a standardized interview guide that ensures all candidates are asked similar and fair questions.<sup>131</sup>

### 3.2.2. Funding and Certification

Following the initial report provided by the CECA, a list of five recommendations and are presented for consideration. These recommendations are an attempt to reconcile some discrepancies and possible issues that may arise from the ASBH’s application and accreditation program for consultants. While a modified written examination, oral examination, portfolio, and observational tactics are improvements to the certification and professionalization process, issues surrounding requests for proposals, certification for individuals at the advanced level, grandparenting a newly streamlined program, developing a council for accrediting educational programs, and generating a demand for certified clinical ethics consultants are all issues that the CECA determines as necessary components that require attention.

#### 3.2.2.1 Request for Startup Funding Proposals

The CECA mention a concern in their recommendations to the board of directors of the ASBH regarding companies that provide test development and implementation. Although these companies are not unfamiliar with start-up testing and implementation methods, maintenance costs and start-up overhead costs can be exponential and thus require attention. The money used to develop the necessary examinations for certification and accreditation must be composed in a

fair and just manner while simultaneously covering the expansive knowledge base involved in clinical ethics consultation. Furthermore, these companies are also responsible for composing universal templates for the above-mentioned portfolio, reference letters, and observational standards.<sup>132</sup>

The CECA notes that over \$100,000 are spent annually to maintain certification testing and compliance standards from companies that typically monitor and produce standardized testing, while over \$500,000 are spent in testing development alone. To reconcile this cost discrepancy, the CECA recommend that the ASBH pursue funding to cover startup costs for testing development. Since the certification process that the ASBH and CECA have developed requires rigorous attention and detail, there can only be minimal restrictions concerning the cost of research and development. Although many individuals believe there is not a high enough demand to support or justify the startup costs of a testing program, the CECA and ASBH believe that demand for standardized testing and certification will increase once a formal process has been established.<sup>133</sup>

The CECA conclude this point by posing five questions. These questions investigate key issues surrounding startup costs for external test development companies. These questions include:

1. How many individuals providing clinical ethics consultation are likely willing to receive certification themselves?
2. What cost differences manifest for individuals who must pay for self-funded testing?
3. What are the pros and cons of outsourcing certification, versus internal certification through the ASBH?
4. What are the liability implications for clinical ethics consultants who do or do not receive certification?

5. How should clinical ethics certification aid and work in conjunction with graduate programs?

All five of the above-mentioned questions require answers before the implementation of a formal testing process. Furthermore, the testing process that has been proposed by the ASBH and modified by the CECA subcommittee cannot come to fruition without formidable answers to the above questions. While question 2 pertains to the financial concerns of the certification project, questions 1, 3, 4, and 5 all focus on the practicality of the pilot program.<sup>134</sup>

#### 3.2.2.2 Creating a Self-Learning Program for Clinical Ethics Consultation Competencies

The CECA sub-committee determined that the ASBH must focus on certifying individuals who provide clinical ethics consultation services at various levels of competency since individuals providing clinical ethics consultation across hospital systems and other venues are not unified in their understanding of clinical ethics nor unified in their education methods. The CECA notes that individuals who are providing clinical ethics consultation must receive thorough and advanced competency training that comprehensively sifts through information using the evaluation methods listed in section 3.1. The CECA deem their evaluation methods as methodically rigorous processes that have the potential to open a practical pathway to a self-learning program that both teaches and demonstrates basic clinical ethics consultation knowledge for individuals providing consultations in a team model. In doing so, a wide range of individuals may receive training in a short amount of time due to the practicality of transferable information through mediums like online classes. These programs are designed to promote ethics consultants to self-educate themselves with tools provided by the ASBH.<sup>135</sup>

Presumably, the tools provided by the ASBH are adequate and ensure advanced educational points for those looking to continue their work as clinical ethics consultants. The basic knowledge of clinical ethics that the CECA and ASBH wish to achieve is based on the

premise that online programs and team-oriented self-learning programs are adequate venues to teach advanced consultation knowledge and skills. Most of the information provided to students who seek online support and education is based on the ASBH's *Education Guide* which provides basic clinical ethics consultation knowledge for individuals providing consultations at a basic level.<sup>136</sup>

Assuming individuals complete this course, students still are not yet able to achieve equivalency in becoming certified clinical ethics consultants. The online self-learning programs are synonymous with the certified IRB professional exam that demonstrates advanced expertise of those involved with research ethics while completion of various modules demonstrates basic knowledge of research ethics. However, the CECA propose a fundamental difference in certification and education for these individuals in that the clinical ethics certification process evaluates more than basic cognitive knowledge.<sup>137</sup> The CECA conclude this section by advocating for the ASBH's exploration into options for licensing basic educational products to generate revenue to help fund the certification process. As the report mentions earlier, proper funding efforts must be made to see that the ASBH's vision come to fruition.<sup>138</sup>

### 3.2.3. Grandparenting, ASBH implementation Standards, and Demands for Consultants

Three issues that develop from the CECA's recommendations to the ASBH involve grandparenting individuals who already possess advanced experience and knowledge in clinical ethics consultation, issues surrounding the establishment of councils that accredit educational programs that the ASBH uses, namely, programs that use the core comps as an educational basis, and the demands for certified clinical ethics consultants. All three issues must be addressed to expedite a certification program for individuals conducting ethics consultations. By examining the process of grandparenting clinicians, as well as the ASBH's implementation of standards, a

greater understanding of what is required of establishing a professional program in clinical ethics becomes clearer.

#### 3.2.3.1 Grandparenting Advance Clinical Ethics Consultants

Naturally, the transition period between the inception of the ASBH's new program and the implementation of a new program as a mandated platform requires transition tactics that do not disrupt the work and progress of established ethics consultants who have been practicing clinical ethics for years. Furthermore, these individuals are knowledgeable about the fundamental skills and competencies that are expected of a professional ethicist and thus may not need to undergo the same stringent features of the program as other individuals.

The CECA committee believes it is unwise to create a system for grandparenting current clinical ethics consultants. Specifically, the CECA's reservations lie in concerns about premature mandates on these individuals. The CECA notes that early applicants for certification will voluntarily do so in an effort to demonstrate their clinical ethics consultation experiences in the absence of a mandate to obtain clinical ethics certification.<sup>139</sup> Questions regarding the legitimacy of volunteer certification for advanced practitioners must be addressed since this presents a risk of wasted time and effort on the part of the practitioner if their efforts are thwarted in the face of new mandatory legislation.<sup>140</sup>

#### 3.2.3.2 Councils for Accreditation and Demands for Certified Clinical Ethics Consultants

The final two recommendations presented by the CECA involve considerations surrounding the development of councils for accrediting educational programs that use the ASBH core competencies for teaching and evaluating and the issue of generating demands for certified clinical ethics consultants. Both issues are extremely pressing due to their power over a certification program coming to fruition.<sup>141</sup> Establishing a council that accredits educational

programs, albeit graduate or fellowship, must serve as an intermediary step toward accrediting programs that educate and train clinical ethics consultants.<sup>142</sup> The ASBH should consider using the Core Competencies as a baseline for clinical ethics knowledge and skill development. This council may also explore continuing education units for education programs that assess knowledge and skill competencies.<sup>143</sup>

Finally, the ASBH and CECA's efforts to establish accreditation programs may go wanting if there is no demand for certified clinical ethics consultants. Accrediting bodies *i.e.*, Joint Commission and other professional organizations, should be aware of the demand for clinical ethics consultants by administering surveys throughout their care systems. These surveys should address patient populations, physicians, and other health professionals. In doing so, there must be a significant demand for more educated consultants that are willing to provide advanced knowledge to families, boards of directors, and patients.<sup>144</sup>

The information above outlines the important recommendations the CECA has provided to the ASBH regarding their pilot program for clinical ethics certification and accreditation. With these important considerations in mind, the report then moves onto detailed strategic plans and information that would be entailed in certification programs, namely, knowledge skill sets for individuals conducting ethics consultations. By examining these methods and skills used to evaluate advanced clinical ethics consultation skills and knowledge points for certification, a better understanding of the pilot program and future effort for certification reveals itself.

#### 3.2.4. CECA Report Appendices

The recommendations presented by the CECA sub-committee to the ASBH presents an array of critical critiques that ultimately provide insights that enhance the ASBH's model for certification and accreditation of individuals conducting clinical ethics consultations. Issuing

requests for start-up funding, pursuing certification of individuals at the advanced level through self-learning programs, accommodating grandparenting issues, accreditation councils for educational programs, and generating demands for certified individuals conducting ethics consultations are all relevant recommendations that ultimately better the ASBH's pilot program for accreditation and certification. Additionally, the CECA's report of the ASBH's pilot program includes three appendices. Appendix A provides names of CECA committee members while appendices B and C contain fruitful information regarding accreditation methods, skills, and knowledge areas. Appendix B: *Methods to Evaluate Advanced CEC Skills & Knowledge for Certification*, dissects the skill areas and knowledge areas of clinical ethics certification into core skills and their corresponding assessment methods.

#### 3.2.4.1 Methods of Evaluation

Appendix B of the CECA report examines the methods used to evaluate advanced clinical ethics skills and knowledge points for certification. The appendix is divided into two main sections: Core Skills and Knowledge for Clinical Ethics and Assessment. While the latter section only lists brief mediums through which individuals become assessed or tested, the former section is subdivided into three main subsections: Ethical Assessment Skills, Process Skills, and Interpersonal Skills. Each subsection is then further subdivided into twelve total skill areas. Since the amount of information within the CECA report's appendices is overwhelming and complex, this analysis assesses the core skills and knowledge points for clinical ethics consultants more so than the actual assessment methods. By assessing the skills and knowledge areas presented by the ASBH and CECA report, the pilot program's components become clearer as well as the certifying body's aims listed in appendix C.

### 3.2.4.2 Core Knowledge and Skill Areas

To assess an individual's ability to conduct a beneficial and effective clinical ethics consultation, various skill sets and skill areas have been presented by the CECA. Furthermore, the CECA's format for the appropriate skills must come before any assessment of knowledge areas concerning clinical ethics consultation. The CECA's order of appendices specifically indicates this. Specifically, the skill areas associated with clinical ethics consultation appear before the knowledge areas. This section specifically deals with Ethical Assessment Skills, or, the first set of skills under evaluation methods.<sup>145</sup>

Ethical assessment skills are categorized by the CECA as skills that are necessary to identify the value or uncertainty of conflict that demands proper ethics consultation. These skills require one's ability to discern and assemble relevant data that is pertinent to a case. The data may range from information gathered from a clinical setting or a less conventional setting like a psychosocial setting. Furthermore, these skills entail one's ability to assess a patient's decisional capacity and how this impacts an ethics consultation. These bits of information are easily tracked through clinical ethics consultation documentation. The CECA notes that clinical ethics consultation documentation is written documentation that is placed in a patient's medical record. The consultant must then assess the social and interpersonal dynamics that exist between the patient and other important stakeholders including family, friends, and medical staff. Furthermore, distinguishing the ethical dimensions of a case while clearly articulating the ethical and practical concerns are pivotal components that aid the identification process of various assumptions that are brought into a case. Additionally, distinguishing ethical dimensions of a case reveal values that are inherently embedded within involved stakeholders.<sup>146</sup> Finally, a key skill that the CECA and ASBH deem is necessary for appropriate clinical ethics consultation



involves a consultant's ability to identify their own relevant moral values and the values of the institution they work for. In doing so, the consultant may assess how these values may affect their decision.<sup>147</sup>

The above-mentioned skills presented by the CECA and ASBH contain various assessment methods that range from documentation, to written analyses, and interviews. All mediums mentioned by the CECA involve some form of testing or reviewable material. The section continues with further skills that fall under the Ethical Assessment Skill category. Specifically, one of the main skills that are necessary for a clinical ethics consultant to possess involves the necessity of an individual's ability to analyze the value, uncertainty, or conflict between involved members.<sup>148</sup> For a clinical ethics consultant to demonstrate their competence, one must access relevant ethics knowledge and clarify the concepts critically for family members and patients. These concepts include confidentiality concerns, privacy, informed consent, and best interest standards. In doing so, clinical ethics consultants can critically evaluate a situation and subsequently use relevant knowledge of bioethics, bioethics law—barring legal advice—and institutional policies to aid in the facilitation process.<sup>149</sup>

The CECA report takes one's ability to critically evaluate and use relevant knowledge of bioethics another step by presenting further criteria for clinical ethics consultants. Specifically, clinical ethics consultants must utilize relevant moral considerations to aid their analysis, identify and justify morally acceptable opinions, and evaluate evidence and arguments that support or reject certain opinions.<sup>150</sup> Furthermore, the CECA recommend that clinical ethics consultants stay active within their community by remaining up-to-date on peer-reviewed clinical and bioethics journals and books. In doing so, clinical ethics consultants will know how to access and implement the information found within their research. Clinical ethics consultants must also be

able to recognize and acknowledge their own limitations and possible areas of conflict. In doing so, consultants may avoid or limit instances of moral distress and professional burn-out.<sup>151</sup>

The skills under the Ethical Assessment category are standard practices that should be known and exercised throughout all clinical ethics consultations. Again, the CECA notes that these skills may be assessed and determined with various assessment methods including case-based written examinations and interviews. The next section of this critique discusses the CECA's Process Skills and Interpersonal Skills. Both sets of skills are examined along with their subsequent Assessment Methods.

#### 3.2.4.3 Process Skills and Interpersonal Skills

Synonymous with the Ethical Assessment Skills listed in the previous section, Process Skills and Interpersonal Skills are deemed by the CECA as pivotal components for clinical ethics consultants and their professional practice. Although both categories are entailed within advanced skill sets for ethics consultants, both Process Skills and Interpersonal Skills must be addressed individually. These skills, although unique in their application, resemble the methods and standards this analysis proposes. While the key aspects of effective clinical ethics consultation lie in the application of an individual's ability to understand and reason through ethically precarious situations, the methods that the ASBH's CECA subcommittee present offer core elements of understanding for clinical ethicists and bolster their abilities as clinicians.

Process Skills pertain to a consultant's ability to facilitate formal and informal meetings, build moral consensus, utilize institutional structures, and document consults. Identifying key decision-makers and involved party members is an important step in facilitating discussion since both individuals partake in the consultation. However, to conduct these meetings constructively, a clinical ethics consultant must set ground rules for formal meetings, express and stay with

families while maintaining a professional role, and establish boundaries for themselves and others.<sup>152</sup> The CECA notes that the most important process skill within this category is a consultant's ability to create an atmosphere of trust that both respects privacy and confidentiality. In doing so, the consultant develops a forum that allows all party members to feel free to express themselves and their concerns about their loved one or the procedures in question.<sup>153</sup>

Another process skill presented by the CECA involves a consultant's ability to build moral consensus among party members. In doing so, consultants help individuals analyze a patient's values alongside their own in a critical and constructive manner. Furthermore, this skill allows individuals to identify their underlying biases, assumptions, and prejudices while attempting to make decisions for their loved one.<sup>154</sup> Finally, the CECA notes that a consultant's ability to utilize institutional structures and resources as well as document consults are skills that must accompany a clinical ethics consultation. This allows other consultants and health professionals to review initial observations and findings regarding a case.<sup>155</sup>

Process skills serve as fundamental tools and elements of a clinical ethicists practice. These skills involve the general work-related skills that a clinical ethicist ought to know and use throughout his practice. Yet, while these skills are mandatory aspects of becoming an effective clinical ethicist, the skills are useless unless they are accompanied with interpersonal skills. There exist various instances where professionals in any given field are superb at their general tasks and work-related functions. Nevertheless, the same individuals can lack various qualities that allow them to perform their tasks effectively. For clinical ethicists, interpersonal skills are a necessary aspect of the job. The work involved in clinical ethics requires the ability to both relay information and to engage in critical listening and understanding with providers, patients, and families. Conducting a consultation in health care may be performed in a fashion that allows the

completion of mandatory tasks, such as identifying ethical issues and questions, establishing actions, and subsequently providing recommendations. Yet, these tasks are ineffective if the consultant does not engage with the involved stakeholders critically and personably.

Interpersonal skills are extremely important in clinical ethics consultations since the nature of ethics consultations inherently involve other individuals. Interpersonal skills involved with clinical ethics consultation require various abilities on the part of the consultant. The consultant must possess superior listening and communication abilities. These skills must be used to promote interest, respect, support, and empathy. A consultant's ability to educate parties involved concerning the ethical dimensions of a case is also of the utmost importance due to the fragile relationship between patients and families.<sup>156</sup>

During clinical ethics consultations, there is no room for communication breakdowns, miscommunications, or quarrels. The consultant's ability to present moral views to the party members, as well as the party member's views is extremely important during the documentation process. This is because passing cases over to other consultants or revisiting cases must contain detailed information regarding the viewpoints and beliefs of all party members involved.<sup>157</sup> Finally, interpersonal skills must entail a consultant's ability to promote communication between party members as well as recognize and attend to various barriers to communication. Since clinical ethics consultants are facilitators above all else, these individuals must possess the skills necessary to relay and interpret information to those who are not completely educated on subject matter, those who misinterpret information, and those who allow emotions to sway their decisions.<sup>158</sup>

The skills mentioned above are all necessary for clinical ethics consultants according to the CECA. However, the skill sets above are not effective unless they manifest through a

knowledge medium upon which a consultant may develop his or her ideas and recommendations. The facets of the CECA report that address process skills and interpersonal skills should not be disregarded. These skills are integral parts of clinical ethics consultations and should be fostered throughout a clinical ethicist's education. However, like many issues involved with formalizing curriculum components for ethicists, various debate exists surrounding what should and should not become entailed in a clinical ethicist's education. Like this dissertation's analysis, albeit represented in a different format, the CECA's report advocates for the amalgam of practical skills and knowledge points. However, the ways in which the ASBH and its CECA subcommittee lack the necessary key components of virtue identification.

Before a detailed analysis of virtue identification is presented in chapter four, the following sections assess the knowledge areas of the CECA report. These knowledge areas address the practical facets of information that trained professionals in ethics ought to possess if they are to perform effective clinical ethics consultations. While these facets of a clinical ethicist's education are fundamental and necessary, the analysis clarifies the importance of further expanding a clinical ethicist's ability to identify virtue in his practice.

### 3.2.5. Methods of Evaluation for Advanced Clinical Ethicists: Knowledge Areas

The CECA report's knowledge area section of appendix C contains various pieces of information that the CECA recommends as minimum content that a consultant should possess. The content ranges from moral reasoning and ethical theory to information regarding local health care institutions' policies and basic information regarding health law. The following section discusses knowledge areas pertaining to moral reasoning and ethical theory. Additionally, the analysis discusses fundamental bioethical issues and concepts that frequently appear throughout ethics consultations as well as practical knowledge areas within health care ethics. These

knowledge areas include information regarding health care institutions, health care systems, and other practical information regarding contemporary health care. This critique attempts to group these knowledge areas together due to their rootedness in theory. Alternatively, the remaining knowledge areas are grouped together due to their basis in practicality and contemporary information regarding health care. Assessing these areas demonstrates the moral reasoning present in contemporary bioethics.

### 3.2.5.1 Moral Reasoning and Bioethical Issues

The knowledge area section of appendix C begins with information regarding moral reasoning and ethical theory as well as bioethical issues and concepts in contemporary health care. The information includes corresponding assessment methods. These assessment methods include written exams, clinical ethics documentation, interviews, applicant information, and various combinations of each method.

Clinical ethics consultants must understand ethical concepts and theories and how they relate to bioethics. These concepts include consequentialist and non-consequentialist approaches, Kantian virtue theory, and theological approaches. Additionally, the CECA recommend clinical ethics consultants are proficient with primary texts and theoretical ethics: *i.e.*, Beauchamp and Childress' *Principles of Biomedical Ethics* and the principal/caustic theories the text entails.<sup>159</sup> A clinical ethics consultant must know theories of justice. Specifically, consultants should understand theories of justice in contexts that are especially relevant to resource allocation, fair distribution, and access. Finally, consultants must know their role and authority with respect to obligations to provide health care.<sup>160</sup>

Bioethics issues and concepts that occur in ethics consultations must be understood and critically analyzed by clinical ethics consultants. These issues and concepts include a patient's

right to health care, self-determination, refusal of treatment, and confidentiality in accordance with a patient's right to privacy. Additionally, consultants should also be aware of "positive" and "negative" rights. Naturally, autonomy and informed consent are pivotal elements of knowledge that clinical ethics consultations must possess.<sup>161</sup> These concepts occur across the field of medical ethics and are relevant concepts that must be applied to clinical situations such as patients receiving adequate information, voluntary and involuntary differentiations, competence and decision-making capacity, rationality, and instances of paternalism. Bioethics issues and concepts especially pertain to one's ability to understand and relay the concepts of confidentiality, fiduciary relationships between providers and patients, and the exceptions to uphold patient confidentiality. Other issues concerning a consultant's knowledge areas that pertain to confidentiality and professional relationships include disclosure, deception, and the impact these concepts have on a patient's privacy.<sup>162</sup>

Since clinical ethics consultants work with the general population, an ethics consultant must know how to aid and act in situations involving difficult patients. In doing so, the consultant not only upholds their duties as a responsible health care professional, but also demonstrates their valor as an ethicist by assisting and addressing patient compliance.<sup>163</sup> In conjunction with patients who may become difficult to address, a consultant's relationship with other professional staff serves as a benefit for an entire health care system. Specifically, clinical ethicists' professional relationship with other health care professionals should be a positive one that both informs and upholds a provider's rights and duties. These rights and duties include, but are not limited to, the parameters of conscientious objection and the duty to care. Clinical ethics consultants must also understand how cultural and religious diversity factor into ethics consultations. This also includes knowledge about biases that are based on race, gender,

disability, and sexuality.<sup>164</sup>

### 3.2.5.2 Ethical Concepts and Understanding Contemporary Health Care

Clinical ethics consultants are also expected to understand the laws, standards, and stipulations surrounding end-of-life care at a health care facility. End-of-life decision-making and the complications this area contains, including issues about medical futility, quality of life, euthanasia, physician-assisted suicide, DNR/DNI orders, and withholding nutrition and hydration must all be present and demonstrated by a consultant through a written exam assessment method and peer evaluation.<sup>165</sup> The ethics consultant must also demonstrate proficient knowledge concerning surrogate decision-making, including decision-making involving minors and incapacitated patients.

A clinical ethics consultant must also demonstrate proficiency in all aspects of beginning-of-life care. The knowledge areas of beginning-of-life care include reproductive technologies, surrogate parenthood, in vitro fertilization, genetic testing, insurance issues concerning maternity, issues surrounding critically ill newborns, conflicts of interest between involved parties and their relationship to a newborn and mother, sterilization, and abortion. These issues involved with end-of-life care alone create various intersections of issues involved with ethics consultations. For instance, ethics consultants are expected to understand sterilization and how it pertains to various health care institution's policies and procedures. However, other issues that require ethical attention include medical research, therapeutic innovation, experimental treatments, and organ donation.<sup>166</sup>

Finally, ethics consultants must understand conflicts of interest involving both families and health care organizations in service to the critically and chronically ill. Knowledge



concerning the issues like insurance, resource allocation, triage, and rationing all promote the consultant's duty toward social responsibilities and obligations to society.<sup>167</sup>

Clinical ethics consultants must have ample knowledge about health care systems and how they relate to managed care systems and federal systems, but ethics consultants must also possess ample knowledge concerning clinical contexts. Clinical contexts involve an array of information including the use of basic terms for human anatomy, diseases, and their prognoses, the history of common illnesses, psychological responses to illness, the processes by which health care professionals diagnose illnesses, awareness of the grieving process, emerging technologies, and a basic understanding of how care is provided to an array of individuals through various venues.

The venues in which ethics consultants must become familiar with include local health care institutions where the consultant works. The details about a consultant's place of work includes the organization's missions statement, services, medical research, medical records, human resources, and chaplaincy.<sup>168</sup> Additionally, an ethics consultant must become proficient with their local health care institution's policies.<sup>169</sup> These topics include informed consent, conflicts of interest, conscientious objection, confidentiality and privacy, human experimentation, advanced directives, and brain death determinations. The practical application of these concepts introduces other topics that ethics consultants must become proficient. These include, but are not limited to, impaired providers, error disclosure, medical futility, and HIV testing, and disclosure.

All of the above concepts also require a consultant to possess beliefs and perspectives of the patient and staff populations. These populations require a consultant's beliefs and perspectives that affect the care of racial, ethnic, cultural, and religious groups served by the health care

institution.<sup>170</sup> The final section of knowledge areas for clinical consultants include relevant codes of ethics, professional conduct, guidelines of accrediting organizations, and relevant health law. The codes of conduct from relevant professional and local institutions, consensus of ethical guidelines, standards of the Joint Commission, and patients' bill of rights and responsibilities are all facets of professional conduct that clinical ethics consultants are expected to know.<sup>171</sup>

### 3.3 Conclusion

To explain popularly used ethics consultation modules, this chapter outlines and applies a difficult clinical case regarding comfort measure only decisions and patient education. By initiating this discussion with an analysis of clinical ethics via Bernard Lo's interpretation of clinical ethics and the ASBH's definition of ethics *via* the Core Competencies, a formalized definition of clinical ethics is established through the comparative amalgamation of these two mediums. The formalized definition of clinical ethics subsequently provides a venue for a description of Mr. Smith's clinical case. The discussion then introduced three extremely beneficial clinical consultation methods, Process and Format, Four Topics, and CASES. In doing so, the discussion explained the details of Mr. Smith's case through the lens of three consultation methods and elaborates the justification behind the physician's decisions. Finally, the discussion arrives at a formidable method of consultation that bases its practice off Joseph Fletcher's situation ethics approach. This discussion ultimately demonstrates that a combination of these clinical ethics consultation methods may be applied and used effectively, provided they act upon a basis of care and love rather than methods of principlism.<sup>172</sup>

While the chapter's discussion of these formidable consultation methods explains the utility of implementing these methods, there currently exists no formal accreditation body that professionalizes the field of clinical ethics consultation in a manner that assesses the

effectiveness of a consultant's consultation methods. In this respect, the legitimacy of the above-mentioned consultation methods have no standard for their practice. The CECA report to the board of directors of the ASBH both outlines the ASBH's pilot program and demonstrates various suggestions and points of improvement. The report insists on developing a curriculum that consists of both skill areas and knowledge areas. Upon successful completion of various assessment methods, clinical ethics consultants then develop a knowledge base that aids in conducting professional ethics consultations. Provided an ethics consultant pass all assessment method procedures, consultants are then able to receive accreditation and professionally practice clinical ethics consultation under the licensure of the ASBH. However, the curriculum guide for accreditation mentioned in this chapter omits key skill points that must become apparent in an accreditation process for clinical ethicists. Uncovering these curriculum points and applying them to a curriculum aids the process of clinical ethics professionalization.

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## Chapter 4: Moral Reasoning, Ethics Facilitation & Virtue

The academic corpus of health care ethics training is vast. Many materials that train budding health care ethicists involve various check lists and protocols for delivering effective consultations to patients.<sup>1</sup> Often, these training protocols involve various skills that attempt to maximize the efficiency and effectiveness of deliberative discussion. The consultation service a health care ethicist provides must entail two tasks. These tasks include making appropriate ethical judgments and effectively facilitating discussion. The latter involves a duty to resolve conflicts between involved stakeholders while the former involves a fundamental aspect of ethics insofar as judgments make up the subsequent decisions of the moral agent.<sup>2</sup> However, the philosophical grounding for these two tasks does not receive proper attention.

Chapter three of this dissertation demonstrated the ways in which contemporary consultation methods might accommodate these two tasks. Furthermore, chapter three illustrated the contemporary efforts the ASBH has made to measure and evaluate clinical ethicists' abilities in performing consultations effectively. The purpose of its efforts is to arrive at a feasible means of credentialing and professionalizing health care ethics consultants. However, the knowledge and skills aspects that the ASBH looks to measure only cover a portion of what should be expected of a professional health care ethicist. While the aspects the ASBH seeks to measure and evaluate are important and should be considered, clinical ethics consultants must become versed in moral reasoning if they are to perform their jobs effectively. The analysis conducted in chapter four illustrates the importance of virtue-identification in clinical health care ethics consultations. Identifying virtue in health care ethics reveals the philosophical underpinnings of moral decision-making and the proper methods of facilitation involved in health care ethics consultation.



By identifying virtue, a key prerequisite understanding of analytical moral reasoning skills emerges and permeate several facets involved with health care ethics consultations. Uncovering these analytical moral reasoning skills ultimately aids the consultation process by providing consultants with an applicable set of reasoning skills that ground themselves in analytic moral theory.<sup>3</sup> To accomplish this task, chapter four describes specific moral reasoning skills for ethics consultants and subsequently demonstrates how these skills manifest in a research ethics context. While the applicability of these skills extends to all areas of a clinical ethicist's duties, research ethics serves as a quintessential area of medicine that requires ethical interventions. Identifying virtue and moral reasoning as key components for an ethics consultation curriculum through the medium of research ethics demonstrates the applicability of these skills and their necessity in professionalizing the field of clinical ethics.

#### 4.1 Moral Reasoning for Ethics Facilitation

Health care ethics consultation approaches decisions in health care with a moral lens. This moral lens allows individual consultants to engage with a moral agent and uncover moral determinations for patients and their families.<sup>4</sup> However, current methods that aid a consultant's arrival at moral determinations confine themselves to skill-based assessments that, although useful, must also be understood in terms of moral reasoning. For instance, Jonsen, Siegler, and Winslade's Four Topics approach covers aspects of clinical consultations that ensure the ethical treatment of patients. The Four Topics method grounds its reasoning in the four principles of biomedical ethics: Beneficence, Nonmaleficence, Autonomy, and Justice.<sup>5</sup> However, the Four Topics approach, among other consultation skills, becomes far more effective if the ethicist uses these practical skills after understanding the function of analytic moral reasoning and its relationship with ethical decision-making.

#### 4.1.1. Kant's Virtue Ethics: Understanding Moral Ends

Exploring a basis for analytic moral reasoning becomes tenable when a philosophical foundation for both moral judgments and ethical facilitation evolves into a competency-based curriculum. Analytic moral reasoning in health care ethics consultation is extremely beneficial because it expects and encourages ethicists to engage with dilemmas critically. Alternatively, without analytic moral reasoning, consultants possess an inclination to observe the current skills of health care ethics consultations dogmatically.<sup>6</sup> Dogmatic interpretation of rules creates rigidity and does not allow for adaptation according to the variance of ethical situations. A standard set of rules and evaluative methods for clinical ethics consultation, although effective, lacks the plasticity needed to adapt to ethical issues in health care. Reimagining standard clinical ethics consultation approaches, as a philosophical purist into praxis, both encourages critical thinking as well as bolsters current methods of consultation.<sup>7</sup>

##### 4.1.1.1 Virtue Ethics Over Dogmatic Rules: Self-Improvement and Happiness

Contemporary ethics typically fragments into deontological and utilitarian approaches. These options are popular among normative theories due to their focus on the person rather than the situation.<sup>8</sup> This emphasis on the agent rather than the situation focuses on the traits of an individual rather than obligatory laws that emerge from varying ethical situations. However, virtue ethics serves as a combatant viewpoint that counters the rigidity of deontology and utilitarian pursuits. Typically, virtue ethics is an approach that diverges with deontology's staple thinker, Immanuel Kant. Contemporary moral theories like Alasdair MacIntyre and Philippa Foot have chastised Kant as a thinker who has rigidly structured morality into a process of rule-following and obedience.<sup>9</sup> In many respects, Kant contributes to analytic philosophy's rejection of virtue. These criticisms poke at the shortcomings Kant's moral theory displays when

juxtaposed with traditional Greek virtue ethics insofar as Kant's deontological approach heavily bases itself upon an ethic of dogmatic rules rather than an ethic of virtue.<sup>10</sup> However, this does not mean that health care ethics consultants cannot reap a tremendous amount of critical insight from Kant. By reimagining his deontological structure, Kant's moral theory provides insights into virtue ethics.<sup>11</sup>

Virtue ethics attempts to identify the agent as a morally "good" person and subsequently determine what the good agent would do or would not do. This understanding of virtue ethics prioritizes ontology over praxis. In terms of Kantian virtue ethics, acts that entail ends in themselves rather than a means to an end are ethically formidable due to the moral motivation of the agent. When the agent's motivations direct toward a good that direct or intend a good action, the agent is acting virtuously.<sup>12</sup> The Kantian moral agent is the quintessence of a good health care ethics consultant. If a consultant approaches an ethical situation with the same good will that ought to encompass a morally fortuitous agent, the consultant will act consistently and respect the rules and protocols of the hospital, state, and any other governing body. It is important to note that the acts of a moral agent equipped with good will does not abide by these laws and rules out of obedience but because the agent understands and lives the rationally legislated rules of a system.<sup>13</sup>

Kantian virtue ethics further provides philosophical import to ethics consultants when deontological principles of maxims and duty apply. The maxims associated with Kant's deontological structure underlie a moral agent's intentions. These maxims pertain to dutiful intentions that apply to long-term goals. Since long term goals become tenable through various means, the kind of maxims that are particularly relevant to a health care ethics consultants relate to ends in themselves.<sup>14</sup> Kant explains this argument in his *Tugendlehre* by explaining that all

acts have ends and that ends are objects of free choice. Following this argument, the ends toward which an agent directs their actions are self-governing. Consequently, the maxims an agent constructs are also self-governed insofar as these maxims direct toward a moral end. However, two moral ends that take precedence in Kant's moral theory are the agent's duty to strive toward the agent's own perfection and the promotion of happiness in others. These two ends are ultimate responsibilities in terms of achieving virtue.<sup>15</sup>

#### 4.1.1.2 Kantian Virtue: Qualities of a Consultant

Kant's moral theory emphasizes virtue at its core. Nonetheless, the two ends which moral agents ought to dutifully pursue must receive further analysis. Health care ethics consultants require an ability to critically analyze situations, facilitate discussion, and make analytic moral judgments. Under the purview of Kantian virtue ethics, this analysis demonstrates that both the agents flourishing as a moral authority as well as promoting the happiness of others are cornerstones of ethical work. However, both ends must be framed within a practical receptacle if an ethics consultant is to make analytical moral judgments in health care.

Among the skills ethics consultants must acquire, analytic moral reasoning is a category of imaginative skills that have not receive priority. In fact, the ASBH has given little attention to this area, specifically because of its seemingly inapplicable nature. The practical skills that ethicists learn and exercise typically involve proper bedside manner, conversational mediation, and rules that dictate permissibility. However, by examining a philosophical basis for virtue, ethicists may become moral agents in their practice and subsequently engage in analytic moral decision-making when exercising practical consultation skills. A moral agent accomplishes the specific ends toward which the agent must pursue by exercising virtues that inevitably engage in ends themselves. In other words, the virtues are ends in themselves rather than means to various

ends. For the sake of this analysis the virtues of wisdom, justice, compassion, and humility serve as demonstrative skills that promote a consultant's analytic moral reasoning abilities.

It is fitting to begin with the virtue of wisdom due to the relevance this virtue possesses in honing one's ability to analytically reason. Since ethics consultation is an interpretive endeavor, critical experience and knowledge is a necessary component. Wisdom allows health care ethicists to ascertain details of a moral situation. Ranging from medical indications to patient preferences, the virtuous ethicist cannot be satisfied with minimum descriptions of a clinical situation.<sup>16</sup> Instead, it is the duty of the ethicists to evaluate the observable facts within a case and comprehend a detailed account of the events and interactions. The level of detail, although initially robust, subsequently reduces to ascertainable pieces of information that emphasize depth over breadth.<sup>17</sup>

Commonly referenced in health care ethics, the virtue of justice stands among four focal virtues associated with principlism. Understanding justice in terms of moral virtue both directs a consultant's end toward the betterment of themselves, their organization, and their patients. Understanding the virtue of justice allows ethicists to maneuver between health care ethics structures that may or may not yield benefits for patients.<sup>18</sup> Justice promotes analytical reasoning by encouraging ethicists to use a temperate approach to issues that threaten patients and their self-flourishing. Among these various issues are gender discrimination, resource allocation, and hospital hierarchies. Rather than just dissecting a situation's intricacies into observable elements of right and wrong, emphasizing justice as a virtue in health care ethics encourages analytic reasoning for consultants and aids facilitation.<sup>19</sup>

While justice embodies the epitome of Kantian ends by bolstering the moral agent's ends toward betterment of self and others, courage serves as a virtue that combats some of the most

serious issues in bioethics. Courage possesses tremendous influence in developing analytical reasoning skills because of its ability to promote a moral agent's beliefs.<sup>20</sup> Since the benefit of others and self-improvement are the two main Kantian ends toward which ethics must direct itself, courage aids analytical reasoning by challenging moral agents to adhere to their beliefs and what is ethically appropriate in the context of consultation.

The final two relevant virtues for developing analytic moral reasoning skills in health care ethics consultation are compassion and humility. These facets of moral agency go together due to their attention toward the betterment of others. Compassion is a necessary virtue for health care ethicists because of the sensitive needs of those who are suffering.<sup>21</sup> While this aspect of professional ethics seems obvious, it is important to exercise this virtue with frankness and poise. Ethics consultants can easily slip into emotive notions when encountering a patient who is under physical and emotional duress. Although an ethicist's emotions ought to bolster the ethicist's abilities to reflect on human suffering, emotions should never cloud or disrupt the ethicist's focus and decision-making abilities.<sup>22</sup>

Humility is often overlooked in both moral virtue theory and in consultation methods. Humility requires ethicists to approach each medical situation with a humble attitude and a reserved demeanor. The knowledge an ethicist possesses is often overwhelming for patients, families, and health care professionals. Due to the sensitivity of ethics situations, patients and involved stakeholders may be disconcerted by complex information or attitudes that exert arrogance. Considering this, ethicists should acknowledge their abilities and bracket their expertise. Upon encountering a situation that demands ethical expertise, ethics consultants should access the important and relevant information regarding a clinical case. Synonymous with

the above-mentioned virtues, humility inherently connects with justice, courage, and compassion.<sup>23</sup>

Wisdom, courage, justice, compassion, and humility are virtues that a health care ethics consultant must identify and practice if the consultant is to exercise analytic moral reasoning skills. Although various virtues may also apply to this analysis, these fundamental virtues are primary bases for analytic reasoning because of their roots in Kantian virtue theory. By first understanding the primary ends towards which a consultant must gear his attention, all subsequent ways in which an ethicist conducts a consultation may direct toward the betterment of himself and the patient.<sup>24</sup> Although these virtues receive priority in this analysis, a key element in honing analytic reasoning skills interconnects with one's ability to identify virtue. Moreover, identifying virtue is a task that one cannot easily accomplish since a virtuous life is an activity that contains ends within its practice. In other words, the pursuit of virtue is never complete. The pursuit of virtue is perpetual and chronically refined and consequently considered, under the Greek conception, as an *energeia* (ἐνέργεια).

While Kant's conception of virtue outlines an epistemic demand, the ontological identification of virtue still requires consideration. Furthermore, identifying the existence of virtue in a health care ethics consultation allows for practical application in health care ethics consultations. To determine how to identify virtue, this analysis investigates Aristotelian virtue ethics. In doing so, Aristotle's ethics uncovers practical ways in which an ethicist may achieve analytic moral reasoning skills in his practice.<sup>25</sup>

#### 4.1.2. Aristotelian Virtue Ethics: Assessing Analytic Moral Reasoning Skills

Virtue serves as ends in themselves that inherently directs one's functions toward the betterment of oneself and the people affected by one's actions as the agent. However, identifying

how each virtue manifests becomes difficult without proper guidance. Identifying virtue must become the primary objective of a health care ethics consultant if the consultant aspires to perform his function adequately. Nonetheless, identifying each virtue in terms of analytic moral reasoning is extremely difficult in health care ethics due to the severity of the situations involved coupled with the array of implicated stakeholders. By addressing an Aristotelian approach to identifying virtue and the subsequent actions that follow, specifically the development of analytic moral reasoning skills, the key components of a clinical ethics consultant's curriculum will both demonstrate necessary learning points and describe traits that a consultant must possess.

#### 4.1.2.1 Adjudicating Extremes for Reasoning Skills: Excess and Deficiency

Aristotle notably establishes an ethical mean approach for identifying virtue. One of his primary tasks in the *Nicomachean Ethics* is to determine what happiness (*Eudaimonia*) is and how happiness may become an achievable goal. Aristotle claims that happiness is inherently coupled with performing a function well. For health care ethics consultants, performing the primary functions of facilitation and conflict management are paramount. These activities, though admittedly onerous, are tenable if consultants use analytic moral reasoning skills through the medium of virtue. In doing so, a hermeneutic of ethical praxis appears: Happiness for self and others occurs by living virtuously and performing one's function well. Performing one's function well and living virtuously inherently entails directing one's moral ends toward self-improvement and the improvement of others.<sup>26</sup>

Identifying virtue in a practical sense first requires a moral agent's willingness to become self-directing toward beneficial ends. Without the desire to improve and perform one's function well, it is impossible for a clinical ethics consultant to recognize how virtue manifests in a



practical and effective manner.<sup>27</sup> Virtues are complex and often misidentified due to desires, thoughts, images, emotions, and actions. Nevertheless, the appetitive desires associated with dissuading virtue diminish once the moral agent accepts his function as a facilitator and resource for patients, families, and health care professionals.<sup>28</sup> Kant's ethical assessment posits that emotions are irrational impulses that do not guide a moral agent's reasoning abilities. However, Kant also notes that emotion can become shaped by moral education. While moral education begins at an early age, reasoning through complex moral situations in health care requires perpetual drilling of concepts and skills rooted in virtue.<sup>29</sup> Since the goal of this analysis is to demonstrate how clinical ethics consultants may develop heightened analytic moral reasoning skills, a method that aids ethicists in identifying their own appetitive desires and emotions both promotes poise within the moral agent and serves as a means of identifying virtue in ethical practice.<sup>30</sup>

Adopting an Aristotelian approach to identifying virtue catalyzes living virtuously. These processes are mutually inclusive in Book II of Aristotle's *Nicomachean Ethics*. In his text, Aristotle attempts to uncover the intermediate nature of virtues. This section of Aristotle's ethics, commonly referred to as the "Aristotelian Doctrine of the Mean," typically understands moral agency as a duty that must identify and recognize the intermediary understanding of a given emotion. Assessing and regulating emotions accordingly exposes a corresponding virtue as a median point.<sup>31</sup> For instance, courage is a virtue that lies between cowardice and rashness. While a deficiency in courage manifests in cowardice, an excess of courage results in impulsive and often unreasonable action.<sup>32</sup>

The Aristotelian doctrine of the mean possesses applicability to all virtues, yet this approach may still be confusing. Identifying a mean for any situation does not necessarily yield

virtue at the end of the proverbial rainbow. Identifying virtue becomes especially difficult in health care situations that demand moral recourse. Rather than exclusively adopt the Kantian ends toward which moral agents should direct their actions, a reimagining of Aristotle doctrine of the mean proves beneficial in health care situations. The varying emotions that occur while performing a health care ethics consultation may make or break a formidable ethical assessment. Although there are various practical skills that aid the consultation process, these skills cannot become practical without first honing moral analytical reasoning skills.<sup>33</sup> Identifying and honing analytic moral reasoning skills is a tenable activity if the moral agent can first recognize his emotions regarding a situation and subsequently implement warranted emotions when necessary. Aristotle's ethics insists that moral agents attempt to use certain emotions at the right times regarding situations, involved stakeholders, and motives. In this respect, the same appetitive emotions that dissuade analytical moral reasoning may become beneficial tools. For instance, appropriate anger is beneficial when fueling a moral agent's desire for courage while appropriate fear and confidence aids temperance.<sup>34</sup>

The approach to identifying virtue mentioned above in no way condones the exile of emotion, for emotion is a necessary component to conducting successful ethical assessments. By the way of example, compassion must accompany emotion in some capacity because it is a virtue that allows one to empathize with another's suffering. If a moral agent engages in compassion, he must identify with the sufferer in some way. In many respects, compassion requires the moral agent to see himself as a vulnerable member of a community *i.e.* as the sufferer. Finally, compassion requires an appetitive desire to help. If the moral agent seeks to alleviate the suffering of an individual, they must inevitably feel for the weakness of the suffering individual.<sup>35</sup> With this assessment in mind, moral agents must emote in they seek to live

virtuously. However, identifying and using proper emotions only becomes possible if a moral agent seeks to exercise his profession virtuously. It follows that analytic moral reasoning skills are abilities that develop when a moral agent identifies the proper use of emotions in ethical situations with the goal of performing a function virtuously.<sup>36</sup>

Although it may be clear that emotion is a necessary component for the identification of a virtue like compassion, emotion is still relevant across all virtues. Courage requires a proper allocation of warranted emotions due to its rootedness in fear. Without fear, courageous action cannot take place because the moral agent does not endure a difficult situation. In the Platonic dialogue the *Laches*, Socrates argues that proper deliberation, calculation, and reason are possible through wisdom. To endure through a frightening situation is ultimately empty unless the fear itself is subordinate to wisdom.<sup>37</sup> Health care ethics consultants can learn a great deal from Plato's teachings. Fear accompanies difficult ethical situations in health care for all parties involved. Despite this, if the moral agent regulates emotions properly by performing a function well, the moral agent is engaging in the identification of virtue and subsequently exercising analytical moral reasoning skills.<sup>38</sup>

#### 4.1.2.2 The Use of Analytic Moral Reasoning in Health Care Ethics Consultation

Identifying virtue and honing subsequent moral reasoning skills allow health care ethics consultants to use these skills in their practice. Although the variance of ethical situations in health care make consultation efforts difficult, regulating the emotive desires of patients, families, and even consultants is a difficult task. Considering this, well-developed virtue ethics occurs when negotiation occurs. Without proper negotiation between involved individuals, relationships will not flourish. Proper regulation of emotions may come differently to various consultants. By way of example, presenting the practical facts of a situation may provoke

emotive notions for one ethicist but not for another. For the sake of this analysis, good analytic moral assessment comes from entering a situation with the understanding that proper emotive action must become regulated through an understanding of virtue. Virtue identification becomes especially relevant under Aristotelian virtue ethics.<sup>39</sup>

Aristotle states that the moral agent must know that he has a duty to perform virtuous actions, decide upon these actions, and perform these actions from a firm and unchanging disposition (1105a30-1105b).<sup>40</sup> These three points do not specify that emotion cannot accompany the moral agent at the decision-making outset. Instead, having an emotional background prior to assessing the situation, provided the moral agent performs proper emotional regulation, may provide dutiful notions of right and wrong.<sup>41</sup> This assessment also aligns with principlism by appealing to the goals of the four principles of bioethics. The principle of nonmaleficence is especially pertinent to this discussion insofar as it accompanies an emotive desire to do no intentional harm to patients. While the principle is clear, the emotion that accompanies the principle absconds from the agent's view until the principle applies to a situation. Appealing to virtue is more effective than other means of consultation because analytic moral guidance emerges from analytic moral reasoning.<sup>42</sup>

A contemporary contribution by moral theologian Joseph Fletcher aids this analysis by providing an insightful method of using virtue ethics in contemporary ethical practice. Through examining Fletcher's method, the demand for analytic moral reasoning skills in health care ethics consultations becomes apparent. Furthermore, due to his theory's ability to adopt current ethical infrastructures, Fletcher's pragmatic approach to virtue ethics justifies and augments the ASBH's practical skills listed above. Fletcher is known for developing situation ethics—an ethical approach that understands how different ethical situations may manifest.<sup>43</sup> Although the vast

differences between human beings and their clinical situations serve to bolster the beauty of autonomy, an ethical approach that can adapt to the differences of human beings is greatly in accordance with virtue. Situation ethics does not limit its practice to a singularity and thus does not apply standards and ethical norms to all situations.<sup>44</sup>

In some respect, Fletcher's approach demands a great deal of heroism from clinical ethicists for various reasons. Fletcher's analysis insists that an ethicist must regulate his emotion by means of virtue identification, performing his duties virtuously, and subsequently engaging in analytic moral reasoning skills to maximize facilitation efforts. However, this task becomes extremely onerous in the face of terror, fear or a determination for self-protection. The heroism of an ethicist derives from performing his duties in the face of fear with nothing but analytic moral reasoning at his side.<sup>45</sup> Analogous with the Aristotelian soldier, a clinical ethicist must regulate his emotions by implementing analytic moral reasoning. Rushing into a situation that presents objective danger or risk to a patient or involved stakeholder is rash while decisional stagnancy provoked by fear indicates cowardice. Alternatively, if the ethicist uses proper emotive regulation by implementing moral reasoning skills into his decision, the ethicist subsequently makes a balanced recommendation that embodies virtuous practice and effective facilitation.<sup>46</sup>

#### 4.1.3. Character Development and Virtue Identification in Ethics Curriculums

Traditional conceptions of virtue and moral theory throughout the philosophical corpus possess qualities that can contribute to modern health care ethics and clinical ethics consultations. Kant's deontological principals, Aristotle's doctrine of the mean, Fletcher's situation ethics, and the pragmatic approaches of Beauchamp and Childress' principlism all may have a crucial hand in modifying ethics consultation competencies and aid in developing

bioethics as a professional discipline.<sup>47</sup> Additionally, the ASBH's core skills are in line with the ethical goals of the moral theorists listed above due to the cooperative nature of professional ethics. However, while governing bodies that regulate the educational facets of ethics consultation and teaching have adopted various methods in illustrating relevant information for clinical ethics consultants, key factors regarding philosophical notions of character development, stewardship, integrity, and virtue have become diminished in the educational curriculum for bioethicists.<sup>48</sup> Understandably, professionals responsible for the design of ethics competencies and curriculums may deem these concepts as antiquated, irrelevant, or perhaps too broad for the purposes of ethics education. However, the importance of virtue and moral theory contribute to ethical character in professional ethics and must receive attention. While this important prerequisite of ethics education for clinical consultants was at one time emphasized—albeit briefly—in the first edition of the ASBH's core competencies, the removal and subsequent lack of analytic moral reasoning competencies results in a significant shortcoming in clinical ethics consultation methods.<sup>49</sup>

#### 4.1.3.1 ASBH Amendments to Core Competency Editions

In 1998, the ASBH revealed the first edition of the *Core Competencies for Health Care Ethics Consultation*. This report was the first of its kind in many respects.<sup>50</sup> At the time, the core competencies spawned from a project that required the efforts of various professionals and health care organizations. The conglomerate of twenty-one individuals possessed a like-minded approach to clinical ethics in that the task force focused on defining the nature and goals of clinical ethics consultation, identifying the types of knowledge and skills involved in consultation efforts, addressing organizational ethics issues, and discussing the importance of consultations under the guise of specific institutional policies.<sup>51</sup> Furthermore, the task force

responsible for the development of a set of core competencies for budding clinical ethicists further reflected its passion and dedication for clinical ethics by incorporating the expertise of a diverse group of individuals who contribute to the multi-disciplinary nature of bioethics. The text intended to address bioethical issues in health care that range from beginning of life issues, to genetic testing, and cancer research. While the core focus of the text is to prepare individuals to conduct clinical ethics consultations, the unique character of the project arose with its understanding that no formal educational document existed prior to the ASBH's inception of the core competencies.<sup>52</sup>

The demanding task that the ASBH's task force set out to complete culminated in a well-constructed and formatted piece of literature that covered a tremendous amount of information with brevity and clarity. Naturally, with the growing demand for clinical ethics consultation, the nature and scope of consultation competencies must adapt and remain malleable.<sup>53</sup> Emerging technologies, cultural changes, and hospital protocols all affect the scope and design of a set of competencies that intend to benefit clinical ethics consultants. Due to the chronic shift in clinical focus, the ASBH released a second edition of the core competencies in 2011. This text included expansions and amendments of previous sections that seemingly improved the overall competencies and, in the eyes of the task force, better encompassed the necessary information required of clinical ethics consultants.<sup>54</sup>

Although the second edition of the ASBH's core competencies amended its focus and scope due to the changing nature of health care, the new ASBH task force removed a key dimension of moral reasoning from the original edition. The second component of the current version of the ASBH's core competencies, "Core Competencies for Health Care Ethics Consultation" marks a significant replacement. Subsection 2.4, "Attributes, Attitudes, and

Behaviors of Ethics Consultants,” replaces the original title, “Character and Ethics Consultation.”<sup>55</sup> To compensate for the removal of a character component to ethics consultation, the second edition of the ASBH’s core competencies includes a brief section on “Moral Reasoning and Ethical Theory.” This section appears under the “Core Knowledge for HCEC” section of the text and includes four ethical perspectives: Consequentialist/non-Consequentialist approaches, theological/religious approaches, principlism, and related theories of justice.<sup>56</sup> These theories, although important, are categorized under core knowledge points for ethics consultants. Although the first edition of the ASBH core competencies contained a section on character that encapsulated a better illustration of an ethics consultant’s duties, the character component as well as the amended attributes, attitudes, and behaviors section of the second edition are classified as core knowledge points.<sup>57</sup>

While the changes between editions seem small, the detriments of these changes lie in the removal of competencies pertaining to the underlying elements of a good clinical ethics consultant. These elements, although presented as simply “character” in the first edition of the text, adhere to the regulation of virtue in clinical ethics consultations.<sup>58</sup> The underlying shortcoming of the ASBH’s amendments lie in a focus-shift. This shift begins with an emphasis on philosophical concepts and migrates to a behavioral perspective. Despite that the use of virtue and subsequent analytic moral reasoning skills are unique to this analysis, the ASBH’s removal of character and substitution with behavior/attitude components creates a fundamental gap in the curriculum that otherwise may have bolstered moral reasoning skills. While the first edition of the ASBH’s curriculum possessed one half of a vital teaching component, the second edition removed this half and replaced it with another. In effect, a formidable ethics curriculum between both editions becomes possible if the analysis satisfies two conditions. First, both character and



behavioral functions, or emotive functions, must become mutually inclusive. Second, both character and behavioral functions of clinical ethicists must be categorized as core skills, not knowledge. In doing so, the moral development of ethicists becomes efficient and effective by introducing skills that regulate emotive decision-making and facilitate character development during clinical recommendations.<sup>59</sup> The regulation of emotion inevitably enhances proper character development. As a result, clinical ethics consultants gain analytic moral reasoning skills that aid in identifying virtue, its deficiencies, and its excesses.<sup>60</sup>

Character development is an important aspect of clinical ethics consultation. While the practical skills and core knowledge outlined throughout the ASBH core competencies covers an extensive amount of information, the matter of character open various pathways to virtuous behaviors and attitudes that permeate beyond the confines of clinical ethics consultation and saturate the health care organizations. The connection between character and organizational ethics could also explain the amendment of section three in the first edition of the ASBH's core competencies, "Organizational Ethics" along with its subsections: "Defining Organizational Ethics" and "Some Preliminary Recommendations."<sup>61</sup> It is no coincidence that piece on character precedes the piece on organizational ethics. This additional amendment further illustrates the importance of character in health care ethics consultation and the areas of health care it affects.<sup>62</sup> The practical skills and knowledge outlined in the ASBH's curriculum becomes far more ascertainable if the underlying regulation of emotion and virtue development develops first.

Addressing the importance of character in the ASBH's core competencies not only demonstrates the value of virtue-ethics in shaping a moral atmosphere, but also aids in illustrating the nature of a competency.<sup>63</sup> The role of a clinical ethics consultant is an important one due to the impact a consultant's recommendations possess. The vastness of a clinical ethics

consultant's expertise requires justification within its practice. The concept of competencies both allows consultants to remain diligent in their work and aids consultants in thinking quickly and efficiently.<sup>64</sup> Clinical situations move quickly and so too must ethicists. Just as is the case for professional care staff, an ethicist cannot pause and retreat to a library to assess an ethical theory or find aid in justifying a clinical decision. Instead, competencies must serve as training tools and educational points that leave a lasting impression on professional ethics consultants.<sup>65</sup> Nonetheless, the role of character, insofar as character promotes moral virtue and reasoning, is a pivotal tool for ensuring a consultant's ability to exercise and implement competencies properly.<sup>66</sup>

#### 4.1.3.2 Competency Skills and Virtuous Practice: Regulating Emotion and Skills

Expanding on the need for character development in clinical ethics consultation requires an analysis of the scope and function of skill competencies. In doing so, skill competencies present themselves as educational tools that demonstrate their applicability to various facets of a health care organization, including chaplaincy, social work, and lay-person occupations.<sup>67</sup>

By elaborating the ASBH's understanding of core competency skills, the need and utility of character development for clinical ethics consultants becomes a pivotal requirement of bioethicists. Additionally, the goal of uncovering and implementing analytic moral reasoning skills throughout a consultation system becomes a far more tenable feat if proper character regulates and promotes balanced emotions.<sup>68</sup> Emotions are inseparable and incredibly important aspects of decision-making in health care. Nevertheless, emotions may result in poor decision-making if the moral agent making decisions does not know how to properly regulate his emotions during ethical deliberations.<sup>69</sup> While the ASBH core competencies provide practical skills regarding the occupation of health care ethics consultation as well as the methods in which

one conducts consultations, these skills risk becoming misunderstood, misused, and inappropriately interpreted if the competencies lack proper emotive guidance.<sup>70</sup>

Examining the nature and function of emotion in decision-making processes grants a greater understanding of competency development and curriculum formation. Furthermore, the demand and need for emotion regulation becomes vital within clinical ethics practice. While taming emotions is possible, the regulatory catalyst of virtue ethics serves as a teachable model for shaping character. The omission of character development in the ASBH's second edition of the core competencies both undermines the nature of clinical ethics consultation and inhibits the proper emotive development of clinical decision-makers.<sup>71</sup> Nonetheless, both editions of the ASBH's core competencies present fundamental components that allude to the importance of virtue-identification. Inevitably, virtue identification techniques shape emotion and subsequently foster analytic moral reasoning skills for ethics consultants. These skills improve the overall quality of consultations and pragmatically direct clinical bioethics toward a promising future in professional health care.<sup>72</sup>

The ethically relevant information that clinical ethics consultants must demonstrate a great area across a health care institution's infrastructure and permeates medical situations that range from the social to the terminal. By establishing competencies in consultation, ethicists become reaffirmed in their expertise and responsibilities.<sup>73</sup> The rationale for health care ethics consultation competencies remains unchanged. Under its goal of quality improvement, the ASBH task force intends to educate and guide consultants through the variety of ethical discrepancies that form in clinical and organizational situations.<sup>74</sup> While emotional regulation does not receive attention, competency skills receive tremendous priority due to their effectiveness. In other words, the competency skills possess qualities that expand far beyond the

myopic scope of hot-topic issues, *i.e.*, abortion.<sup>75</sup> Instead, these competencies intend to expose the strengths and weaknesses of consultants in a productive manner. Be that as it may, the ASBH task force on ethics competencies addresses and compares the methods in which competencies apply in different mediums: individual consultants, consultation teams, referral services, off-site services, and ethics committees.<sup>76</sup> While each consultation medium possesses advantages and disadvantages, the concept of character development through emotive regulation, virtue-identification techniques, and analytic moral reasoning skills remain applicable and beneficial aspects to clinical ethics consultation.<sup>77</sup>

The priority of the ASBH's core skills lies in the fact that without these skills, the subsequent knowledge points outlined in the ASBH's consultation curriculum simply cannot apply to clinical situations. The skills may be divided into three sets: ethical assessment skills, process skills, and interpersonal skills. Beginning with ethical assessment skills, the identification of the nature of a conflict or ethical discrepancy is the first step in determining the need for a consultation. While the consultant is not necessarily responsible for calling a consultation, he is responsible for gathering the relevant information needed to assess and recommend options for involved stakeholders. Some of the skills involved with ethical assessments include access to medically relevant information, recognizing the social and interpersonal dimensions of involved stakeholders, and evaluating one's own personal limitations and involvement with a specific case.<sup>78</sup>

While the list of ethical assessment skills attempts to thoroughly reflect a variety of ethical possibilities, the last skill mentioned—personal limitations and involvement—serves as an excellent example regarding the need for character development. Emotion is inherently wed to the ontological status of human beings. Without emotion, decision-making is impossible because

emotion drives human thought processes toward relevant decisions. Consequently, a lack of fostering proper character development through virtue-identification, analytical moral reasoning may be disregarded as a proper means of regulating emotion and decision-making. The alternative result is an emotive response to ethically perilous situations. Clinical ethics consultants are in no position to let the sway of erratic emotions dictate professional recommendations and thus must develop a skill set that aids in intellectual adjudication.<sup>79</sup>

Process skills also contain various dimensions that risk unsuccessful responses to an ethics consultation request due to unregulated emotion. Process skills include an ethicist's ability to understand and relay the realistic expectations of a given clinical situation. These skills involve identifying which individuals need to become involved with a consultation as well as the kind of consultation medium that would most effectively address a situation, *i.e.* committee, individual, external service, etc.<sup>80</sup> While process skills encompass important and necessary aspects of two clinical ethics consultations, these skills are also subject to emotive sway if not properly regulated. Process skills involve communicative and collaborative efforts to effectively work with other professional individuals, stakeholders, and patients. Avoiding bias by regulating emotions in a well-ordered manner increases patient safety measures and aids in proper communication between involved departments. However, these skills also require character development through analytic moral reasoning, which without could results in fatal errors and ethical shortcomings.<sup>81</sup>

Finally, and perhaps most relevant in terms of character development, include interpersonal skills. Clinical ethics consultants must conduct social interactions with involved stakeholders for various reasons. Understanding a clinical situation requires a consultant to listen well and to communicate his interest, respect, and support. Recognizing the relationship barriers

between party members aids facilitation efforts and subsequently adds an educational component to the consultation process.<sup>82</sup> Nevertheless, a lack of moral fortitude and character may seriously damage one's interpersonal skillset for various reasons. First, consultants who are unable to compassionately relate to a clinical situation in a balanced and regulated manner risk engaging in an excess or deficiency of virtuous practice. The resulting outcome can seriously compromise professional recommendations due to a lack of regulated emotion.<sup>83</sup> Second, without a formidable and developed character as well as analytic moral reasoning skills, consultants may be unable to educate individuals about their options and seriously compromise learning opportunities for professionals, patients, and other staff members. Third, a lack of analytic moral reasoning via poor character development results in skewed views and perceptions about a clinical situation. While a consultant must facilitate and resolve conflict, this shortcoming can result in the opposite, namely provoke discrepancies between involved stakeholders.<sup>84</sup>

The ethical assessment, process, and interpersonal skills outlined by the ASBH core competencies are important skills that possess tremendous practicality and efficacy. However, without the proper regulation of a clinical ethicist's emotions, the facilitation of situations through a virtuous lens hinders conflict-resolution efforts and thus diminishes the use of analytic moral reasoning.<sup>85</sup> Alternatively, the development of analytic moral reasoning skills through moral discernment aids emotive regulation. While identifying virtue in clinical settings is initially a difficult task, honing one's skills in this area is an effective means of acquiring analytic moral reasoning. By clinical ethics consultants become formidable practitioners of the skills mentioned in the ASBH core competencies and further bolster the knowledge-basis for proper clinical ethics practice.<sup>86</sup>

The purpose of the competency skills illustrated above capture the effectiveness of a well-formulated ethics curriculum. The skills and knowledge listed in both editions of the ASBH's core competencies are extensive and cover a tremendous amount of material that possesses real applicability in clinical ethics situations. While the knowledge points include various facets of health care ethics that a consultant should become familiar with, *i.e.* patient rights, principle-based reasoning, end-of-life decision-making options, genetic testing and counseling, etc., the skills portion of the competencies is a far more important prerequisite set of information for clinical ethics consultants.<sup>87</sup>

#### 4.1.4. Emotion, Virtue, and Analytic Moral Reasoning

The three focal topics of this analysis include emotion, virtue, and analytic moral reasoning. The intention of this analysis is to demonstrate analytic moral reasoning as a set of competency skills. However, emotion and virtue are necessary components that aid in developing a moral agent's ability to hone these skills.<sup>88</sup> While this analysis stresses the importance of identifying virtue in clinical practice, the practicality and function of this task may be difficult for individuals who lack a formal background in analytic moral theory. Despite this dilemma, bioethics is a multidisciplinary field that welcomes varying expertise. By examining instances of virtue identification, analytic moral reasoning skills emerge and demonstrate their effectiveness in contemporary clinical ethics curriculums.<sup>89</sup>

Honing analytic moral reasoning skills requires practice and engagement. While clinical ethicists possess a variety of skills, their ability to reason in a way that adopts both practical and efficient methods required in professional health care present difficulties. For instance, the ASBH's core competencies is a well-received text because it possesses practical skills that teach clinicians practical methods in health care ethics consultation. Be that as it may, the practical

skills outlined by the ASBH become far less effective if moral agents lack the ability to deliberate effectively. Proper deliberation mutually includes a moral agent's ability to reason analytically, yet virtue prototypically manifests as an abstract concept that rarely receives praise for its propensity for practical application. By identifying virtue in practical instances, the analytical and the theoretical are wedded, inevitably shaping a teachable curriculum for ethicists.

#### 4.2. Reasoning and Virtue: A Research Ethics Model

Examining the philosophical foundations of informed consent in medical research by addressing the philosophical theories of deontological and utilitarian ethics illuminates alternative theories and exposes the problems that accompany them. This dissertation has thus far attempted to promote a turn toward virtue ethics as a practical means of obtaining mutual understanding between involved stakeholders in health care. One topic in health care that encapsulates this dichotomy is research ethics. The discussion that occurs between researchers and research participants must receive proper attention due to the contentious and controversial history of medical research on human subjects.

To approach this topic as a means of uncovering the utility of virtue ethics as key components of a clinical ethics consultation curriculum, the discussion begins with a historical account of the inception of informed consent via the Nuremberg Code. From this historical analysis, the discussion turns toward deontological and utilitarian theories of philosophy followed by the difficulties that accompany these theories and their influence on informed consent in research. The discussion then explains the existence and importance of morality in medicine and the virtues that accompany morality. Finally, the discussion returns to the former discussion of virtue ethics in terms of practical and moral virtues. In doing so, this analysis demonstrates a philosophical theory that upholds autonomy while simultaneously providing



agreement and understanding from all parties involved in research. This philosophical approach to the history of medical technologies illuminates the discussion's argumentative pathway to developing professional ethicists.

#### 4.2.1. History and Development of Informed Consent: A Philosophical Approach

Due to its power, influence, and lasting impression on contemporary medical research with humans, this historical analysis of informed consent begins with the Nuremberg Code. The ten-point statement of the Nuremberg Code, although vastly specialized toward the crimes committed during World War II, greatly contributes to a formalized understanding of informed consent in research and delineate a foundational understanding of human rights when performing medical research.<sup>90</sup> This examination of the historical influence of the Nuremberg Code will not only explains the foundational genesis of informed consent in medical research but also allows for an examination of the problems that accompany a lack of informed consent and the philosophical justifications for informed consent.

##### 4.2.1.1 Informed Consent in Medical Practice and Research: The Nuremberg Code

The 139-day Nuremberg trial exposed the war crimes against humanity that were committed in concentration and extermination camp experiments during World War II. The judges of the trial based their decisions of those accused on foundational philosophical principles that demonstrated a massive violation of human rights, bioethical principles, and notions of humanity.<sup>91</sup> The Nuremberg Code demonstrated its uniqueness by emphasizing principles of natural law and human rights in relation to medical experimentation with humans.<sup>92</sup> Furthermore, the philosophical points the Nuremberg Code attempted to address articulate the importance and meaning behind informed consent. In fact, the matters of informed consent are at the heart of the various crimes committed against human beings during the Nazi experiments. Thus, the trials

attempted to develop a proper formulation of what informed consent is and how it may be protected in order to identify the crimes committed during the Nazi experiments.<sup>93</sup>

Despite the comprehensiveness of the Nuremberg Code, it only addresses issues of informed consent that were especially relevant to the crimes committed during the Nazi experiments. The rules and regulations detailed in the code are often criticized to be more applicable to barbaric individuals rather than civilized individuals.<sup>94</sup> However, contrary to these criticisms, the Nuremberg Code sparked a world-wide consensus regarding the voluntariness that must be involved in obtaining consent, especially when engaging in experimentation with human subjects.<sup>95</sup> Furthermore, the Nuremberg Code's indication of the importance of obtaining free and voluntary informed consent reinforces philosophical ideals that must be in place when performing any kind of intervention with human beings.

These philosophical principles are reinforced in the 10-points the Nuremberg Code outlines. The first point stresses the overall importance of the document and the goal it attempts to accomplish by emphasizing the absolute necessity for voluntary consent of human subjects.<sup>96</sup> The first point mentions that informed consent may only occur if the consenting individuals are not pressured or forced to grant consent to a procedure or experiment.<sup>97</sup> The first point also discusses the importance of providing research participants with ample information regarding a study before they consent to participating in the study.<sup>98</sup> The subsequent points detail the importance and philosophical implications of informed consent in greater detail by specifying nuances that accompanied the Nazi experiments. These points include the importance of a study contributing to the good of a society, protections for patients by first running trials on animals thus ensuring the experiment is safe, and the right of informed patients to discontinue their participation in a study if they find the study is detrimental to their health and safety.<sup>99</sup>

Despite the importance and influence of the Nuremberg code, the document is often viewed as incomplete in relation to its guiding role in ethical research.<sup>100</sup> By means of example, the document does not consider issues concerning pediatric research, vulnerable populations, or mentally impaired individuals.<sup>101</sup> Nevertheless, the document places tremendous emphasis on informed consent and, albeit esoterically, applies various philosophical principles that accompany informed consent. The two relevant philosophical principles this analysis addresses in terms of informed consent include deontology and utilitarianism. Yet, to examine the philosophical theories implicated by informed consent, this analysis must analyze issues that informed consent addresses and the underlying justifications of informed consent. In doing so, the core ethical requirements for medical research with humans may be identified.<sup>102</sup>

#### 4.2.1.2 Informed Consent and Research Participants

The Nuremberg trials and subsequent code exposed the horrific medical experiments that occurred during World War II and prompted biomedical ethics to emphasize the importance of informed consent in medical research.<sup>103</sup> Although informed consent was placed at the forefront of the ethical discussion surrounding the Nuremberg trials, the subsequent code begs the question: What makes informed consent so vastly important in medical research with humans? The justification for informed consent lies in the principle of autonomy. Autonomy, or self-care, describes the inherent rights of human beings to freely make decisions that, in concurrence with their own discretion, serves as a means for choosing justly because the agent freely makes the decision.<sup>104</sup> The Nuremberg Code exemplifies the need to uphold autonomy in its stipulations that state that another individual cannot have dominion and control another human being.<sup>105</sup> Autonomy can be understood in terms of liberty and agency. Liberty entails the independent choosing that is free of influence, while agency entails the capacity and capability of an

individual to choose.<sup>106</sup> The mandatory respect for autonomy is rooted in the fact that rational human beings possess the capacity to choose and make decisions for themselves. Autonomy in informed consent provides justification for moral norms that, when followed, allow further investigation into standards of medical practice. The Nuremberg Code and the autonomous standards it attempts to uphold inherently include two integral aspects to moral ethical practice, namely, nonmaleficence and beneficence.

Tom Beauchamp and James Childress focused their understanding of harm as the inhibition of one's flourishing.<sup>107</sup> Understood in terms of ethical research, harm is especially pertinent to that which induces pain, death, disability, or suffering.<sup>108</sup> Nonmaleficence, as a normative obligation in research ethics, specifies five rules that aid in ethical decision-making. These rules include: (1) do not kill; (2) do not cause pain or suffering; (3) do not incapacitate; (4) do not cause offense; and (5) do not deprive others of the goods of life.<sup>109</sup> These rules emphasize the safety, dignity, respect, and interest of a human being. Since autonomy is the inherent self-care and reasoning that human beings possess, there are inherent moral obligations researchers must abide by when conducting human research.<sup>110</sup>

The principles of nonmaleficence and beneficence serve as philosophical foundations of ethical practice. William Frankena addresses these points by combining nonmaleficence and beneficence into a single set of theories. Frankena presents four obligations: (1) One ought not to inflict evil or harm; (2) one ought to prevent evil or harm; (3) one ought to remove evil or harm; and (4) one ought to do or promote good.<sup>111</sup> The first obligation is one of nonmaleficence, while the remaining three refer to obligations of beneficence.<sup>112</sup> Frankena's combination of obligations presents another example of normative methods of ethical principles and rules that are established in order to justify research with human beings.

The obligations presented by Frankena emphasize the importance of limiting or eliminating possible harm that may befall research participants.<sup>113</sup> Be that as it may, Frankena's combined theories result in a set of norms that may be categorized under the umbrella of deontological ethics. Although effective in some capacity, the deontological aspects of a set of fixed principles can become too stringent and provoke rigidity when attempting to develop a moral theory that remains effective across various cases. To understand the principle of autonomy upon which informed consent in research is based, this analysis examines two distinct philosophical positions that are commonly applied to contemporary medical research. These positions include deontology and utilitarianism. With the historical analysis now having been completed, these two influential philosophical theories may now be addressed. In doing so, their benefits and limitations for autonomy may be discussed.

#### 4.2.2. Philosophical Theories: Deontology, Utilitarianism, and their Influence on Autonomy

The development and history of informed consent aids this analysis by introducing the importance of acquiring of consent in medical research with humans as well as the philosophical import and foundational basis autonomy serves when performing medical research on human beings. The lack of autonomous choice that implicitly results in not acquiring informed consent presents various philosophical issues. Yet, since the Nuremberg Code's inception, various philosophical theories have been implemented and used as means to justify medical research with humans. Specifically, the two philosophical theories that are especially pertinent to the acquisition of informed consent and upholding autonomy in medical research with humans are deontology and utilitarianism. These theories, although well regarded in philosophical circles, demonstrate pathways for understanding how a clinical ethics consultation curriculum may form. The following section attempts to explain these philosophical theories and demonstrate their role

as philosophically based justifications for the acquisition of informed consent and means of upholding human autonomy.

#### 4.2.2.1 Deontological Approaches

Deontological ethics includes a theory of duty, initially developed by Immanuel Kant, that attempts to reconcile the legitimacy of relationships through moral judgments that are justified by obligatory maxims.<sup>114</sup> These maxims attempt to ground morality in reason by addressing the nature of human beings. Kant claims that human beings possess rationality and are motivated to act morally and work emphatically.<sup>115</sup> To act in a way that promotes one's flourishing via decision-making capacities, moral maxims are developed in order to respond to situations in a manner that fulfill inherent duties of the agent.<sup>116</sup> In this respect, an individual only acts autonomously if their decisions are in accordance with one's obligations or maxims. For example, William Frankena's set of theories that attempts to uphold nonmaleficence and beneficence are a set of maxims that attempt to respond toward the duty to refrain from committing harm. In this respect, the consent of a research participant can be viewed as a declaration that requires autonomous choices that can only be legitimate if those choices are based in moral obligations that the consenting agent develops for himself. However, the maxims that an individual may establish for himself must withstand the categorical imperative, or a standard that determines if maxims are consistent and objective.<sup>117</sup> Kant's theory and its categorical imperative attempt to provide uniformity and consistency throughout moral decision-making, regardless of the situation or ethical dilemma.<sup>118</sup>

The Kantian maxim that has often been associated with bioethics—and is categorically justified—is the principle that human beings should never be treated as a means to an end, but treated as an end in themselves.<sup>119</sup> This maxim is especially pertinent to medical research with

humans and the acquisition of consent when performing research. Although human beings possess autonomy and have the capacity to make decisions based on their own moral beliefs, their decisions, under a Kantian framework, must abide by certain moral obligations. For instance, human subjects who volunteer themselves to test new drugs are treated as means to other's ends. However, the same individuals who voluntarily agree to partake in a study have a choice regarding how they want to control and conduct their lives.<sup>120</sup> The research participants in this instance may live by a moral obligation or duty that justifies their decision to partake in the study. Kantian deontology allows autonomous choices to take place through a justifiable framework in which moral choices are made. Rather than possessing autonomy of the will in decision-making, Kant's theory emphasizes the importance of obligatory decision-making that is both in accordance with one's own moral obligations and discourages emotive influences.<sup>121</sup>

Despite the specificity and ample justification behind deontological decision-making, many problems accompany this theory, especially regarding ethical decision-making in medical research. Although categorical imperatives are in place to check and reinforce moral maxims, conflicting obligations become problematic when subscribing to the rigidity of moral maxims.<sup>122</sup> To explore this concern, consider if a researcher promises to provide therapeutic benefits to the blood flow in a research participant's leg, but the research participant loses his leg in an unrelated incident, the maxim and moral duty the researcher set out to perform is now torn asunder and impossible to complete.

The researcher is thus in violation of his own moral maxim despite a conflicting circumstance that was out of his control. Another problematic issue with deontological ethics in research includes the disregard for decision-making based on sympathy and emotion. Kant's deontological theory claims that decisions based on sympathy and emotion have no moral worth

and should thus be disregarded.<sup>123</sup> However, this moral maxim significantly affects the researcher-participant relationship during a study. Despite a researcher's ability to perform his duties well, if in fact his duties are treated as moral obligations toward a beneficial end, the research participant would feel a lack of concern and care on the part of the researcher.<sup>124</sup> In this instance, the stringent nature of deontological decision-making affects the compassion that is required in research with humans.<sup>125</sup>

Kantian deontology provides an excellent framework for moral decision-making, but remains entirely too stringent when addressing a field like medical research with human participants. The variables in medical research with humans are far too vast for an establishment of uniform ethical maxims. However, deontological decision-making in medical research does aid in upholding the autonomy of individuals by providing an additional motive for self-care, namely, a philosophical framework for promoting one's self respect, value, and motivation.<sup>126</sup> An alternative philosophical theory, which may aid in justifying the ethical framework in which autonomy may be upheld in ethical research, is utilitarianism.

#### 4.2.2.2 Utilitarian Approaches

Utilitarianism is one of the most prominent consequentialist theories. This is to say that utilitarianism is a philosophical theory that bases its ethical decision-making on value.<sup>127</sup> Contrary to deontology, utilitarianism is not a theory that acts out of duty or a set of maxims. Instead, utilitarianism concentrates on the value of well-being which is determined in terms of pleasure, happiness, welfare, and satisfaction.<sup>128</sup> Utilitarianism attempts to make moral decisions in a way that overall good is maximized. This may manifest by the amount of people a decision positively affects, or the given effect on a limited group of individuals.<sup>129</sup>



Utilitarianism focuses on the principle of utility rather than the deontological focus of duty. Utilitarianism asserts that maximum benefit should always be produced over harm or detriment.<sup>130</sup> While this theory certainly is appealing, utilitarianism is unclear on what constitutes maximum good. In theory, if good can be identified properly and subsequently maximized, human beings could choose options that would yield tremendous benefits to them. However, choosing an option that yields the most amount of good remains problematic because the same decision may not be one that exercises the autonomous rights of individuals, especially in medical research. For example, a research team performing medical research on an experimental drug may require human test subjects to test the efficacy of the drug on human physiology. To perform this study ethically, the research team must obtain consent from the research participants. Although the research participants are fully informed of the risks that accompany the study, they are also informed that their participation will yield a much greater good for a greater number of people.<sup>131</sup>

Many issues arise under the two philosophical theories discussed above. First, in accordance with deontological thinking, the human subjects are being treated as means to an end, but their right to choose stems from a duty that allows the participants to retain control over their lives.<sup>132</sup> On the other hand, in a utilitarian framework, the human subjects in the study are choosing to be treated as means to, what the researchers consider, a greater end.<sup>133</sup> Research with human beings is an onerous topic when attempting to uncover the greater good. A balance of benefits and risks must be addressed among a conglomerate of decision makers, including ethicists, physicians, and research liaisons. Despite the decisions of these individuals, autonomy is a right that is left up to research participants. In this respect, informed consent under a utilitarian framework could be abandoned for “coerced consent” by means of emphasizing the

importance of a research participant's involvement and the greater good his involvement will provide.<sup>134</sup>

Deontology and utilitarianism serve as philosophical theories that attempt to justify moral decision-making. By applying these theories to medical research with human beings, these theories are often used by a moral agent as justificatory links between autonomous decision-making and informed consent. Yet, the analysis above demonstrates the complications that may arise when attempting to implement these philosophical theories into the acquisition of informed consent. In this respect, the debate forces the ethicist to consider what kinds of ethical analyses a professional should adhere to. In the same respect, both deontology and utilitarianism provide a beneficial standpoint that upholds autonomy and aid ethical decision-making by emphasizing the need for justification in autonomous decisions. Deontology aids ethical decision-making by emphasizing the necessity of a rational will that decides in accordance to values and respect, whereas while utilitarianism promotes the maximization of benefits in all ethical decision-making.<sup>135</sup>

Despite their attractiveness, deontology and utilitarianism have their shortcomings when attempting to reconcile proper autonomous decision-making and the ethical acquisition of informed consent in medical research. Specifically, these theories encounter difficulties when attempting to reconcile issues concerning ethical relativism and vulnerable populations in research. To evaluate a uniform ethical theory for medical research, a discussion of the issues that arise from an application of these theories must be analyzed. In doing so, the benefits to these ethical theories may be examined and applied to an alternative ethical theory.

#### 4.2.3. Difficulties of Informed Consent: Universal Ethical Principles and Vulnerability

Due to the importance and demand for medical research with humans, various theorists have

questioned the universal applicability of ethical principles.<sup>136</sup> Although ethical principles like nonmaleficence and beneficence have been established and generally accepted in the research community, various debates emerge in respect to the optimization and medium in which these principles may be upheld.<sup>137</sup> Deontology and utilitarianism are commonly applied philosophical mediums, yet various issues arise when moral principles are evaluated. There exist many issues that span far beyond the scope of this paper. This analysis specifically examines relativistic issues and the exploitation of vulnerable populations as matters implication by deontology and utilitarianism.

#### 4.2.3.1 Relativism, Informed Consent, and Problems of Deontology

Since deontology focuses on maintaining maxims and adhering to duty, deontological ethics generally focuses on a method that justifies its practice based on consistency. In this respect, a maxim maintains an ethical standard that, when followed, ensures proper ethical practice. However, issues of relativism emerge when the deontological maxim in question is considered. Agreeing upon a proper deontological maxim becomes especially difficult when attempting to develop a uniform protocol for informed consent in medical research.<sup>138</sup> Specific areas in research where informed consent has become difficult include randomization, placebo use, and double blinding, all of which pertain specifically to research participants.<sup>139</sup>

In contemporary research ethics, maxims manifest in the consent documents that are presented to participants.<sup>140</sup> Although these documents cover the legality of research procedures, disclosure, and even reflect advancements resulting from the Nuremberg Code, these documents are still not uniform due to the variance in study procedures. Furthermore, these documents sometimes arrive in oral form, which obviously lacks the tangibility of written consent.<sup>141</sup> Even though written consent provides a physical copy of consent, the concepts and maxims that are

outlined by researchers may not be delineated properly. In terms of deontology, the maxims that a group of researchers set out to achieve are only warranted if the research participants are aware of these maxims and agree to the duty the researchers attempt to fulfill.

Although proper disclosure of information is necessary when conducting medical research with human beings, they do not reduce the risks of a study.<sup>142</sup> Nonetheless, disclosing information does ensure that each research participant is responsible for himself.<sup>143</sup> Things become problematic when the maxims formulated by a group of researchers do not coincide with the understanding and safety of the research participants. For instance, a group of researchers may hold that the results of a study cannot be issued to the individuals who partook in a study before the information is published, even if the information never does get published. This scenario is especially disconcerting if the study is a therapeutic one and certain research participants require the results of the study for their own health or benefit. Although in such a scenario the duty of the researchers would not coincide with the health and safety of the research participants, the researchers would still be justified in their practice under a deontological lens. The above instance exemplifies the difficulties behind deontological ethics. In deontological terms, the researcher's moral justification for maintaining their maxims and working toward their duties is warranted. However, in fulfilling their duties, another group suffers to an extent. In this respect, deontological ethics cannot be used as the primary vessel that houses and promotes normative ethical principles.

Another issue in medical ethics that is affected by deontology involves the recognition and respect for a patient or research participant's advanced directive (AD). Typically, AD's are far more common in clinical practice with patients. However, an advanced directive could certainly become a relevant document during medical research. It is not impossible to imagine a

research situation where a patient's AD becomes effective due to a lapse in judgment by a research team or a mistake during a drug trial. In these instances, the maxims that are specified at the beginning of a study would become subservient to the research participant's AD. While researchers are engaging in a deontological structure when obtaining consent from research participants, patients who possess an AD also have a set of maxims that they wish others to refer to during instances of incapacity. While the researcher's maxims are grounded in duties toward knowledge, the research participant's AD maxims are designed as a relational structure toward a duty to oneself and the human person in general.<sup>144</sup> The power that the maxims described in an AD would have over the maxims of researchers illustrates the importance of human duty but also demonstrates the difficulties of squaring deontology with autonomy. Philosophers like Emmanuel Levinas, Martin Buber, and Martien Pijnenburg claim that the tremendous emphasis placed on autonomy in contemporary medicine and research is extremely problematic due to the burden of decision-making on the research participant or patient, an individual who does not possess ample knowledge of the clinical or research protocols.<sup>145</sup>

Although the maxims involved in deontology are important aspects of maintaining ethical duties, abiding by their stringent requirements requires rigidity and a lack of plasticity in the varying world of medical ethics. Medical practice and research must be viewed in the context of situational encounters with human beings.<sup>146</sup> By implementing the views and professional opinions of researchers, patients, and research participants, decision-making and the acquisition of consent can be conducted in a compassionate and caring manner.<sup>147</sup> Furthermore, by adjusting autonomous control into a process that is mutually adhered to by multiple parties, control of human life is then maintained in a manner that promotes relationships between researchers and

research participants and aids in decision-making processes.<sup>148</sup>

#### 4.2.3.2 Vulnerability in Research: Problems of Utilitarianism

Developing a philosophical theory that optimizes ethical principles and norms is a difficult task. Specifically, forming a philosophical theory becomes especially burdensome when attempting to uphold ethical norms and avoid relativistic notions of its interpretation. The previous section demonstrates the difficulties that accompany deontological ethics and maxim development. While deontology possesses benefits, the theory becomes muddled when one attempts to develop universal maxims that apply to all medical situations. Additionally, the acquisition of informed consent in research remains difficult under deontological ethics due to the influence of researchers and the lack of information for research participants. Although deontological ethics has both its benefits and disadvantages, this discussion now turns toward utilitarianism as the other dominant philosophical theory in research ethics. Specifically, this section will discuss the effect utilitarian ethics has on vulnerable populations in research.

Although the definition of a vulnerable population or individual may vary, it is generally accepted that those who are vulnerable are classified as such based on criteria that render them susceptible to exploitation and thus unable to provide consent for a study or procedure.<sup>149</sup> Vulnerable populations have become a focal point of ethical discussion in bioethics.<sup>150</sup> One of the most pressing issues surrounding vulnerable populations involves the inability to grant consent due to capacity, economic, cultural, or cognitive issues.<sup>151</sup> In this respect, the autonomy of individuals is severely affected, not because these individuals are unable to make decisions for themselves, but because these individuals are unable to protect their own interests and health.<sup>152</sup>

These populations becomes increasingly enticing to unscrupulous researchers who aim

only at obtaining results because vulnerable individuals may easily be manipulated in order to gain their consent, albeit unwarranted consent. In this respect, utilitarianism's shortcomings as a philosophical theory prove quite detrimental. Researchers that intend on gaining results from a study with the goal of aiding a greater number of people may justify compromising a vulnerable population on utilitarian grounds. For example, individuals who are unable to give consent due to capacity issues may be targeted by researchers because conducting experimental procedures on these individuals would likely be rejected by competent individuals. However, since these individuals are vulnerable, they are more willing to give consent as a result of misunderstanding and miscommunication. Researchers may justify these exploitations on the grounds that the results of conducting this research will result in a greater benefit for a larger number of people.<sup>153</sup> Considering this, the ultimate good is still aimed at a group of individuals, but another group suffers at the expense of knowledge acquisition. In theory, utilitarianism justifies the actions of the researchers. However, a universal philosophical theory must establish principles that protect vulnerable individuals from abuse and exploitation. Unfortunately, utilitarianism leaves various gaps in justification and thus remains problematic.

Although the analysis above demonstrates the strengths of deontology and utilitarianism concerning informed consent in research, various issues arise with these theories. While deontological ethics promotes consistency, and aims at dutiful processes, the rigidity and stringent criteria leave little room for plasticity and ethical mobility in varying situations. For utilitarianism, may aim at providing a morally good outcome for one group but inevitably causes a morally detrimental outcome for another group. To reconcile these theories and to reconcile curriculum points that budding clinical ethicists ought to adhere to, this analysis examines the effectiveness of virtue ethics and the impact it may have on bioethics. While the vastness of

research ethics can be overwhelming, the key component of virtue identification serves as a knowledge and skill aspect of a professional ethicist's training that can aid discussion and virtuous deliberations between involved stakeholders.

#### 4.2.4. The Morality of Medicine: Theories in Focus

Since the Nuremberg Code, informed consent has not only aided the ethical practice of medicine and research, but it has also promoted the relationship between researchers and research participants. This analysis demonstrates the philosophical justifications of autonomy and autonomy's role in informed consent through deontology and utilitarianism. Nevertheless, to uncover a philosophical basis for medical research with human beings that both upholds autonomy and justifies obtaining consent, the philosophical details of informed consent and autonomy that extend beyond the stipulations of the Nuremberg Code must be addressed. While the benefits of deontology and utilitarianism have been identified, this analysis has also addressed the difficulties that accompany deontology and utilitarianism when attempting to avoid relativistic notions of ethical practice and issues surrounding vulnerable populations. With these issues in mind, an alternative philosophical theory must be identified and used in medical research. This alternative theory must abide by a standard of professionalism and ethics that maintains the benefits of deontology and utilitarianism while simultaneously evacuating the negative aspects of these theories. To identify this theory, a formal discussion of contemporary medical morality in research must be conducted.

The proper application of moral principles and rules maintains ethical norms that are necessary for engagement with humans and promotes moral excellence in medical research. To promote moral principles and rules in any practice, specific virtues that abide by moral norms must be cultivated. Moral virtue pertains to character traits that are dispositional and reliable.<sup>154</sup>



In respect to medical research with humans, moral virtue must follow by a common morality that, when executed properly, exercises a means of engagement with other human beings that respects the rights of others and justifies engagement with other human beings.<sup>155</sup> If proper virtue is cultivated and promoted as an integral part of medical research with humans, crimes and ethical disservices to humanity may be avoided and may further promote the commonality of moral norms.<sup>156</sup>

Virtue and moral norms are best exercised when universal understanding is accepted across disciplines.<sup>157</sup> Roles of medical researchers must be evaluated in order to develop the inherent virtues embedded in their practice. Despite the specific knowledge healthcare professionals and researchers must relay to their participants, certain social and professional expectations must be met while still upholding fundamental virtues. The virtues that researchers must possess while conducting medical research include, compassion, discernment, trustworthiness, integrity, and conscientiousness.<sup>158</sup>

If exercised correctly, these five virtues cultivate responsibilities that coincide with a professional code of ethics.<sup>159</sup> The first focal virtue is compassion. Compassion entails the capacity to have a sympathetic understanding with a research participant's current situation. This virtue must be recognized and properly regulated with the participant's emotions. If the participant's emotions are too heightened, the understanding and care a researcher ought to provide to a research participant will not be understood properly and could tear asunder the relationship between the researcher and the research participant.<sup>160</sup> The second focal virtue is discernment. Discernment pertains to the Aristotelian understanding of practical wisdom (*φρόνησις*). Practical wisdom involves calculated and reasonable decision-making in situations that call for rationality.<sup>161</sup> The next virtue, trustworthiness, is an essential virtue because it is the

foundation of a reliable patient-researcher relationship. Trustworthiness is a virtue that entails the confident reliance and dependence on another individual.<sup>162</sup> Next, integrity involves the capacity of an individual to abide by the rules and principles set before them. Finally, conscientiousness grants an individual the moral capacity for decision-making.<sup>163</sup> While superior orders or conflicting issues with institutional compliance may arise, the truly virtuous individual will exercise discretion in his decision-making and focus on making calculated decisions when dealing with moral issues in medical research.<sup>164</sup>

The importance of moral virtue in medical practice and medical research with humans is of the utmost importance. Providing a philosophical basis for morality both justifies the practice of medical research with humans and also provides a structure of morals upon which other acts in medicine may take place. However, the moral virtues discussed above are still debated and not viewed as the authoritative and justifiable philosophical foundations for medical professionals and researchers.<sup>165</sup> In this respect, medical researchers question whether or not there exists a foundation upon which a position may be held concerning moral dilemmas.<sup>166</sup> With the discussion of moral virtues of medicine explained, the next section of this analysis addresses how a foundational structure of moral norms may be constructed properly.

#### 4.2.4.1 Medical Morality

Codes and protocols like the Nuremberg Code have been enacted to ensure patients are protected against the dangers of human experimentation, the focal virtues of medical practice are somewhat known throughout the medical community. Yet, while the source of medical morality has been housed in philosophical theories, professional ethics in research still lacks a formal theory that it may universally follow.<sup>167</sup> The philosophical theories of deontology and utilitarianism are used throughout contemporary medical practice and research. Additionally,

their effectiveness remains incomplete and is especially fractured when dealing with issues of ethical relativism and vulnerable populations. This analysis discusses these philosophical theories and their shortcomings in sections 3 and 4 respectively and medical morality as a reconstruction of professional ethics in research and a receptacle in which the focal virtues are concentrated must also be examined. In doing so, a discussion of medical morality outlines the requirements and expectations of medical researchers and provides a basis of morality that a philosophical theory must follow.

Medical morality questions whether a justified philosophical theory exists that maintains obligations of all people involved in medicine.<sup>168</sup> However, identifying this theory becomes difficult due to the vast differences in medical situations and medical research. Due to the variance in opinions from medical professionals, theorists, researchers, and philosophers, issues of moral permissibility arise.<sup>169</sup> A relativistic attitude in medicine and medical research inevitably develops when an array of individuals have varying opinions on ethical matters. The relativism that accompanies contemporary biomedical issues calls for a common morality in medicine. A common morality not only aids in ridding relativistic notions of ethics but also aids all facets of medical practice by providing the means to developing a philosophical system that exemplifies the nature of medicine, medical research, and promotes the focal virtues discussed above.<sup>170</sup>

In an effort to uncover a common morality in medicine and medical research, theorists commonly search for the nature of what makes a medical researcher a good medical researcher.<sup>171</sup> A philosophy that fuses the nature of medical research with dialectical analysis adds disciplined elements and criteria to the process of ethical decision-making in research.<sup>172</sup> This process both aids in ethical decision-making on the part of the researcher and avoids

ambiguity or superfluous practices in ethical decision-making. Most importantly, this process provides evidence of the effectiveness and practicality of the proposed key components for a professional curriculum in clinical ethics consultations.

Philosophical pursuits must be viewed as dialectical pursuits.<sup>173</sup> In other words, the philosophical aspect of medical research must be approached as a tool that can address problems or sets of problems in a constructive manner.<sup>174</sup> The problems associated with medical research and ethics are vast and can range from distinctive objects to ideas or concepts. This range of issues embodies the nature of the history of philosophy and the contemporary issues that accompany medicine today.<sup>175</sup> However, a disciplined philosophy of medical research may be identified if the language, functions, goals, or end (*telos*) are defined and recognized.<sup>176</sup> Dialectical practice serves as a means that can be recycled and revisited in order to solve the limiting factors of a discipline.<sup>177</sup> In this respect, medical research is provided with an ethical grounding that avoids ambiguity and simultaneously remains plastic. For the purposes of this analysis the prerequisite act of receiving consent from research participants is paramount. A philosophical dialectic may aid in remedying the issues of relativism and exploitation in research if the theory, practice, and role of philosophy in research is properly defined. Furthermore, the dialectic serves as a significant means of resolving the discrepancies surrounding informed consent due to the philosophical nature of consent's acquisition.

As a philosopher, the researcher must partake in dialectical processes that develops critical reflections on issues like informed consent.<sup>178</sup> The researcher-philosopher must begin with a problem that coincides with the praxis of medical research and subsequently implement a philosophy of experience.<sup>179</sup> For the purposes of this analysis, the issue of informed consent and the philosophical justifications for autonomy are established as the primary dialectical focus. By

amalgamating the nature of medical research as a practice of obtaining beneficial knowledge while maintaining the ethical integrity of individuals involved, the researcher may then serve a professional role in achieving new aims of medicine and bolster the inherent ethical aspects of his practice, namely the promotion of moral virtues.<sup>180</sup> Due to modern advancements in medicine and the accompanying difficulties of new ethical conundrums, an ethical standard that stretches across several instances must be established if a mutually respected ethics is capable of developed.<sup>181</sup> In order to develop a universal standard of ethical practice, or common morality, basic ethical principles must be identified and used as the grounding for the further establishment of ethical determinations in medical research.<sup>182</sup> Since many variances in medical research exist, philosophy must intervene and play a central role in forming ethical principles that can both be abided by and aid in advancing the practice of medicine.<sup>183</sup> In this respect, philosophy aids medicine and medical research as a means to ending relativistic notions and exploitation of individuals.

To suture the divide between philosophical principles and decisions in medical research, the dialectical amalgam of judgments and morals must be established through specific contexts.<sup>184</sup> Partaking in dialectical conflict resolution and implementing virtue may resolve ethical discrepancies.<sup>185</sup> This process involves defining the specifics of a study, clarifying the language of medicine and philosophy, and uncovering the virtues that must be upheld in a given situation. This process not only aids in implementing philosophical practice in medical research, but also reaffirms the commitments of the individuals involved.<sup>186</sup> The common morality serves as a universal ethical grounding that multi-faceted and variant ethical dilemmas may direct their end. Common morality serves as an applied ethic that develops general principles while the researcher-philosopher serves as a medium in which these principles may be applied.<sup>187</sup>

However, to achieve a common moral standing in research ethics, the varying situation that may develop must be regulated by a philosophical theory that is capable of adaptation. Initially inducted by Aristotle, virtue ethics proves to be a relevant philosophical theory that aids ethical decision-making in research.

#### 4.2.4.2 Alternative Philosophy: Virtue Ethics

Virtue ethics serves as an alternative philosophical medium in which ethical principles may be practiced and upheld. Virtue ethics acts out of an ethic of care and is based in the classical Greek tradition of Aristotle.<sup>188</sup> Virtue ethics involves ethical decision-making that revolves around the idea of practical virtue, *arête* (Ἀρετή), and is understood as the capacity of performing or functioning well.<sup>189</sup> Although the term has been translated and understood as virtue or excellence, it has lost its primary meaning as a term that embodies both moral and practical virtues.<sup>190</sup> Earlier in this analysis, the importance of praxis was identified through deontological ethics, utilitarianism, and moral excellence. Furthermore, this analysis identifies one understanding of *arête* by outlining the moral virtues entailed in medical research and practice in section 5. This analysis now turns toward the practical virtues that are entailed in the concept of *arête*. In doing so, virtue ethics as a philosophy may be properly described and used as a philosophy that aids ethical decision-making when attempting to obtain consent from research participants.

#### 4.2.4.3 Aristotelian Virtue Ethics and Practical Virtues

The virtue approach to medical ethics hinges upon the Aristotelian understanding of virtue and its practice. The traditional principles that bioethics follows are autonomy, beneficence, nonmaleficence, and justice, all are included within the philosophy of virtue ethics as moral and practical virtues.<sup>191</sup> However, in the *Nicomachean Ethics*, Aristotle specifically

distinguishes between practical and moral virtues and explains why they are related to one another.<sup>192</sup> To achieve practical wisdom, Aristotle claims that individuals must discern a mean, or mid-point understanding of two extremes. For instance, the virtue of courage is the mean point between rashness and cowardice.<sup>193</sup>

If an individual can rationally calculate his circumstances in a professional manner, he may choose a reasonable middle-ground between two extreme outcomes.<sup>194</sup> For this reason, autonomous choices that are informed and reasoned well are of the utmost importance when attempting to identify virtuous practice. Although an autonomous individual may choose freely, his virtuous decisions must be made from correctness and must strive toward happiness as an end or *telos*.<sup>195</sup> In this respect, Kant's deontological ethic is vastly associated with Aristotle's virtue ethic due to the responsibility both philosophies have toward an end. However, while deontological ethics remains extremely rigid in its formulation of maxims and rejects emotive notions of care as motivation for ethical practice, virtue ethics presents an array of tools, or virtues, that may be used in any given situation that demand moral resolution. Furthermore, virtue ethic's ability to adjust and adapt to various situations heavily relies on its recognition of practical and moral virtues.<sup>196</sup>

Virtue ethics is unique because it recognizes and implements practical virtues throughout its application. A practical virtue may be carpentry or sewing. However, for the purposes of this analysis, medicine and research are especially pertinent. For Aristotle, it is possible for a medical researcher failed to uphold virtuous practice by not exercising his practical virtues. Both moral and practical virtues must be upheld by identifying and striving toward a mean.<sup>197</sup> In this respect, Aristotle discerns between practical intelligence and moral virtues. To uphold virtuous practice, or, exercise practical intelligence, an agent must exercise moral virtues appropriately.<sup>198</sup> This

understanding of Aristotelian virtue ethics demonstrates the need for calculated discernment between two extremes of practice and the importance of upholding a middle ground.<sup>199</sup>

The framework of virtue ethics may be appropriately applied as an alternative philosophy to deontological and utilitarian ethics in research. In his book *After Virtue*, Alasdair MacIntyre uses Aristotle's theory of moral and practical virtues as a solution to relativistic notions of ethics by creating sects of ideals among individuals. MacIntyre's book is appropriately named considering the framework of his discussion. Once ethics has been established and identified, MacIntyre uses the tools virtue ethics provides to create a resolution to relativistic notions in ethics. In terms of medical research and medical ethics, MacIntyre's solution may be applied and used as an alternative philosophy to the commonly accepted standards of deontology and utilitarianism.

This analysis demonstrates the shortcomings of deontology in medical research by objecting to its rigidity when developing maxims and thus causing a lack of ethical uniformity. Furthermore, this analysis demonstrated the shortcomings of utilitarianism by uncovering the danger this philosophy possesses of exploiting individuals in medical research. MacIntyre's virtue ethics resolves these discrepancies by creating sects of ideals that may be upheld within a community.<sup>200</sup> Medical researchers may make up a community with the moral virtues in medical research making up the common morality within that community. Practical virtues like an attentive radiologist, an accurate statistician, or data analyst are vocational virtues that are subject to change depending on the study.<sup>201</sup> If researchers and research participants aim toward ethical ends by communicating with each other as a community, the common morality of medical research may be established under moral and practical virtues. This process then bolsters



practical autonomous decisions and justifies the acquisition of consent for researchers and research participants.

#### 4.3. Conclusion

This analysis demonstrates that analytic moral reasoning skills are a facet of health care ethics consultation that is not only necessary but also extremely beneficial to conducting effective facilitation methods. By examining the philosophical Kantian ends of self-improvement and the improvement of others, ethicists gain an understanding of moral duty to their practice and to themselves. Kant's philosophy opens a doorway through which for ethicists may pursue key elements in moral analytic reasoning, namely, virtues. If health care ethics consultants grasp the significance of virtue as well as its relationship to performing functions well and to striving toward the Kantian ends discussed in this analysis, facilitation and conflict resolution efforts are more effective. Aiding an ethicist's ability to discern between warranted and unwarranted emotions in consultation settings allow the ethics consultant to critically engage in practical consultation skills and conversation efforts.

By examining the nature of virtue and understanding how to conduct consultations virtuously, health care ethics consultants may engage with their patients, patient's family members, and other health care professionals in a more effective and efficient way. The issues these theories present become apparent when considering autonomous decision-making in informed consent in research ethics. Through addressing the origins of formal informed consent via a historical analysis of the Nuremberg Code, deontological and utilitarian ethics may be understood as theories that attempt to promote informed consent in research that uphold the stipulations of the Nuremberg Code. However, the difficulties of the theories described presents inherent threats to autonomy and autonomous decision-making due to the lack of information for

research participants.

The rigidity of deontology and the biases of utilitarianism present several issues when attempting to develop a philosophical moral theory that clinical ethicists may follow. By outlining the importance of moral virtue in medicine, virtue ethics presents itself as an alternative philosophical theory that bolsters human autonomy by upholding virtues that inevitably result in proper information disclosure and support from medical professionals. Additionally, virtue ethics presents itself as a philosophy that maintains the beneficial relationships of all parties involved in medical research. Addressing medical research through the philosophy of virtue ethics presents the discipline as a community and fosters beneficial partnerships and results. If virtue ethics is implemented properly into a core curriculum for clinical ethicists, standards of moral excellence, specifically concerning autonomy and informed consent, are upheld and promote both the acquisition of medical knowledge and the mutual respect for human beings.

While the discussion in chapter four demonstrates the philosophical groundwork upon which clinical ethicists may base their skillset, the application and measurement of these skills and knowledge points are easily disregarded without a proper method of evaluation. By exploring organizational venues in which key curriculum components manifest, clinical ethicists becomes better equipped to further professionalize their discipline. Furthermore, an evaluation of the organizational structures associated with integrating a formalized ethics curriculum bolster's this analysis goal at implementing key virtue components to an ethics consultation curriculum.

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## Chapter 5: Residency Requirements for Clinical Ethics Consultation

Often misrepresented and confused with corporate policing, the role of ethics within organizations, hospitals, and health care systems requires ethical revamping, analysis, and evaluation. Rather than accept the negative connotations that have been associated with organizational and health care ethics, chapter five demonstrates the positive impact organizational ethics possesses as a resource for introducing clinical ethics consultation to a wider system base. Furthermore, this analysis shows the importance of adopting theories of virtue ethics when assessing institutional policies in health care ethics. While the literature on organizational ethics and ethics education in hospital systems is as contemporary as the topic itself, virtue ethics has made a formidable mark on the corpus.<sup>1</sup> By identifying virtues, their role in organizational ethics, and the pivotal roles health care institutions play in professional life, the accessibility of a residency-based curriculum for health care ethicists and organizational leaders alike becomes tenable.

The discussion begins with a thorough discussion of organizational ethics and the role ethics possesses in this venue. By identifying the role of organizational ethics, both the potential for educational expansion and the difficulties that accompany implementing education in the organizational sphere becomes elucidated. The role of professional ethics is compared with the role of ethics in organizations and subsequently turns the discussion toward integrity in organizational medicine. This approach is appropriate since this analysis focuses upon key components for an ethics consultation curriculum. However, chapter five also attempts to show that that the key curriculum components introduced in this analysis are applicable to individuals in an array of health care roles.

While focused upon residency requirements for clinical ethics consultants, chapter five

also attempts to demonstrate the way in which a venue like a residency program can accommodate an ethics curriculum like the one outlined by the ASBH. Furthermore, this analysis shows that a formidable venue for ethics education cannot manifest without organizational support and becomes far more effective if the program implements the key curriculum points mentioned in this analysis. Organizational support only manifests in a health care organization that focuses on becoming an organization that promotes ethical stewardship. The discussion culminates with a hypothetical model for a clinical ethics residency program in section 5.1.4. where the qualities of a quintessential ethics program, derived from an ethically-based organizational framework, manifest and become implemented into a practical format.

While the ethical framework established by examining organizational infrastructure and residency programs in chapter five is effective, the discussion then turns to applied program issues that demonstrate the difficulties behind introducing the key consultation curriculum points articulated in this analysis. While the intention of this analysis is not to establish and implement an entire lesson plan or curriculum for clinical ethicists, this analysis does attempt to introduce key components for ethics consultation curriculums that are already in the process of becoming established. The second half of chapter five discusses the various issues and roadblocks that face ethicists and difficulties that accompany establishing clinical ethics as a professional discipline in medicine. The analysis discusses the cultural attitudes that clinical ethics faces, the roles that clinical ethics can play in non-medical departments, and the issues surrounding current efforts at establishing a training program for ethicists by examining the European efforts of introducing hospital-based bioethics programs. In doing so, the analysis attempts to demonstrate the possibility of establishing a clinical ethics consultation curriculum that accommodates the curriculum points presented in this analysis.

## 5.1. Professional Ethics in Organizations

A teachable model of virtue ethics aids this process by facilitating moral choices in an organizational infrastructure.<sup>2</sup> This discussion begins with a presentation of ethics within organizations as well as the scope of health care organizations. From corporate agendas to organizational hierarchies, this analysis identifies virtue across a professional spectrum while simultaneously demonstrating the importance of human rights and the obligatory roles organizations must adopt. The discussion then proclaims the need for virtue within organizations by identifying contemporary instances of virtue in practice at the corporate level. The discussion concludes with an assessment of virtue as a teachable skill in formalized residency programs for ethics consultants and other administrative authorities, thereby demonstrating the key components for an ethics consultation curriculum. By assessing the nature and scope of virtue within organizational ethics, this analysis shows the benefits and accessibility of an ethics residency program for health care professionals.<sup>3</sup>

The role of ethics in organizations is far more debated than the presence of ethics within organizations. However, the current difficulties in determining the role of ethics, including its limitations, stem from a misuse of ethics education and a misunderstanding of ethics in general. By identifying instances of ethics in professional practice, both the role and scope of ethics at the organizational level becomes clear. The concepts of professional character, integrity, and stewardship play vital roles in the betterment of an organization. These characteristic elements within organizational ethics are both indicative and obligatory of a moral institution.<sup>4</sup>

### 5.1.1. Professional Ethics and The Role of Organizational Ethics

Two commonly accepted premises concerning human rights include: (1) All human life is sacred and, (2) All human beings are ends within themselves. While the former premise receives

support and solidification from various religious doctrine and contemporary standards of care, the latter premise derives from the Kantian conception of human rights.<sup>5</sup> Since every human being is sacred, individuals or, an organization of individuals, should accept or reject decisions based on the effect these decisions have on other human beings. While decision-making on the individual level accompanies an array of considerations, organizational decision-making is a far more onerous task due to the varying perspectives that arise from a collective of individuals. For the sake of this discussion and the role of ethics in health care, hospitals serve as the primary organizational institution where ethical decision-making occurs.<sup>6</sup>

Organizational ethics pertains to a category of notions that wed institutional goals with corporate character. These notions derive from tactical business plans that amalgamate compliance, legality, and regulations. However, the scope of organizational integrity and stewardship must extend beyond these bare facets of institutional functionality. Health care organizations must seek a greater understanding of institutional leadership by expanding their regulations and corporate requirements beyond the above-mentioned facets of organizational structures.<sup>7</sup> While the expansion of a health care organization's ethical scope must encompass the ASBH's standards for policy positions and behaviors regarding patients, employees, and partners, the primary goal of a health care organization must lie in upholding the quintessence of virtue, ethical principles, value-based decision-making, and upholding an appropriate code of conduct. In this respect, a fluid relationship amongst these goals inevitably yields a virtuous organization.<sup>8</sup>

Understanding professional character and professional ethics becomes clear if a practitioner's moral responsibilities demonstrate continuity with their corresponding organization's responsibilities. With the development of corporate models for health care



institutions, physicians have adopted a stakeholder role that permeates the barrier of ethical practice.<sup>9</sup> Physicians have steadily become involved in the financial interests of health care institutions by investing or owning ambulatory surgery centers, radiology clinics, and prenatal hospitals.<sup>10</sup> Furthermore, the same physicians financially profits from the services provided by an institution. While physicians require compensation for their services, the financial benefits rendered from services have created an ominous and pervasive relationship between healthcare providers and society. Since the same services provided by physicians are not accessible without an institutional venue, individuals are left with no recourse but to engage with an organization that weds its practices and financial motivations with one another. Since the financial motivations behind health services inherently bias health care providers, human beings are at risk of becoming means to a financial end, rather than ends in themselves.<sup>11</sup>

The current state of financial bias and financial relationships within health care organizations create a significant challenge for health care ethics. Specifically, a resolution to how a health care organization can determine how to fulfill its duties to patients while maintaining the sanctity of human life and human flourishing. Although a humanitarian aim is not always the goal of an organization, maintaining human dignity and respect throughout an organization's practice is paramount to the goods and services provided. However, health care institutions inherently address the dignity of human beings in their practice. Assessing the dichotomy between services provided and respect is tenable if the moral agency of hospitals and health care teams receives attention. This task is difficult at the institutional level because fiscal considerations and self-interest have saturated the moral lens of individuals.<sup>12</sup> While financial concerns are unavoidable, the overall intentions of an organization ought to hold ethical weight especially when dealing with individuals who require a service. By examining the model of a

virtuous practitioner, appropriate methods of organizational practice become tenable.

Furthermore, the appropriation of a philosophical basis for medical practice aids in mending the shortcomings of organizational practices.<sup>13</sup>

#### 5.1.1.1 Professional Integrity, Organizational Stewardship, and Mission Integration

The scope of an organization depends on the intentions and goals of the institution. The intricacies of a health care organization's services dictate an organization's intentions. However, health care institutions like hospitals, nursing home facilities, and other relevant health care organizations work directly with human beings in need of aid that they cannot receive on their own. Due to the nature of their work, health care organizations accompany an inherent obligation to their clientele.<sup>14</sup> While other institutions may strictly deal with the livelihood and financial interests of individuals, health care organizations assess and manage inalienable aspects of human life, namely, the human body and the ailments that afflict biological structures. Since the services that health care organizations provide deal specifically with the flourishing of human life, health care organizations inseparably wed themselves to standards that must uphold professional integrity and stewardship across their practice.<sup>15</sup>

A virtuous organization demonstrates its tact to the public through its practitioners. Simply put, an organization is virtuous if its employees and involved stakeholders perform their functions in a reciprocal manner. At the heart of organizational integrity lies a premise of completion. Specifically, the concept of integrity attempts to bridge the gap between public and private character of an organization.<sup>16</sup> Synonymous with the late Hannah Arendt's work in *The Human Condition*, the exposure of the public and private life of an individual is indicative of one's inherent character.<sup>17</sup> However, when dealing with an organization, the private affairs of any given institution must become reflected outward to the public. This process requires

organizational integrity. In many respects, organizational integrity is a promise made to the public who directly associate with a health care institution. While divulging every detail of a health care organization to the public is not possible, it is the responsibility of the organization to assure and maintain its goals and obligations to the people the organization serves. In this respect, a tremendous amount of trust embeds itself within the concept of organizational integrity.<sup>18</sup> The organization must trust the public insofar as the public recognizes the limitations and scope of a health care organization, while the public trusts the health care organization to perform its duties in full service and respect to its patients.<sup>19</sup>

While integrity pertains to the relationship an organization upholds between its practices and the public, stewardship involves the obligatory maintenance required to uphold a trusting and effective institution. Since health care institutions are in the business of health and well-being of others, stewardship becomes the conceptualized manifestation of moral partnership and duty that inherently ties to the mission of a health care institution.<sup>20</sup> Furthermore, stewardship inspires virtue within an organization insofar as the work conducted by an organization seeks to better the community it serves. Stewardship bolsters a health care organization's commitment to a community by clearly delineating goals that involve care, virtuous practice, fairness, and justice.<sup>21</sup>

The mission and values of a health care institution revolve around the betterment of human health and human flourishing. While the core values and mission of a health care institution vary, it is important to balance the goals of a health care institution with the impending necessities of a free-market economy.<sup>22</sup> In this respect, the integrity and stewardship of an institution challenge the pressures of financial gain with a mission of healing and service.

Promoting the mission and core values of a health care institution requires a thorough understanding and establishment of a mission statement that emphasizes core values.<sup>23</sup>

A health care institution's mission statement should exercise brevity but also power in its language. For instance, the mission statement of Trinity Health, a Michigan-based Catholic institution reads, "[w]e, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."<sup>24</sup> This mission statement is effective for several reasons. First, it indicates the institutions role and functionality. Second, the statement clearly illustrates the organization's catholic identity. Finally, the statement attempts to demonstrate that the mission goes beyond the duties of a health care system by penetrating various facets of human well-being.<sup>25</sup>

The efficacy and prowess of a work force is demonstrative of a well-formulated mission statement. Employees of a health care organization ought to refer to their institution's mission statement throughout their everyday practices to remind themselves and others that the role of their organization extends far beyond a single employee's duties. With every subsequent project, report, procedure, consultation, or task health care organization provides, institutional understanding of the boundlessness that a mission statement entails can significantly impact the conduct and atmosphere of the work place.<sup>26</sup> While core values of a given health care institution curtail to the specific duties of that institution, the underlying function and values that an organization formulates base themselves in stewardship and integrity. Examples of core values include reverence, commitment to those who are poor, and justice. Core values should become part of an organization's corpus if they demonstrate relevance and serve as catalysts for expediting the institution's mission. For instance, a catholic health care organization may possess a core value of reverence due to its basis in honoring the sacredness and dignity of every person.

Reverence is a core value that should be on every health care professional's mind when seeing a new patient and thus fits well into the mission and values of a healing enterprise.<sup>27</sup>

Core values like justice and stewardship demonstrate their rootedness in an organization's mission due to their efficacy in helping patient populations and corporate decision-making. However, this analysis indicates the relevance of virtue throughout an organization. In this respect, the core values and mission of a health care organization should align with, or become identical, with moral virtue.<sup>28</sup> In doing so, identification of virtue becomes an imminent aspect of organizational work. The unavoidable and inherent nature of identifying virtues that double as core values prompt employees to develop and hone analytic moral reasoning skills throughout their practice. While the virtue of justice focuses on fostering proper relationships to promote the common good, stewardship honors the heritage of these proper relationships and subsequently holds those who foster the same relationships accountable for the human, financial, and natural resources entrusted within a health care organization.<sup>29</sup>

Although integrating core values and mission integration within an organization weighs heavily in moral theory, the processes and tasks involved within integrating stewardship integrity further associate with ethics and corporate compliance. Mission Integration, insofar as virtue ethics serves as its foundation, must oversee all organization processes. This includes responsibilities for strategic planning and implementing goals, conducting contract agreements, and overseeing partnership relationships with other organizations.<sup>30</sup>

The core values discussed above demonstrate the administrative scaffold that all health care organization should acknowledge. Without these grounding principles and values, the educational possibilities involved in identifying virtue and promoting analytical moral reasoning skills processes thwarts the quality and relevant discourse necessary for stewardship and

integrity. Stewardship and integrity is at the foundation of organizational health care. These foundational aspects of health care not only aid the contemporary development of virtuous care, but also serve as investment strategies for future organizations and practitioners. Continuing the mission of a virtuous organization is a tenable feat in a competitive market if the goals of an organization focus on the betterment of individuals and the promotion of human well-being.<sup>31</sup> While a lasting and effective financial infrastructure is a necessary component for an organization's function, it is still a secondary component when juxtaposed with the importance of an organization's moral fortitude. Structuring an entire health care organization around a mission of stewardship and ethical integrity solidifies a promising future and aids in establishing a virtuous institution.<sup>32</sup>

#### 5.1.2. The Need for Virtue in Organizational Ethics

Although integrity pertains to a relationship grounded in trust, various characteristics contribute to the overall composition of organizational integrity. Furthermore, many of these contributions are moral virtues that directly pertain to the betterment of an institution's functioning and its contributions to human flourishing. These characteristics include, among others, courage, honesty, responsibility, accountability, justice, respect, humility, and commitment.<sup>33</sup> The overlap created between these characteristics moral virtue contain a two-fold benefit for organizational integrity and stewardship. First, the acknowledgement and practice of these virtues bolster the moral fortitude of the same individuals responsible for a well-functioning organization. Second, these virtues aid in solidifying a relationship of moral integrity between a healthcare organization and the populations the organization aids. By identifying virtue in professional practice, health care organizations are subsequently able to develop methods of analytical moral decision-making throughout their practice.<sup>34</sup>

### 5.1.2.1 Identifying Virtue in Professional Practice: An Organizational Case

Bolstering moral fortitude in organizations is a widely-recognized need amongst ethicists and moral scholars alike.<sup>35</sup> The enhancement of an organization's understanding of moral virtue and professional practice yields significant corporate progress. Additionally, a morally-sound organization both enhances employee's understanding of an institution's mission and aids in solidifying a trusting relationship between an organization and its clientele. This analysis demonstrates this relationship as organizational integrity in a later section, yet the moral elements that contribute to this relationship manifest as moral virtues. Synonymous with Aristotelian virtue ethics discussed in chapter four, one may identify moral virtues in organizations by acknowledging virtue as a mean between two possible extremes. While an array of virtues manifest in a health care organization, courage and justice appear frequently. For the sake of this discussion, these two virtues encompass relevant facets of analytical moral reasoning. However, it is important to acknowledge the utility of virtuous application across a given health care organization.<sup>36</sup>

The seemingly broad nature of virtues may initially dissuade facilitation efforts in organizational ethics, yet the method of identifying virtue is the focal intention of this analysis. Identifying instances of courage and justice, for instance, within an organization promotes lasting skills and aid in the development and understanding of virtue in practice.<sup>37</sup> Within health care organizations, instances of courage and justice are embodiments of good decision-making, facilitation, conflict resolution, and character development. The analytic moral reasoning skills developed from identifying moral virtue in health care organizations not only forges integrity and stewardship to its patients but also develops an analytical method for health care professionals and health care organizations.<sup>38</sup>

Excesses and deficiencies of moral virtues manifest differently. Concerning moral courage, ‘cowardice’ is representative of virtuous deficiency while ‘rashness’ is representative of virtuous excess. Regarding Justice, excesses and deficiencies result in imbalances of power. Deficiencies and excesses of virtue frequently appear in health care ethics consultations and are frequently the crux of ethical discrepancies. However, organizational ethics cases possess a unique character within their hierarchical status.<sup>39</sup> The shifting of roles, responsibilities, and statuses within an organizational structure can easily provoke power imbalances. However, the ideal organizational structure remains fluid to accommodate adjustments in policy.<sup>40</sup> An organizational hierarchy functions virtuously if the changes conduct with interest of the individuals affected by the organization.<sup>41</sup>

When an organizational ethics issue arises in health care, the result can often trace to an excess or deficiency in virtue. These excesses and deficiencies in virtue, although problematic, present opportunities for moral agents to recognize the differences between shortcomings of moral fortitude and opportunities for ethical deliberation. To illustrate the difference between excess and deficiency in virtue, consider the following case: Two doctors perform a routine outpatient procedure on a 34-year-old female. Both doctors, although familiar with the procedure, use new equipment that they have no training with nor possess organizational authorization to use. Additionally, a salesperson from the equipment manufacturer assists the procedure by operating the equipment while the doctors perform the procedure. A nurse expresses concern regarding the apparent violations of organizational policy, but the physicians disregard the nurse’s concerns. During the procedure, the patient dies.<sup>42</sup>

The above case contains an array of ethical discrepancies including violations of organizational policy. However, the most threatening ethical concern regarding this case



involves an overstepping of expertise. The physicians responsible for the patient's care did not act courageously because they overstepped their expertise and did not exercise poise. Although both physician's may have felt confident in their abilities, a critical failure occurred during the procedure due to a lack of analytical moral reasoning.<sup>43</sup> Had both physicians taken a moment to identify what actions align with virtuous medical practice, they may have reconsidered making a rash decision, namely, performing a procedure with minimal equipment experience with an unauthorized individual. Alternatively, a deficiency of moral courage in this instance may have resulted in an act of cowardice. Cowardice can manifest in a variety of different ways concerning this clinical case, *i.e.* covering the mistake up, blaming the malpractice on another individual, or lying on electronic medical records to protect one's reputation.<sup>44</sup>

While the physicians in the above-mentioned case exhibit vast misrepresentations of virtue, the healthcare organization responsible for the conduct of the physicians must identify their inappropriate actions and develop institutional policies to aid in thwarting these detrimental instances in the future. Furthermore, the health care organization can make efforts to bolster underappreciate and valuable the voices of health care professionals that do not receive proper attention due to hierarchical structures, *i.e.* nurse-physician relationships. While an institution's policies must uphold the same standards of stewardship and integrity discussed earlier in this analysis, organizations must also abide by a standard of practices that reinforces these standards.<sup>45</sup> While this aspect of organizational ethics seemingly belongs in the realm of compliance, the two disciplines are complimentary insofar as they intent to reinforce organizational policy for the sake of the organization's mission. Although the addressing the importance of wrongness, sanctions, and conflict resolution arise later in this analysis, understanding how to identify virtue in medical practice aids health care organizations in

developing a method that facilitates analytic moral reasoning skills. These skills saturate the various components of a health care organization and aid in preventing the metastasis of excessive and deficient instances of virtue or, organizational wrong-doing.<sup>46</sup>

#### 5.1.2.2 Virtue as a Competency in Organizational Ethics: Developing Moral Fortitude

Recognizing how virtue manifests in health care organizations is far more tenable if moral agents can recognize deficiencies and excesses of virtue. In doing so, moral agents develop analytical moral reasoning skills that shape the moral fortitude and character of an organization and its involved stakeholders. Shaping moral fortitude and character of a health care organization promotes the foundational dimensions of virtuous practices like stewardship, integrity, and the flourishing of patients.<sup>47</sup> However, it is important to note that the betterment of an organization results from the effective implementation and practice of analytic moral reasoning skills. If implemented efficiently and effectively, the subsequent cultivation of moral fortitude and character follows suit within a health care organization. The proper implementation of analytic moral reasoning skills shapes moral fortitude and character because exercising analytic moral reasoning skills involves active participation in virtuous practices.<sup>48</sup>

Leslie Sekerka, Richard Bagozzi, and Richard Charnigo demonstrate the effectiveness of virtuous practice by coining the phrase “Professional Moral Courage” (PMC). According to the authors, PMC is both measurable and teachable. In this respect, the difficulties associated with promoting virtue in health care organizations are moot due to the quantifiable and teachable nature of virtue.<sup>49</sup> However, the ability to measure and teach PMC also begs the question: to what degree does measuring and teaching PMC promote moral decision-making, positive organizational scholarship, and organizational ethics? It is necessary to examine PMC as a competency or, a central theme that can apply to ethical situations and directly influence virtue in

action. A competency is a general description or overview of skills used to effectively perform tasks in a workplace. Synonymous with the ASBH's core competencies, the same stringent criteria should apply to virtue in health care organizations and clinical care alike.<sup>50</sup> However, the difference between practical core competencies and shaping virtues as competencies lie in their skillsets. While the ASBH's core competencies intend to guide and aid facilitation efforts of clinical ethics consultants and other health care professionals, virtuous competencies shape and develop analytic moral reasoning skills for clinicians, ethics consultants, and all health care administrators.<sup>51</sup>

Sekerka, Bagozzi, and Charnigo's confidence in the measurability and teachable components of PMC is promising for various reasons. First, deeming virtue as a competency opens a variety of avenues for organizational leadership and ethical promotion in health care. Recognizing the necessity of understanding virtue as competencies across a health care organization promotes confidence in moral agents. Rather than questioning whether a moral agent should deliberate between two extremes, moral agents subsequently accept the process of seeking moral means as obligations rather than mere options.<sup>52</sup> Second, accepting virtues as practical competencies shape moral attitudes and character in a health care organization. While practical competencies demonstrate viable protocols in ethical practice, competencies in virtue encourage moral agents to actualize and pursue moral goals. These goals entail prudence, honesty, and even other virtuous facets like justice.<sup>53</sup> Finally, upholding virtuous competencies aid in the process of identifying virtue in health care settings.

This analysis has stressed the importance of identifying virtue as a means of forming and honing analytic moral reasoning skills. These skills are subsequent byproducts that result from actively participating in virtue-identification. However, analytic moral reasoning skills must

present themselves in a way that fosters understanding and applicability at the organizational level. By introducing and accepting these skills as competencies, health care organizations achieve a teachable model for their employees and clientele.<sup>54</sup>

### 5.1.3. Virtue Ethics as Institutional Policy: Integrating Virtue-Competencies

The above section indicates the necessity, function, and benefits of treating virtue as a practical competency in health care organizations. By identifying instances virtue and understanding virtue as teachable and measurable competencies, health care professionals and health care organizations achieve analytic moral reasoning skills that aid facilitation efforts.<sup>55</sup> However, implementing analytic moral reasoning as a tool that aids conflict resolution efforts is best suited if these skills integrate into organizational policies. By first addressing how virtuous competencies integrate into organizational policies, methods of conflict resolution, ethical facilitation, and moral cooperation efforts become clear. These competencies subsequently aid in bolstering the ethical conduct of a health care organization by introducing and teaching analytic moral reasoning skills.<sup>56</sup>

#### 5.1.3.1 Moral Policy and Moral Agency

An underlying goal of this analysis is to create a relationship between professional ethicists and health care organizations. This relationship is necessary in establishing hospitals as conglomerate moral agents and their accompanying health care teams. In effect, hospitals become moral agents themselves and function with inherent moral obligations within their practice.<sup>57</sup> This relationship is possible if individuals adopt virtue competencies to identify virtue in health care settings. Identifying virtue promotes analytic moral reasoning skills and subsequently bolsters the ethical character of an organization. However, introducing virtue

competencies and analytic moral reasoning skills becomes a far more tenable feat if these competences and skills assimilate into organizational policies.<sup>58</sup>

Establishing a formidable ethical policy throughout a health care organization requires moral agents that both understand the moral goals of their institution as well as the processes necessary for the organization's ethical success. Introducing the concept of moral agency throughout a health care organization is difficult to disseminate.<sup>59</sup> Moral theories and ethical principles are uncommon training competencies for health care individuals and typically aim toward individuals who specifically deal with moral facets of an organization, *i.e.* legal departments, compliance, and ethics. However, introducing ascertainable concepts of moral agency and autonomy creates an organizational attitude that is susceptible to learning analytic moral reasoning skills.<sup>60</sup> Although primarily directed for clinical ethics consultants, these skills and competencies can easily assimilate into various positions throughout the organizational hierarchy. Furthermore, establishing an organization-wide understanding of moral agency aids conflict resolution efforts and bolsters the effectiveness of cooperation.<sup>61</sup>

Due to the hierarchical structure of health care organizations, individual moral agency becomes efficiently introduced to an entire system if managers, staff leaders, and other higher officials are first informed and shaped into quintessential moral agents.<sup>62</sup> The subsequent watershed of moral fortitude increases if upper management understands the intricacies and effectiveness of developing moral agencies. The ethical goals of a health care organization should attempt to refine autonomous behaviors in a manner that promotes virtuous decision-making.<sup>63</sup> In this respect, leadership becomes a paramount concern for an organizational hierarchy. The sought-after qualities of an organizational leader involve various facets of ethical decision-making, stewardship, organizational integrity, and tactical planning, yet the primary

obligation of a leadership role in a health care organization directs its duties toward cultivating autonomous behaviors that exercise virtuous practice.<sup>64</sup> While autonomy is a principle that is heavily discussed with patient populations, organizational ethics places a tremendous emphasis on employee decision-making. Whether an employee's duties involve micro-surgery or sanitation throughout the hospital, every employee has an opportunity to exercise their autonomy. However, it is up to the moral agent to determine what autonomous choices will foster a flourishing environment that promotes healing and well-being.<sup>65</sup>

While ancient philosophical conceptions of virtue pertain to the betterment of the human soul, virtuous actions that apply to contemporary health care organizations focus on enhancing the effectiveness of appropriate medical and business practice. The betterment of the moral agent is still an effect of virtuous practice. Condemnation for obstructing virtuous policies in a health care organization possesses a two-fold consequence. First, deficiencies and excess of virtue, misidentifications of virtue, and a lack of analytic moral reasoning jeopardizes the integrity and safety of the institution and its patrons. Second, the moral fortitude and virtuous abilities of the moral agent that engages in wrongdoing diminishes their occupational integrity and becomes susceptible to future wrongdoing, *i.e.* medical error.<sup>66</sup> Since the results of improper analytic moral reasoning and virtuous practices are so detrimental to the mission of a health care institution, an organization's job must entail disciplinary actions. Often, conflict resolution involves reprimanding a blame-worthy party. Although unpleasant, this action itself exercises justice and attempts to reconcile organizational compliance procedures.<sup>67</sup>

A moral agent should possess the capacity to decide what ought to occur in any given situation. Concerning organizational ethics, moral agents develop subsequent actions that translate a decision into a behavior. Leadership in health care organizations takes on a difficult

role due to the accompanying responsibilities that associate with upper management.<sup>68</sup> To reflect the responsibilities of moral agents in health care organizations, consider the following case: After a merging partnership with a subsidiary health care organization, the manager of the newly amalgamated billing department is seeking to fill a vacancy. The manager finds a seemingly perfect applicant who fits all professional criteria and appears to demonstrate the necessary skills needed for the position. Later, the human resource office discovers that the applicant has been falsifying travel reimbursement funds from the previous healthcare organization prior to the merge.<sup>69</sup>

The above case pertains to ethical discrepancies that range from improper uses of autonomous decision-making, fraud, truth-telling—or lack thereof—and misappropriation, to name only a few. The case attempts to demonstrate the moral agency of the manager looking for a new employee as well as the moral agency of an ethics consultant responsible for assessing the facts of this case. While moral agency and autonomy is present within each stakeholder, this illustration concerns the application of virtuous moral agency and ways in which autonomy applies in an appropriate manner. This application both bolsters the educational possibilities of ethics and influences the normativity of ethical deliberation at the organizational level.<sup>70</sup> The manager is in a position of leadership which requires advanced skills in analytic moral reasoning. Without these skills, the outcome of the above case has an increased probability of ending detrimentally. The necessary skills that dictate virtuous leadership techniques aid in conflict resolution and facilitate ethical discrepancies both at the clinical and organizational level. With the analysis of the moral agent illustrated, the following section presents distinctions in moral theory and presents ethical qualities of a virtuous leader in health care organizations.<sup>71</sup>

### 5.1.3.2 Conflict Resolution and Cooperation: Ethical Leadership and Integrating Competencies

Identifying virtue in health care situations, both clinically and organizationally, certainly aids in resolving ethical discrepancies. However, health care organizations benefit tremendously by implementing virtuous tactics in their deliberative processes by reconciling issues in business-conflicts, hierarchical discrepancies, and policy development.<sup>72</sup> This analysis demonstrates the importance of moral agency and autonomy, yet the application of autonomous behaviors that align with virtue benefit a health care organization when the moral agent is in a leadership position. Examining the qualities of a morally virtuous leader indicates further benefits of virtuous practice in organizational ethics and professional health care.<sup>73</sup>

Ethical decision-making at the organizational level in health care is a complex and difficult endeavor. This difficulty arises primarily from the consequences that arise from organizational decisions and the scope of parties affected. Resolving a quarrel between two involved party members is comparatively a simpler task than resolving a dilemma for an entire enterprise.<sup>74</sup> However, while the implications and repercussions from organizational decision-making are tremendously impactful, the basis upon which these decisions ground themselves involve the same ethical decision-making processes as prototypically minute ethical situations. By identifying and exercising moral virtue at the corporate level, analytic moral reasoning skills foster formidable attitudes of autonomous leaders.<sup>75</sup>

Improving methods conflict resolution and ethical facilitation require successful leadership qualities at the organizational level. Virtuous leaders possess the ability to both recognize unethical practices and instances where agents improperly implement degradations of virtue. Organizational leadership is a critical component to a virtuous health care organization because virtuous leadership shapes and perpetuates how autonomous decisions become aligned



with an organizations mission of stewardship and integrity.<sup>76</sup> Besides the ability to recognize excesses and deficiencies of virtue in a health care setting, the qualities of a virtuous leader cultivate an environment that promotes collaborative efforts. These efforts aid in conjuring an environment where all employees, lay-persons and professional alike, desire to contribute to the overall mission and purpose of the health care organization. Virtuous leadership is attentive to employee's needs and empowers individuals to become self-motivating. Additionally, virtuous leadership contributes to conflict-resolution efforts and moral cooperation standards by establishing a communicative buttress that weds and supports the private and public realms of ethical practice.<sup>77</sup>

Virtuous leadership in health care is not a task strictly delineated for corporate figures and administrative positions in upper-management. The beauty and effectiveness of analytic moral reasoning skills that derive from identifying virtue lies in the plasticity and applicability of leadership throughout an institution. This analysis emphasizes courage and justice as illustrative virtues in a health care institution. However, atypical virtues that are applicable to health care organizations also serve as formidable. Concepts like attentiveness, empathy, healing, moral persuasion, foresight, and concept analysis are acceptable virtue-competencies that, like courage and justice, are capable of deficiency or excess.<sup>78</sup> Virtuous leadership in a health care organization promotes identification abilities and the subsequent analytic moral reasoning skills that derive from this identification. For instance, an excess of attentiveness may result in over-analyzing a situation and thus establish an environment that does not allow others to perform their tasks independently or effectively. Alternatively, a deficiency in attentiveness may result in a disregard of important information which can lead to patient endangerment or medical error.<sup>79</sup>

Virtue identification and subsequent analytic moral reasoning skills have tremendous benefits at the organizational level in health care. These skills permeate and apply across an entire system if enacted properly. However, the acceptance and practice of these skills take further effect if the adoption of these skills have organizational repercussions if not followed accordingly.<sup>80</sup> Synonymous with their accompanying practical skills, *i.e.* the ASBH core competency skills for clinical ethics consultation, the adoption of analytic moral reasoning skills must assume a critical role and demonstrate substantial influence. To reinforce the practical identification of virtue and the resulting skills that follow, health care organizations must determine if blame-worthiness and disciplinary sanctions are necessary components for ethical success.<sup>81</sup>

Fostering a health care environment that promotes safety and stewardship requires an organization that prioritizes institutional policies that thwart detrimental outcomes. One of the most formidable and long-standing traditions in bioethical facilitation includes the principle of cooperation. A historically Catholic concept, the principle of cooperation is far easier to understand than it is to apply.<sup>82</sup> Moral cooperation bases itself upon intention. If a moral agent intends to cooperate with an immoral act, he is morally culpable. If a moral agent unavoidably or unknowingly associates or involves themselves with a morally wrong action of another, he is not morally culpable. It is important to note the distinction of intention when addressing moral cooperation. If the moral agent does not intend to perform an immoral act, then he is not morally culpable. For example, if some individual loads a handgun and gives the firearm to another individual under the firm impression that the recipient intends to shoot a target, but the recipient shoots an innocent bystander with malicious intent, the individual who loaded and handed the firearm to the recipient is not morally culpable because their intention was not to commit or aid

in the immoral act. However, if the individual loading the firearm hands over the gun to the other individual with the full understanding that the recipient is using the firearm to commit a malicious or evil act, the former individual is morally culpable. The moral culpability of the agent assumes the agent's intent to cooperate with a given act.<sup>83</sup>

The above description and illustration of moral cooperation is applicable within health care organizations. A hospital administrator who violates corporate policy under false pretenses due to the influence of another individual does not willingly cooperate with the act in question. Alternatively, the same administrator who signs a document that intentionally violates patient rights for monetary gain is morally culpable, despite the administrator never directly interacting with patient finances. Moral cooperation plays a vital role in conflict resolution due to its ability to discern intention and involvement in immoral acts.<sup>84</sup> Moral cooperation becomes complicated when attempting to discern an individual's involvement with an act that violates organizational policy. Proving illicit formal cooperation, or, the cooperator's direct consent to partake in an evil act by directly assisting in the execution of the act becomes a difficult task when multiple party members and medical facts are involved. Even more onerous is the process of justifying and identifying licit material cooperation, or, reluctant cooperation with an immoral act that another individual performs.<sup>85</sup>

The process of identifying virtue and its deficiencies and excesses aids in identifying varying types of moral cooperation. The excesses and deficiencies of virtue are inherently involved in acts of illicit formal cooperation –the form of cooperation that is blame-worthy and requires disciplinary actions.<sup>86</sup> For instance, the organizational administrator who willingly signs a document with the intention of undermining patient rights for monetary gain demonstrates a deficiency of integrity and stewardship. Alternatively, actions that exercise a proper balance of

virtue reveal themselves in individuals who cooperate in an immoral act but have no intention of committing the immoral act, *i.e.* a surgical nurse who intends to do nothing more but prepare a well-organized and sterile operating room for a surgery that terminates a viable pregnancy in a catholic hospital. The surgical nurse has no intention nor knowledge of a prohibited abortion, nor does he intend to violate hospital policy. The surgical nurse is exercising virtuous behavior by performing his task well and engaging in his duties under the assumption that the surgical team will perform their task in compliance with organizational policies. Although the abortion could not have taken place without a prepared operating room, the surgical nurse had no knowledge, nor intention to engage in the illicit act.<sup>87</sup>

The above examples illustrate both the ways in which moral cooperation manifests and the usefulness of analytic moral reasoning skills. Both scenarios of moral cooperation exhibit opportunities for virtuous recognition. Whether the recognized instances of virtue entail deficiencies or excesses, the mere act of recognizing virtue-related instances promotes analytic moral reasoning skills for moral agents.<sup>88</sup> However, it is important to note the differences in educational opportunity. While the surgical nurse is already engaging in his job virtuously, one must assume that he possesses analytic moral reasoning skills. The surgical nurse has no reason to believe the instruments he prepares serve as means to an evil end. However, the physicians performing the procedure, as well as the hospital administrator in the previous example, face an opportunity to exercise analytic moral reasoning skills. Understanding the implications and intentions of an action are learning experiences if a health care organization recognizes these opportunities and capitalizes on these educational instances. By implementing virtue ethics into a structured program in teaching hospitals, fellowship programs, and internships, health care organizations can directly contribute to fostering morally fortuitous attitudes in health care.<sup>89</sup>

#### 5.1.4. Integrating Virtue Ethics into a Residency Program for Clinical Ethicists

The cornerstone of this analysis demonstrates the methods and practicality of introducing virtue-identification in health care organizations. The benefit of honing virtue-identification techniques lies in the subsequent development of analytical moral reasoning skills. These skills, although tenable, still require a practical medium that teaches and reinforces these skills. While the practical skills in the ASBH's core competencies for clinical health care consultants is composed in a teachable format, these same skills are infinitely more accessible and effective if analytic moral reasoning skills are assumed as a prerequisite condition for clinical consults.<sup>90</sup> Despite the various existing preliminary programs in ethics education, *i.e.* fellowship programs in ethics, internships, etc., these programs do not reinforce the techniques and educational facets illustrated in this analysis. To aid current efforts of bolstering ethical practice in health care organizations and professional ethics, the following section demonstrates the effectiveness of refined organizational curriculums for medical residents, ethicists, administrators, and other involved stakeholders. In doing so, these integral methods demonstrate the moral prowess of health care professionals and demonstrate the inherent virtue embedded within clinical ethics consultation careers.<sup>91</sup>

##### 5.1.4.1 Shaping Moral Character by Integrating Virtue Ethics into Organizational Curriculums

The most commonly recognized health care preparatory techniques are medical residencies. These programs, depending on specialty, vary in duration, educational information, and procedural experience. Residencies are designated only to health care organizations that can accommodate a teaching staff, curriculum, and venue for recent medical school graduates. While the structure and variance of medical residency programs are key factors in curriculum design, programs relate to one another with the intention of formal professionalization.<sup>92</sup> Similarly,

health care professions like nursing, ultrasound-technicians, and nutritionists possess a formal introduction to a new organization. Often, the training for these professions manifest as internship periods, probationary learning periods, or residency programs. Although the curriculum's variations depend upon organizational policy, each specialty usually accompanies three major educational facets: Classroom work, practical or hands-on experience, and professional review.<sup>93</sup> While these health care curriculums are supported and regulated by a governing body, *i.e.*, ANCC for nursing, ABPS for physicians, etc., clinical ethicists lack a formal certifying administration. Although health care ethics education modules are implemented throughout training programs, these ethical training modules only manifest in credits, classroom work, or preparatory course.<sup>94</sup>

The stringent requirements health care organizations stipulate coincide and cooperate with the organizational standards of a corresponding certifying body. While no such institution exists for clinical ethics consultants, organizations like the ASBH and the CECA subcommittee of the ASBH are working diligently to establish certification criteria.<sup>95</sup> However, the classroom work, practical or hands-on experience, and professional review that accompany residency programs can apply to residency programs in a seamless fashion. Synonymous with organizational leadership, a health care organization that serves as a venue for residency programs, internships, and fellowships alike must equip themselves with ethical criteria that supports the mission of the institution. Additionally, a health care organization that intends to integrate a program that teaches, certifies, and bolsters ethical education must do so by implementing the virtuous identification tactics illustrated in this discussion. Implementing these tactics is pivotal for fostering analytic moral reasoning skills amongst ethicists and health care

professionals alike due to the lasting and applicable quality of moral reasoning skills across a health care institution.<sup>96</sup>

The variability of professions within health care organizations can accommodate a virtue ethics curriculum by adopting simple organizational principles. These principles are synonymous with the qualities associated with ethical leadership illustrated earlier in this analysis. However, implementing virtue ethics into organizational curriculums must conform to a model that aids in shaping moral character across an institution.<sup>97</sup> Before a virtue ethics curriculum is considered, the institution must possess a code of ethics that does not conflict with other facets of organizational policy. Furthermore, the institution's code of ethics is articulated to employees in a way that is accessible and unambiguous. The organization must have an existing protocol for resolving conflicts and grievances. Finally, the prerequisite criteria must possess a protocol for enforcing their code of ethics in a reasonable and just manner.<sup>98</sup>

Accreditation for hospital instantiation must possess the above-mentioned facets to gain approval and license to practice under an appropriate governing body, *i.e.*, the joint commission of hospital accreditation. However, due to the current lack of a formal accreditation body for assessing ethically relevant education modules, a virtue ethics approach to organizational and professional ethics is a tenable alternative that can both integrate into current organizations and become a lasting model amidst future accreditation efforts.<sup>99</sup> Introducing virtue ethics techniques into residency programs, fellowships, and other forms of professional education is possible provided the existing organization possesses the ethical criteria mentioned above. However, the institutionalization of virtue ethics is a process that requires a professionally trained ethicist to relay information to health care professionals and other budding ethicists.<sup>100</sup>

Finally, establishing an organization that promotes and teaches virtue ethics to its residents and other associated staff promotes an ethical culture that promotes virtuous behavior across an entire system. A health care organization that teaches virtue identification techniques subsequently yields a culture of analytic moral reasoning.<sup>101</sup> These skills not only allow professionals to delineate professional roles and boundaries, but also aid in facilitating ethical decision-making, resolving medical and organizational conflicts, and contribute to a widely shared philosophical understanding amongst involved organizational stakeholders.<sup>102</sup>

To institutionalize virtue ethics throughout health care organizations, a series of professional suggestions expedite the integration of newly-established methods of teaching. First, under the guise of virtue ethics education, organizations develop formidable techniques that delineate professional roles. Understanding the differences in professional roles bolster progress and limit conflicts related to responsibility and duty. Second, an organization that is trained in identifying virtue and subsequently develops analytic moral reasoning skills is placed in an advantageous position to develop a code of ethics that not only expands upon an existing code of ethics, but also refines an organization's purpose and mission.<sup>103</sup> The newly established mission of a health care organization under the guise of virtue ethics promotes desired ethical behaviors and aids in addressing "grey areas" in corporate, clinical, and social decision-making. Finally, establishing an organizational culture that fosters virtue ethics inevitably redefines a corporate ethics committee that curtails education, policies, and regulatory functions for professionals across a system.<sup>104</sup>

The implementation of virtue ethics throughout a health care organization is not only possible but necessary. Virtue serves as a positive addition to an organization frame work due to its ability to permanently instantiate moral reasoning skills that promote an ethically-oriented



culture. Most importantly, facilitating and implementing virtue ethics throughout a health care organization eliminates unethical behaviors and bolsters productivity and effectiveness of a healing enterprise.<sup>105</sup>

#### 5.1.4.2 Ethics Consultation as a Virtuous Profession

While this discussion attempts to demonstrate the lasting utility and efficacy of virtue ethics and analytical moral reasoning skills throughout health care organizations, virtue ethics is also indicative of the nature and scope of clinical ethics consultation. Clinical ethics consultants are inherently involved with an occupation that involves the integration, implementation, and dissemination of virtue.<sup>106</sup> While virtue manifests in different instances, including its deficiencies and excesses, it is the task of the clinical ethicist to recognize and explain the ways in which virtue manifests. In this respect, the trained ethicist is the first line of defense for ethical deliberation. From this standpoint, the clinical ethicist is responsible for not only assessing instances of virtue, its deficiencies, and its excesses, but he is also responsible for articulating the methods in which virtue articulates in a health care setting. Furthermore, since the ethicist is familiar with the ethical concepts that derive from virtue, he is also responsible and obligated to educate other professionals in health care about virtuous practices and how to regulate their application.<sup>107</sup>

Clinical ethics consultants cannot perform their tasks effectively without a firm basis in philosophical concepts. However, due to the multidisciplinary aspect of health care ethics, a comprehensive education in the history and moral theory is not a practical endeavor, nor is this approach beneficial for health care ethics.<sup>108</sup> While the multidisciplinary aspect of health care ethics consultation does not comprehensively partake in an education rooted in the history of philosophy, individuals who choose to pursue a career in health care ethics can bypass a formal

education in philosophy by developing virtue-identification skills. Consequently, these individuals who come from different backgrounds attain a philosophical grounding in moral theory by obtaining analytical moral reasoning skills.<sup>109</sup>

Analytic moral reasoning skills allow individuals from various disciplines to partake in a philosophical approach to health care situations without extensive experience with the philosophical moral corpus. In this respect, clinical ethics consultants are inevitably wedded to a virtuous profession. However, it is important to distinguish the virtuous nature of the profession and the individuals who are involved in the profession.<sup>110</sup> While the nature of the profession itself is virtuous because clinical ethics consultations—under the guise of analytical moral reasoning skills—requires identifying and implementing virtue, the individuals engaged in the profession does not possess inherent virtue. While this distinction does not attempt to ascribe moral priority to consultants, this discussion does assert the virtuous nature of clinical ethics consultations.<sup>111</sup>

Perhaps the greatest aspect regarding the virtuous nature of clinical ethics consultation involves the dissemination and growth of virtuous ethical cultures within health care organizations. Organizational culture shares principles that are accepted by a like-minded group that intends to solve problems and integrates policies that reconcile issues and prevent future discrepancies.<sup>112</sup> Due to clinical ethics consultation's ability to promote virtuous activity throughout an organization, clinical ethics consultants also promote an atmosphere of the organizational moral agency. Although moral agency prototypically pertains to individual autonomy, an effective clinical ethics consultant team can foster an adaptive moral learning atmosphere that can educate an entire health care organization. The power and influence of a virtuous profession like clinical ethics consultation revitalize learning strategies, organizational

rationality, and aids in preventing organizational failures. Consequently, health care ethics consultation is inherently a virtuous profession due to its promotion and dissemination of virtuous behaviors.<sup>113</sup>

## 5.2 Applied Program Issues

While the organizational facets mentioned above demonstrate the difficulties associated with integrating virtue ethics into a wide-span consultation curriculum, the possibility of expanding an ethics consultation curriculum to ethics consultants and to medical professionals is also a tenable endeavor. Moreover, utilizing residency programs as a venue that supports and disseminates necessary information to clinical ethicists in training has proven to work well in an educational fashion. The ASBH core competencies for clinical ethics consultants has laid significant groundwork for a more developed consultation curriculum in the United States. By combining the ASBH's practical knowledge and the analytic moral reasoning skills acquired from virtue identification mentioned in this analysis, a comprehensive ethics education is bolstered and has a significant stake in professional health care.

Although this analysis thus far has advocated for the implementation of additional curriculum points to solidify a comprehensive professional ethics program for consultants, there inherently lie several issues that accompany this endeavor. This analysis is not intended to compose and disseminate an ethical lesson-plan to budding ethicists and health care professionals. Instead, this analysis proposes virtue elements of moral reasoning that ought to be included in a professional credentialing program for clinical ethicists. In doing so, this tactic may bolster an ethicist's understanding of clinical ethics and function in a manner that emphasizes analytic moral reasoning skills in practical health care situations.

By examining applied program issues, this analysis does not intend to solely identify the issues that exclusively accompany an ethics program for clinical ethicists, but also to examine the difficulties associated with implementing virtue-ethics curriculum points into a practical education model, *i.e.* into a venue like a residency program. This process is elucidated by examining what efforts must be made to introduce these curriculum points and the ways in which existing programs have introduced novel education points.

#### 5.2.1. Cultural and Professional Barriers: Ideal Ethics Programs

The breadth of literature pertaining to ethics education is vast and yet simultaneously lacking in substantive content.<sup>114</sup> While there exist various texts that attempt to inform budding ethicists about the methods and tactics used in practical facets of clinical bioethics, there is a significant gap in the corpus regarding philosophical contributions that specifically pertain to contemporary methods of bioethics consultation.<sup>115</sup> Furthermore, there exists significant literature pertaining to the effectiveness of virtue in medicine but a lack of literature pertaining to the effectiveness of understanding virtue in ethics consultation. In this respect, the contributions presented in this analysis aid the development of clinical ethics consultants by introducing an accepted methodology to a developing professional discipline.<sup>116</sup>

A description of a quintessential ethics training program elucidates the ways in which virtue training can effectively partake in the development of certification programs for clinical ethicists. Furthermore, a description of ideal ethics training for clinical ethicists, under the guise of this analysis' key components for an ethics consultation curriculum, unearths subsequent issues that require attention. However, the cultural roadblocks in hospital medicine that prevent ethics from thriving as a professional discipline ought to receive attention since these barriers affect the way in which a quintessential ethics program may manifest. Assessing what cultural

barriers stand in the way of clinical ethics aid this analysis by demonstrating what measures may encourage the acceptance of clinical ethics in professional health care. The following subsections describe the difficulties associated with the current cultural climate that clinical ethics consultants and their programs face. Additionally, the following subsections address the difficulties associated with ethics access in contemporary hospital settings.<sup>117</sup>

#### 5.2.1.1 Viewing Ethics Consultation as a Service

To ascertain the way in which an ideal ethics program functions, clinical ethics consultation must be viewed by the health care community as a service that is both accessible and effective. If viewed like a normal consultation service, ethics consultation services ought to function like any other medical consultation specialty, *i.e.* gastroenterology, cardiology, etc. In contemporary medical practice, specifically in American hospital systems, a patient is under the medical care of an array of individuals who are led by an attending physician. This attending physician, although responsible for the overall care and course of treatment for the patient, is a specialist in a specific area of medicine. While many attending physicians specialize in specific fields, many attending physicians are specifically trained as hospitalists; skilled in-patient physicians who work exclusively in hospital settings.<sup>118</sup> Although patients or their surrogates are responsible for expressing values, wishes, and relevant medical treatments, it is the responsibility of the attending physician to decide whether to abide by these wishes. Additionally, the attending physician has the authority to request additional consultations, place medication orders and codes, and ultimately determine the course of treatment for a patient by acquiring and implementing relevant information.<sup>119</sup>

The role of the attending physician is pivotal and possesses a fair amount of weight in clinical decisions. When it is medically indicated to bring in expertise from an external specialty,

the attending physician ultimately places an order to obtain this additional resource. However, while the attending physician has the final word in ordering an external consultation, ethics consultations can be requested by resident physicians, other consultants involved in a patient's case, and even patient's themselves if they express a medically relevant concern about their care.<sup>120</sup> While the physician can decide to accept or reject a consultant's recommendations, the ways in which a consultant is addressed and acquired may manifest differently. In this respect, ethics consultants ought to be treated in the same manner. Additionally, ethics consultations are far more effective if a hospital's culture views an ethics consultation service as an individual entity that is consulted like any other medical specialty.<sup>121</sup> However, what has been distinguished in clinical ethics is the cultural understanding that all individuals may request an ethics consultation. While it is the ethics consultant's expertise that determine if a consult is a relevant ethics consult, it is the prerogative of all individuals involved in a health care system to request an ethics consultation.<sup>122</sup>

Despite the inherent nature and availability of ethics consultations, ethics consultation services are often disregarded, feared, or simply unknown.<sup>123</sup> Various instances where it is appropriate to request the expertise of an ethics consultant are often discarded by attending physicians due to several issues. In this section, the discussion addresses three primary reasons why cultural attitudes in health care disregard or do not utilize ethics consultation services. First, various attending physicians do not understand the purpose and scope of clinical ethics. In this respect, many physicians believe ethics consultants investigate gross misconduct, enforce compliance procedures, and implement disciplinary actions. These facets of professional investigation are not within the purview of clinical ethicists. Instead, these facets belong to human resource representatives, compliance officers, and legal departments. While these

elements of investigation are designed for departments that can implement disciplinary actions, ethics can still assist if there is in fact an ethical discrepancy that demands the expertise of a moral agent.<sup>124</sup> By addressing these issues in a manner that demonstrates the scope and practice of clinical ethics, physicians may view ethics consultation services as a resource rather than a threat. Although this task may be accomplished by various interventions, this analysis contends that the presented key components for an ethics consultation curriculum ultimately aids the eventual acceptance of professional ethics consultations in health care.

A second conception of clinical ethics that deters physicians involves the chain of command in hospital settings. Many physicians are often not accepting of consultations that have not first gone through their approval. While the attending physician of a patient has the final approval for written orders, ethics consultations are unique in the respect that ethics consultants can be requested by all stakeholders. This issue causes duress for attending physicians, particularly due to the interactions clinical ethicists have with patients, their families, surrogate decision-makers, and other medical professionals.<sup>125</sup> This point reflects the first issue since health care ethics consultation is often viewed as a disciplinary service. If viewed as a service, patients, team members, and other stakeholders receive professional advice from individuals who are neutral in their approach to conflict and thus quintessential mediators during value-laden uncertainty.

A final reason why there is reluctance by physicians to effectively implement the assistance of ethics consultation services lies in issues of availability. While many hospitals require an ethics presence for accreditation, only a select few facilities possess the resources for an individual-based consultation model for clinical ethics consultation.<sup>126</sup> Most of hospital-based ethics programs are housed in teaching facilities, *i.e.* Mayo Clinic, Cleveland Clinic, etc. These

facilities can accommodate and individual-based consultation model for clinical ethics consultations due to their resources. Additionally, these facilities have a propensity for various types of education in health care due to their status as medical education institutions.<sup>127</sup>

The above-mentioned reasons why ethics consultation is not viewed as a service thwarts the development of ethics programs and stagnates the process of solidifying ethics consultation service as a professionally recognized discipline in health care. Consequently, the proposed curriculum points in this analysis are also thwarted due to these issues. However, these issues, although they may not become resolved in this analysis, should certainly receive attention. While it is difficult to resolve or change the cultural dichotomy of American health care, it is surely not an impossible endeavor. By merely identifying the primary barriers health care ethics consultants face, the possibility of establishing a consultation curriculum in an environment that facilitates all facets of health care becomes far more tenable. While this analysis intends to identify and introduce key components for an ethics consultation curriculum, the larger picture of this endeavor is to aid the effort in establishing ethics as a normative and professional discipline.<sup>128</sup>

#### 5.2.1.2 Sole-Consultant Models: Resolutions to Issues and Ideal Residency Programs

To address the issues that thwart the cultural acceptance of clinical ethics involvement in health care, a description of a quintessential ethics program in a hospital setting both responds to these issues and demonstrates how the key curriculum points in this analysis are applied. Additionally, this contribution aids in developing a quintessential consultation education program for clinical ethicists. Although not the focal point of this dissertation, it is helpful to examine how a clinical ethics consultation curriculum that implements the virtuous key curriculum components mentioned in this analysis may manifest in an educational setting. While this described concept of an ideal clinical ethics program is presented in a way that maintains the



virtue components mention in this analysis, ethics departments may remain malleable in their development and overall function in an institution. Malleability of a department allows room for change and, like the founding fathers of American bioethics, pragmatic development.<sup>129</sup>

Clinical ethics departments ought to function with a sole-consultant model. Instead of referring specific cases to a board of ethics committee members, involved stakeholders should have access to a 24/7 ethics service that can attend to ethical discrepancies in real-time.<sup>130</sup> These consultants work on an on-call schedule to accommodate the needs of a hospital system regardless of size. Additionally, these consultants perform their consultations in-person. This tactic is contrary to the Four Topics method mentioned in chapter three. However, this method is far more effective in remedying the above-mentioned issues.

To teach within this format of consultation, residency or fellowship programs serve as an efficient venue. Each program is structured around an individual institution's guidelines and is contained within an existing educational venue, *i.e.* a teaching hospital, in full compliance with their corresponding accrediting body.<sup>131</sup> These accrediting bodies include the Accreditation Council for Graduate Medical Education (ACGME), The Joint Commission, etc.<sup>132</sup> Hospital residency programs for clinical ethicists work and perform their residency alongside medical residents, hospital chaplains, social workers, nurses, and all other specialties that possess residency programs and require ethical facilitation within their clinical practice.<sup>133</sup> The clinical ethicist residency program is designed in this manner to further wed the relationship of ethics with health care systems, specialists, professionals, and departments.<sup>134</sup> Finally, each accompanied residency program must be accredited by a corresponding accreditation body that is deemed appropriate by each teaching hospital's administration *i.e.* Clinical Pastoral Education

program (CPE) certified through the ACPE, NACC, CASC, or another appropriate governing body.<sup>135</sup>

Synonymous with medical residents, ethics residents perform daily rounds, chart, keep track of patients, and attend regular courses throughout their residency tenure.<sup>136</sup> These courses combine a continuing education curriculum with specific clinical instances within a health care setting. Ideally, ethics residents will review the same patients treated by medical residents, social workers, nurses, and other newly inducted residents.<sup>137</sup> Furthermore, residency programs should work together as much as possible.<sup>138</sup> Ethics residents and medical residents may attend the same post-round meetings to learn from each other's observations, reflections, and clinical expertise. In effect, medical residents gain a better understanding of ethical conduct in their practice while ethics residents gain a better understanding of medical jargon, clinical situations, and treatment options for patients.<sup>139</sup>

While the duration of each residency program becomes established by the teaching hospital, accrediting body, or both, residency programs for ethicists should take one to two years.<sup>140</sup> Each program is largely self-governed under the knowledge bases outlined in this dissertation. However, a large portion of residency training for clinical ethicists involves the applied knowledge and theories of moral philosophy with the situational aspects of health care.<sup>141</sup> Naturally, it is impossible for ethicists to perform this task without the skillsets presented by the ASBH. By emphasizing both aspects of the residency curriculum, ethicists become prepared to address various issues throughout a health care institution.<sup>142</sup>

Coupled with the criteria set out in the CECA report, a requirement of clinical ethics residents involves keeping a log of clinical cases. Implementing a documented portfolio that maintains patient confidentiality may become an effective tool in demonstrating the effectiveness

of a consultation and the skills and knowledge possessed by the resident.<sup>143</sup> Recorded mock consultations should become utilized to evaluate individual residents. A requirement of ethics residency involves peer and administrative review of these portfolios for successful completion of the residency program.<sup>144</sup> Additionally, regular examinations keep track of each ethics resident's progress. The residency program concludes with a practicum examination as well as a final written examination.<sup>145</sup> These exams intend to assess the competency of the resident's theoretical knowledge regarding moral theory as well as the standards and practices of contemporary health care ethics consultation. Passing these exams after a full residency program ensures licensure and accreditation of the ethicist, provided the ethics resident is in good standing with his coursework in the residency program.<sup>146</sup> The success of the proposed key curriculum components hinges upon the implementation of a sole-consultant model and is taught in a manner that is similar in content and form as the program described above.

Contrary to ethics committee models, a sole-consultant model is a far more effective means of both delivering effective ethics consultation and disseminating ethics education throughout a hospital system. Moreover, a sole-consultant model is a far more manageable venue in which virtue ethics components may manifest. While ethics committees possess an important function and role within hospital ethics, expecting a team of health care professionals to dedicate their time to understanding and implementing moral virtue in their practice is too onerous.<sup>147</sup> Alternatively, a sole-consultant model operates in a manner where individual consultants—trained in moral theory—handle cases personally and subsequently deliver information back to the ethics committees for educational purposes. While the ethics committee under a sole-consultant model is not responsible for clinical ethics consultations, the committee does have a role in quality improvement work, education dissemination, and community outreach.<sup>148</sup>

Additionally, ethics committees are remotely involved with consults under this model when consultants require the input and moral determinations of a hospital community.<sup>149</sup> Since hospital cultures and communities vary, it is wise to gather the perspectives and attitudes of individuals who compose a hospital ethics committee. This tactic derives cultural attitudes of a health care community and aids a consultant's ability to deliver effective recommendations.<sup>150</sup>

The sole-consultant model is effective and remedies the primary issues associated with clinical ethics involvement in hospital medicine. Specifically, the implementation of a sole-consultant model accomplishes focal tasks: First, the sole-consultant model effectively introduces ethics into a health-care culture that aids in eliminating pre-conceived notions of ethics. These pre-conceived notions include viewing ethics as a disciplinary department, a department that investigates gross misconduct, and a department that delivers legal advice.<sup>151</sup>

The sole-consultant model works to alleviate these misconceptions by placing individual consultants at the bedside with attending physicians and other medical professionals. Second, the sole-consultant model, in conjunction with modified ethics committee functions, provides effective delivery methods of information.<sup>152</sup> The lack of ethics awareness in hospital settings is often rooted in unavailable services. Ethics consultation services are often based in hospital ethics committees. These committees are comprised of individuals who often have minimal ethics training and come from a diverse background of expertise. By implementing a sole-consultant model, committees can provide additional functions like quality-improvement projects, community outreach efforts, and hospital-wide education. By disseminating information, medical professionals subsequently learn the proper function of clinical ethics and are thus more likely to accept these services. These methods alleviate the burden of other

departments and work toward establishing an ethically rich culture throughout a health care institution<sup>153</sup>

This analysis does not suggest that ethics committees are ineffective in their tasks. On the contrary, the sole-consultant model for clinical ethics does not work without an ethics committee that performs its functions well. The key curriculum components in this analysis offer skills in analytic moral reasoning that apply to both clinical situations and organizational leadership. A consultant who is trained under the same criteria outlined by the ASBH core competencies in conjunction with the key curriculum components of virtue identification yields a professional who can function as an effective consultant for value-laden discrepancies in health care. Additionally, proper implementation of a clinical ethics professional who has been trained properly has the potential to guide and train others who are interested in clinical ethics. While this model remedies the issues mentioned above, additional issues lie in the organizational sphere of health care, including policy development, quality improvement, and root cause analyses.<sup>154</sup>

#### 5.2.1.3 Teaching Virtue as a Key Component for an Ethics Consultation Curriculum

The utility of this analysis has manifested in identifying important facets of a clinical ethicist's curriculum. However, the key components for an ethics consultation curriculum upon which this dissertation is based resides in the application and implementation of virtue identification for clinical ethicists in health care settings.<sup>155</sup> While these skills are applicable in both public and private life, the utility of virtue identification in the work associated with clinical ethics consultations aid a consultant's ability to morally deliberate and thus aid in presenting formidable recommendations for affected stakeholders in ethically precarious situations. Nevertheless, teaching virtue becomes an onerous task if an existing curriculum does not allow the implementation of virtue in its lessons. Additionally, teaching virtue is a difficult task if there

exists no formal method for relaying otherwise abstract information. Thankfully, Aristotle's presentation of virtue in his philosophy of ethics assures that virtue is indeed a teachable skill that can be refined and developed with practice.<sup>156</sup>

Explaining a way in which virtue may be taught to clinical ethicists ultimately demonstrates how the key components for an ethics consultation curriculum manifest. The previous components of this discussion all include skills and knowledge points that, presumably, can be taught and refined through their implementation and use in clinical ethics.<sup>157</sup> For example, using the formidable consultation methods elaborated in chapter three can become more and more effective if they are rehearsed and implemented in clinical cases. Yet, the topic of virtue seems to allude this kind of development due to its abstract nature and theoretical framework. In his *Nichomachean Ethics*, Aristotle asserts that virtue can indeed become more refined with practice. Like any other practical skill such as carpentry, sailing, or mathematics, virtue can be taught and refined through repetition and hermeneutic development.<sup>158</sup>

While this rather abstract assessment of virtue identification and practice is clear, these methodologies and theories still need a practical application into a formal certification program. In this respect, the ways in which clinical ethicists may become versed in virtue ethics and virtue identification can manifest in a rather objective format. Along with the various educational components that clinical ethicists are expected to know, virtue identification techniques can be taught in a way that works in conjunction with other educational facets of a clinical ethics consultation curriculum. First, education techniques for teaching virtue identification may manifest in practical instances of clinical ethics. Clinical ethicists in training may receive various mock cases in which the consultant must identify the central ethics issue. In doing so, the clinician is now faced with identifying excesses and deficiencies of virtue.<sup>159</sup>

Once these extremes are identified by the consultant, the consultant may then discern the mean between these two extremes, thus identifying the virtuous action located in the given clinical situation. Subsequently, the clinician may act accordingly by implementing recommendations that coincide with the identified virtue. By way of example, consider the following clinical case:

An ethics consultation service is contacted by a cardiology team for advice regarding a 79 y.o. woman who is admitted to the hospital for shortness of breath and hypertension. The team reveals that the cause of the patient's distress is brought on by a mitrovalve that was improperly performed. The patient has an array of comorbidities and will die if the issue is not corrected. Initially, the cardiology team has two options for the patient. (1) The cardiology team can work in conjunction with palliative care to make the patient comfortable and allow the illness to take the patient's life. (2) The cardiology team can replace the valve. The second option is very risky due to the patient's advanced age and seriousness of her illness. Many of the cardiologists are uncertain if this is a good course of action due to the high likelihood that the patient will die. However, the cardiologists' main reason for contacting the ethics consultation service lies in a choice to tell or to not tell the patient about a third option. Option three is a relatively new procedure that has far less risks than option two. However, the patient has medicade out of state and the surgery will cost \$50,000. Since the cardiologists know that the patient cannot afford this operation, the team has a moral issue concerning whether or not to inform the patient about this option.

The above-mentioned case is a common ethics consult that clinical ethicists must be prepared to respond to. While instances such as this are often corroborated with other team members, the case contains various ethical conundrums that demand attention. In terms of

practical virtues, Aristotle notes that courage comes before all other virtues and all other virtues are based upon courage.<sup>160</sup> In this respect, courage is easily identified as a focal virtue upon which ethics consultants may use to discern proper ethical recommendations for the cardiology team. However, merely identifying courage as a virtue associated with this clinical case simply because Aristotle claims that courage is at the root of all virtues is not enough to justify the identification of virtue in this instance.<sup>161</sup>

To align with the proposed key curriculum components and techniques outlined in this dissertation, clinical ethicists must be trained in identifying virtue by identifying the excesses and deficiencies of the virtue in question. Regarding the above-mentioned case, arguments can be made for various virtues in this scenario. Virtues like courage, justice, temperance, and poise are all virtues that one may justify in this clinical circumstance. However, an ethicists ability to discern the proper use of virtue lies in the identification of that which virtue is note. In doing so, the proper elements of virtue are identified and thus serve as a springboard for argumentative pathways in resolving moral discrepancies.<sup>162</sup>

In order to test and hone a clinical ethicist's abilities in identifying virtue and virtue's absence in clinical situations, clinical ethicists must indicate excesses and deficiencies in virtue in ethical cases. These evaluations ought to be mention in an educational evaluation and should not be entailed within the formal recommendations presentation to care teams and medical professionals. An evaluation of virtue in clinical cases allows a proper development of recommendations for clinicians.<sup>163</sup> For example, the above-mentioned case displays various deficiencies in virtue that could manifest from certain paths that may be taken by the clinical ethicist and the team. While withholding information from the patient may exemplify a deficiency of justice and a divulgence of too much information may exhibit rashness, informing



the patient about risks and benefits of the procedure while simultaneously emphasizing the importance of the cost parameter of the treatment yields a just and courageous divulgence of information for the patient. Regardless, the merely identifying the excesses and deficiencies in virtue in this case, thinking through these processes facilitates analytic moral reasoning and furthermore promotes analytic moral reasoning skills for clinical ethicists.<sup>164</sup>

Virtue identification stands as the focal key curriculum component for an ethics consultation curriculum. Identifying virtue in various clinical situations aids a consultant's abilities by helping him tap into the knowledge and skillsets established through formal education techniques and allows the consultant to engage in ethics cases critically. Additionally, this method allows clinical ethics consultants to also implement their expertise regarding an array of moral theories like utilitarianism and deontological methods. However, teaching this model of reasoning requires various mock instances that specifically test for and evaluate one's ability to identify the excesses and deficiencies of virtue in clinical situations. While this novel technique in shaping clinical ethicists possesses an array of difficult educational facets, it becomes far more effective if it is taught in a sole-consultant model of clinical ethics.

### 5.2.2. The Extent of Ethical Utility

The sole-consultant model serves as an excellent venue to accommodate the proposed curriculum points mentioned in this analysis. The implementation of a sole-consultant model remedies various issues that are currently present in hospital-based clinical ethics. However, the scope and purview of clinical ethics is still significantly undermined when an ethicist's duties do not affect other medical professionals.<sup>165</sup> The role of a professional in a medical setting should have direct impact on patients, providers, and administrators. While the clinical work of a bioethicist has a significant impact upon a health care system, the effects are often not viewed on

a system-wide scale. This is a central issue surrounding clinical ethics consultation and is yet another blockade in the efforts to professionalize clinical ethicists.<sup>166</sup> While implementing the key curriculum components into a clinical ethicist's education are paramount for the professionalization of the field, it is equally important that the larger scope of medical professionals understand the utility of this discipline. By examining the scope of clinical ethics, the broader utility of the discipline becomes apparent. Specifically, examining the scope of clinical ethics outside of bedside consultants illuminates moral theorists' utility in organizational practice and quality.<sup>167</sup>

#### 5.2.2.1 Ethics Involvement in non-Clinical Hospital Departments

The previous section of this chapter discussed the ideal format in which a sole-consultant model would manifest. The duties of an ethicist were briefly described to alleviate the issues surrounding the relationship between medical professionals and clinical ethicists. However, a further description of how an ideal ethics department aids issues surrounding wider acceptance of clinical ethics as a professional discipline is elucidated. This task bolsters the need and utility of ethics consultants and demonstrates the vast-applicability of their expertise.<sup>168</sup>

An ideal ethics consultation department ought to function alongside three major groups in health care. These groups include compliance, quality improvement, and risks management departments. Naturally, these disciplines have their own functions and do not comprise various other departments where clinical ethics is applicable. However, these facets of health care aid the steps toward professionalizing clinical ethics consultants by introducing individuals to resources that extend beyond consultation expertise.<sup>169</sup> Ethics consultants are perfectly suited to aid these departments in their practice due to the nature and scope of their practice. Issues within a hospital system require specialized attention. While ethics consultation does not intend to

infringe upon these areas, it is still within the scope of ethical practice to aid these areas of expertise when ethical discrepancies arise.<sup>170</sup>

Quality departments typically assess patient safety, gaps in care, and aim to improve the overall functionality of a health care system. For instance, a hospital's mortality metric may indicate that the monthly deaths at a specific institution are much higher than national data, or compared to neighboring health care systems. The quality department is responsible for tracking the mortality trends among other systems and comparing their own data. While this task is a statistical endeavor, the actions that take place within quality department attempt to alleviate volatile practices in hospital medicine.<sup>171</sup> Quality departments use statistical methods to evaluate the cause of issues like increased mortality. Furthermore, these issues cannot be remedied without an action plan. Clinical ethics consultants can have a tremendous impact in quality initiatives due to the nature of ethical work in hospitals.

Expanding upon this example, most hospitals assess mortality metrics with code status determinations upon admission. Patients who enter a hospital with a do not resuscitate order or, change their code status to a do not resuscitate order within the first twenty-four hours of their admission, do not impact a hospital's mortality metric upon the patient's demise. While quality improvement departments identify this process, working in conjunction with ethics departments can help curb a hospital's mortality metric by engaging in value discussions with patients upon their admission. Patients are asked about their code status preference upon their admission, but this process is loosely based and does not weigh a patient's values appropriately. By integrating ethicists into this conversation, patient values are upheld while simultaneously assisting the goals of quality improvement departments.<sup>172</sup>

Similarly, clinical ethics can have a significant impact on compliance and risk management departments. These departments typically work to protect the hospital or health care system from legal ramifications by ensuring the hospital is engaging in proper legal regulations. Additionally, these departments intervene when there are specific instances where the hospital is at risk for legal repercussions or threats. Legitimacy of a department depends on its overall utility and clinical ethics departments are no different.<sup>173</sup> To justify the professionalization of clinical ethicists who are trained with the key components mentioned in this analysis, clinical ethicists need to demonstrate that their expertise have a direct impact with hospital departments that regulate issues like cost, risk, and overall patient care. While patient care seems like an obvious benefit of clinical ethics, measurable impact of clinical ethics in departments like compliance and risk are of the utmost importance if professionalization of the field is to occur.<sup>174</sup> Consider the following clinical case where risk management and compliance may coincide with clinical ethics:

A forty-year-old man is admitted to the hospital after suffering a traumatic spinal cord injury after a car accident. The patient is diagnosed with quadriplegia and has become vent dependent. Although the patient is unable to speak or move his arms and legs, he can blink. The patient's surrogate decision-maker is his mother. The patient also has a sister who has become involved with the decision-making process. Both the mother and sister of the patient are confident that the patient would not want to spend the rest of his life with life-sustaining interventions. The family explains that the patient has lived an active life-style and would not consider his current situation an appropriate quality of life. The patient, although limited in his ability to communicate, possesses capacity and can communicate through a series of blinking. However, some friends of the patient do not believe this is the course of action the patient would

have wanted. The friends of the patient write threatening letters and record the patient on their phone to depict an alternative view of the patient's wishes. It is at this point that the compliance and risk management departments are involved in this case due to the threatening nature of the letters and videos supplied by the patient's friends.

The above-mentioned case demonstrates the kind of instances where compliance and risk departments become involved in clinical instances. Clinical ethics involvement aids in resolving the issues in this case by facilitating dialogue and clarifying communication efforts between the patient and the other involved stakeholders.<sup>175</sup> A clinical ethicist equipped with the key virtue components mentioned in this analysis aid the issues mentioned above by using professional interpretation skills and conflict resolution. By implementing a clinical ethics consultant, the patient's wishes become clear by building rapport with the family and demonstrating appropriate dialogue between involved stakeholders. One of the primary roles of a clinical ethicist involve ensuring the proper delivery of informed consent. By involving clinical ethicists in risk and compliance cases, the clarification of goals and values of involved stakeholders becomes a paramount endeavor. This level of involvement indicates yet another positive impact professional ethics can have on a health care system. However, viewing clinical ethics a professional discipline and consultation services still faces various challenges.<sup>176</sup>

#### 5.2.2.2 Ethics as a Billable Service

The goal of professionalizing clinical ethics may become accomplished through various means. While this analysis has offered ways in which curriculum points can aid the overall professionalization of clinical ethicists throughout their training, the means of viewing clinical ethics as a normative consultation service is still a glaring issue. This analysis argues that ethics should be viewed and utilized like any other medical consultation service, *i.e.* gastroenterology,

cardiology, etc. However, this tactic begs the question of whether clinical ethicists should bill for their services.<sup>177</sup> In American health care, individual consultants bill for services provided, including consultations. Typically, if an attending physician determines that another professional's expertise is needed, a consultation order will be sent out. The individual consultant will provide expertise and subsequently bill the patient for their services. In this respect, ethics consultants are no different from other medical professionals. However, distinct differences in practice may allude to advantages and disadvantages of billing for clinical ethics consultations.<sup>178</sup>

Clinical ethics consultation can only become a professional discipline if medical culture views clinical ethicists as a legitimate consultation service in hospital settings. Billing for medical services legitimizes a professional discipline for various reasons. First, billing for professional services demonstrates the importance of a specific practice. Billing for services rendered indicates the prowess and knowledge provided by a professional.<sup>179</sup> Additionally, the scope and practice of a discipline that bills for its services indicates the level of importance the practice provides. Second, billing for clinical ethics consultation aids an overall institution's resources by obtaining funds from insurance companies and patients. Hospital funding and overall resources for a hospital system are greatly improved if services like clinical ethics consultations are billed. The overall revenue of a hospital has the potential to provide additional services and more full-time employees for hospital departments.<sup>180</sup>

While billing for clinical ethics has its advantages, specifically, the potential to promote clinical ethics consultants as professionals in health care, there are various drawbacks to billing patients and insurance companies for clinical ethics consultations. First, implementing billable practice for clinical ethics consultation has the potential to yield negative connotations for ethics

consultants. Recently, various consultants in health care have been known to abuse billing systems. Ordering unnecessary tests, consultations, and medication orders for patients have fueled abuse throughout American health care. While medical professionals who call upon ethics consultants do not reap the benefits of billing for these services, receiving ethics consultations from patients and their families have the potential to plummet if these individuals are charged for calling upon this service.<sup>181</sup> Second, ethics consultation services are inherently conjoined with patient rights. Within hospital policies, patient rights chapters typically indicate the rights that belong to patients upon their admission to the hospital. Access to chaplain services, translation services, and ethics consultation services ought to be entailed within a patient's rights.

Billing for ethics consultation services infringe upon a patient's inalienable rights since billing for services involves placing a monetary restriction on individuals who cannot afford certain services.<sup>182</sup> Third, it is unjust to claim that ethics consultation services are available to all individuals in a health care organization if only one party is responsible for paying for the service. For example, a physician may request an ethics consultation for a patient who is obtunded and does not have an available surrogate decision-maker. However, even if the ethical discrepancy surrounding the patient is not reconciled, the patient is left with the financial responsibility, including increased medical premiums or out-of-pocket payments if the patient does not have health insurance coverage.<sup>183</sup>

Billing for ethics consultation services, although an option for legitimizing the profession, places a greater burden on patients and health care than a benefit. The primary issue lies in infringing upon a patient's rights to a service that is otherwise accessible. While not billing for ethics consultation services is an issue in professionalizing the field, it is still possible to legitimize clinical ethics consultation without billing for its services.<sup>184</sup> By implementing the

key curriculum points presented in this analysis, the subsequent analytic moral reasoning skills that follow aid the legitimization of the profession without placing a financial burden upon involved stakeholders. Demonstrating the effectiveness of clinical ethics consultants with the curriculum points in this analysis legitimize the practice of consultants without requiring monetary justification. Among other various issues, billing for ethics consultations still poses many difficulties, specifically in American health care. To address the difficulties that accompany the implementation of new curriculum methods for clinical ethicists, examining additional contemporary efforts in hospital-based bioethics programs may alleviate some of this discussion's practical concerns.<sup>185</sup>

### 5.2.3. Additional Contemporary Efforts in Hospital-Based Bioethics Programs

While this discussion emphasizes key curriculum components that ought to be added to American bioethics programs to professionalize the discipline, it is extremely beneficial to examine existing efforts of implementing hospital-based bioethics programs. The most formidable effort made derives from Renzo Pegoraro, Giovanni Putoto, and Emma Wray's efforts for establishing hospital-based bioethics programs for European countries (EHBP). Examining Pegoraro, Putoto, and Wray's program is intended to assess the provision of bioethics education in European countries and subsequently implement a model of bioethics courses in these participating countries. By examining their techniques, a greater understanding of how the proposed curriculum components in this analysis can be implemented into American bioethics is elucidated.<sup>186</sup>

#### 5.2.3.1 The European Hospital-Based Bioethics Program Model

Similar the discussion regarding technology in chapter two, the European hospital-based bioethics program model established in Pegoraro, Putoto, and Wray's text, *Hospital Based*



*Bioethics: A European Perspective*—henceforth referred to as Pegoraro’s text/project—was first inspired by the advances in science and technology and the changes these advances have had on health care.<sup>187</sup> The increased benefits of technology and science in health care have arguably presented an equal number of ethical concerns. While hospitals serve as a venue that promote collaboration of multiciliary expertise, a troubling dichotomy exists when an amalgam of professionals gather in this type of venue. The collaboration of expertise yields the potential for extremely beneficial advancements in medicine and medical practice. However, there also exists the potential for clinical dilemmas.<sup>188</sup>

Pegoraro’s text tackles this troubling dichotomy by establishing The European Hospital Bioethics Program (EHBP). This program was assembled by a bioethics team from ten European countries: France, Germany, Italy, Lithuania, the Netherlands, Poland, Portugal, the Slovak Republic, Slovenia, and the United Kingdom. By first identifying the objectives of these countries and the EHBP, a greater understanding of Pegoraro’s project and the beneficial components it possesses for establishing a professional training program for American bioethicists. Additionally, examining the objectives and qualities that comprise the EHBP has the potential to grant greater insight into the applicability and effectiveness of the proposed curriculum components presented in this analysis.<sup>189</sup>

Five primary objectives are presented by Pegoraro. These objectives are presented to demonstrate the commonality of bioethical goals between the ten countries that comprise the EHBP and solidify the ideal curriculum these countries would like to see in a hospital-based bioethics program. First, the EHBP seeks to assess the accessibility of bioethics education in hospitals. This objective is intended to develop base-line data and aids in assessing the overall need for Pegoraro’s project. Specifically, and, contrary to the ASBH’s efforts, Pegoraro’s

approach intends to assess the broad range of western and central-eastern European countries' need for a hospital-based bioethics program.<sup>190</sup> Astutely, Pegoraro's program attempts to assess the needs of these countries by referring to the contents and methods of existing programs. Second, Pegoraro's project uses the baseline data assessment from objective one to develop a bioethics course model that is subsequently tested in participating countries. Third, Pegoraro's project turns its focus to hospitals as the main venues for bioethics education. This method is extremely relevant for implementing clinical bioethics programs since hospitals serve as quintessential venues for the dissemination of clinical bioethics and care for a multitude of populations.<sup>191</sup>

The first three objectives of Pegoraro's project demonstrates the assessment tactics and justification for hospital-based bioethics programs. Although published in 2007, this tactic is not a completely novel endeavor. Since the move toward bioethical practice in medicine in the 1960's, various strategies and methodologies have been developed to assist the dissemination of ethics education to providers, patients, and other involved stakeholders. However, isolating expertise in a singularity has been a difficult endeavor. This analysis asserts that Pegoraro, the ASBH, and the EHBP's efforts share commonality in their objectives and scope of practice. The fourth objective of Pegoraro's project exemplifies this point by seeking to establish a common framework on clinical bioethics that is specifically designed for hospitals in European Union countries and countries of Central-Eastern Europe.<sup>192</sup> While the ASBH's attempts at a bioethics program for clinical ethicists is focused on American bioethics, the overall theme of establishing a methodology and education framework for a concentrated group of hospitals remains consistent. Naturally, the differences between European and American medicine vary greatly. Still, the ethical interventions that are shared between these two camps are consistent and, for the

most part, agreeable with one another. While bioethics methods inevitably require malleability between these camps due to the varying cultural practice of medicine, both camps share the understanding that bioethics requires flexibility in its practice.<sup>193</sup>

Finally, the fifth objective of Pegoraro's project aims to create a network of hospitals that are focused and dedicated to establishing an interactive bioethics forum. This objective is unique and lacking in American bioethics efforts. Since the sharing of ideas promotes the convergence of information, it is only practical to share findings with neighboring hospitals in like-minded health care systems. While the United States attempts to accomplish this objective by hosting bioethics conferences, forums, and collaborative conventions, there is no unifying method of bioethics education to share with neighboring hospital systems. In this respect, Pegoraro and the EHBP's methods of networking bioethics education is an excellent catalyst for establishing a unified methodology for teaching hospital-based bioethics. While there inherently lie differences in culture that do not allow a 1:1 conversion or sharing of bioethical teaching methods, there are significant benefits the ASBH and EHBP can gain from one another.<sup>194</sup>

Unlike the ASBH and EHBP, the analyses presented in this dissertation do no attempt to develop a hospital-based curriculum. Instead, this analysis attempts to introduce key components for an ethics consultation curriculum. While these curriculum points may manifest in academic circles, they are intended to apply to a wide array of educational venues including hospital-based programs. To develop a greater understanding of the EHBP's task and the applicability of the key curriculum points mentioned in this analysis, a deeper examination into Pegoraro's project and his shift from deontological ethics helps explain the overall function and benefit of virtue ethics and the development of analytic moral reasoning skills.<sup>195</sup>

### 5.2.3.2 Pegoraro's Shift from Traditional Deontological Methods in Medicine

While the objectives mentioned in Pegoraro and the EHBP's model are effective for European bioethics education in hospitals, there are inevitable cultural changes that must take place in American hospital systems if these methods are to come to fruition. Detailed in chapter four of this analysis, American bioethics has deep seeded roots in traditional deontological methods of evaluation. In his analysis, Pegoraro identifies this issue in European bioethics, too. The traditional deontological structure Pegoraro describes is an integral part of the inception of bioethics. However, Pegoraro notes that adjustments and amendments to deontological structures in bioethics are a necessary component to forming a formidable and unified method of hospital-based bioethics education.<sup>196</sup>

Traditional codes like the Hippocratic oath have received criticism when viewed through a traditional deontological lens. Focusing upon innate rules and principles that govern and guide clinical decision-making have a relevant function. However, the same rigidity behind these rules can cause issues when adoption to the changing tides of health care. Pegoraro emphasizes this point in his first chapter by discussing the impact the human rights movement has had upon global health care. While deontology initially held its roots in moral justification, Pegoraro argues that the deontological structure, instituted by Immanuel Kant, has transformed into a medically relevant deontology.<sup>197</sup> Events like the establishment of the European Union Code on Medical Ethics have presented expanded principles upon which practitioners and ethicists alike ought to become familiar with due to the changing tide of medical expertise and technological advances. While this is not a shift from deontology, establishing new principles aids the necessary efforts in professionalizing bioethics as a normative discipline. Many scholars argue that the adaptation of principles that Pegoraro emphasizes is the very function deontology is

designed for. However, shifts in deontological structures and principles have helped shape Pegoraro's project and thus aided in forming the EHBP's hospital-based bioethics program.<sup>198</sup>

Additional points that Pegoraro mentions that indicate the shift in deontological structures in bioethics education entail the establishment of the American Medical Association's Code of Ethics, the introductions to informational technology, the Bioethics Committee of the Council of Europe (CDBI), and the European Group on Ethics (EGE). All the examples presented by Pegoraro's analysis demonstrate the need to adjust principles founded upon deontological foundations to adapt to changing tides in bioethical reasoning and thus aid in solidifying a progressive education program for hospital-based ethics.<sup>199</sup> Specifically, Pegoraro notes that these adjustments are primarily driven by the changing tide in technological advancements in health care. Pegoraro notes that this shift transforms deontology into a medical deontology. Medical deontology services as a specific guiding principalistic method for abiding by rules. However, this shift also occurred due to the drastic change influenced by the human rights movement. Pegoraro notes that the European Convention of Human Rights (ECHR) tremendously influenced the dichotomy between legality and ethically fortuitous approaches.<sup>200</sup>

The shift from legality to a deontological structure that accommodated impending principles led to the establishment of European International Legal Instruments in the Field of Biomedicine. These instruments intended to establish a connection between human rights and health care and combine them with the care context that human rights stand for. Pegoraro presents important rights that are established based on legal provisions of bioethics:

1. Human beings have a right to be treated with respect and dignity
2. Human beings have the right to the highest attainable standard of physical and mental health
3. Human beings have the right to consent or to refuse medical interventions including those related to research

4. Human beings have the right to protect against arbitrary interference with privacy or with family
5. Human beings have the right to enjoy the benefits of scientific progress and its application
6. Human beings have a right to protection for their rights, especially for vulnerable persons

The six rights Pegoraro presents are not inherently different from the rights outlined by American bioethics efforts. However, in American bioethics, these rights are often presented on an individual-basis per a hospital's patient's rights guidelines.<sup>201</sup> Pegoraro's point is that these rights ought to be inherently entailed within the preview of bioethical practice. The above-mentioned rights are not completely alien to American bioethics. However, due to the nature and scope of the cultural differences between European and American bioethics, the above-mentioned rights, although ideal, do not abide by the cultural norms in American biomedical ethics. With the above-mentioned rights in mind, Pegoraro notes that the process of understanding the role and place of bioethics in health care require examinations at other normative approaches that have shaped the relationship between health care providers, society, and ethicists.<sup>202</sup>

The two final points that Pegoraro notes in his assessment regard tradition and the power of bioethics holds on other disciplines. First, the professional codes of medicine and ethics provide a historical background for the development of a modern clinical ethics program for budding clinical ethicists. The legal, professional, and moral aspects of this facet of development must become inherently entailed within the development of a formidable hospital-based bioethics program. However, bioethics as a traditional discipline, according to Pegoraro, trumps the secondary and tertiary aspects of ethics mention in his analysis. Second, Pegoraro notes that philosophy and other humanities have a tremendous role in establishing a formidable bioethical education program in hospital-based ethics. In this respect, Pegorara's analysis bolsters the need

and effectiveness of the key components for an ethics consultation curriculum mentioned in this analysis.<sup>203</sup>

To palliate the issues associated with an alternative bioethics program, it is important to note that Pegoraro's attempts at creating a viable hospital-based bioethics program is indeed successful in the context he proposes. While every facet of his approach may not become strictly applicable to American-based bioethics programs, the key curriculum points mentioned in this analysis have the potential to be applied to both European and American bioethics curriculums, despite the original derivation of curriculum points from an American bioethics perspective. The key components of virtue listed in this analysis that ultimately develop analytic moral reasoning skills for clinical ethicists aid Pegoraro's program by implementing a method that shifts from the deontological framework Pegoraro criticizes. Although categorized under applied program issues in this analysis, Pegoraro and the EHBP's efforts aid this discussion's efforts in accepting new curriculum points for hospital-based bioethics programs. By implementing Pegoraro's methods, the inherent morality of clinicians may be examined further and aid this analysis' overall goal of implementing uniform curriculum points for budding clinical ethicists.<sup>204</sup>

### 5.3. Conclusion

Professional ethics within organizations is of the utmost importance in contemporary health care. Organizational ethics serves as a venue that formally introduces, collaborates, and professionalizes health care.<sup>205</sup> While the organizational aspect of professional health care is important for the overall organization and structure of a health care institution, the ethical components associated with a health care organization further bolster the mission, identity, and core values that aid an organization's flourishing.<sup>206</sup> This analysis attempts to demonstrate the effectiveness of virtuous practices in health care organizations in an effort to examine the

possibility of establishing an ethics consultation training curriculum that supports the curriculum points mentioned in this analysis.

By implementing virtue ethics throughout a health care organization, analytic moral reasoning skills are subsequently developed and honed throughout the system. Fostering these skills has an array of positive outcomes for the entire organization.<sup>207</sup> By training individuals to identify instances of excess and deficiencies of virtue, individuals inevitably ascertain instances of virtuous practice by understanding its antithesis. Identifying virtue and its deficiencies or excesses cultivates an organizational atmosphere that promotes moral agency throughout its system.<sup>208</sup> This process is completed by introducing virtue-identification techniques as mandatory competencies throughout a health care organization. Synonymous with the ASBH's core competencies for clinical ethics consultants, establishing virtue identification techniques as mandatory competencies both promotes an ethical atmosphere and recognizes the mission and identity of an institution as the pinnacle of moral professionalism.<sup>209</sup> The subsequent moral agency derived from analytic moral reasoning and virtue identification facilitates conflict resolution techniques by bolstering moral cooperation. Furthermore, ethical leadership becomes a far more important role due to the hierarchical nature of health care organizations and the influence upper management possesses.<sup>210</sup>

Since clinical ethicists are the most qualified individuals for facilitating virtuous behaviors in a health care system, a formal education in the form of a residency program expedites the integration of virtue throughout an institution. The integration of virtue ethics into organizational curriculums justifies the virtuous nature involved in the profession of clinical ethics and demonstrates the need for both formalizing ethics education in health care organizations and implementing virtue ethics as a standard competency.<sup>211</sup> While a robust



philosophical background is an extremely helpful asset for clinical ethics consultants, it is simply impossible to expect a multidisciplinary field like bioethics to accommodate individuals who possess this prerequisite. Alternatively, a health care organization's educational emphasis on virtue-identification techniques yields a set of analytic moral reasoning skills that serve as a profound substitute for an extensive background in moral theory. These analytic moral reasoning skills are fundamental and infinitely useful due to their ability to bolster and adopt practical competencies, promote ethical character, and further establish an organization's duties toward stewardship and integrity.<sup>212</sup>

While a residency program indicates a formidable venue for hosting the key components mentioned in this analysis, there are inherently various issues that accompany this task. First, the cultural attitude in medicine toward clinical ethicists continues to thwart professional efforts in establishing a comprehensive ethics residency program. The analysis indicates that this issue, among others, has the potential for resolution if the sole-consultant model is adopted in hospital medicine. The sole-consultant model expedites a cultural shift in medicine by palliating the fears of health care professionals and educating professionals about the role and scope of clinical ethics.

Additionally, issues that inhibit formidable ethics presences in hospital settings include the lack of information other departments possess concerning ethics consultation. While clinical ethics consultants are viewed to focus on bed-side ethics, there are various venues where ethics expertise can help an entire hospital system. Departments like compliance, risk management, and quality improvement can benefit from clinical ethics expertise since patient care is at the center of their practice. Identifying the gaps in knowledge surrounding clinical ethics knowledge and

implementing this information to a larger hospital system aids the effort in establishing clinical ethics residency programs in health care systems by assisting a cultural paradigm shift.

Finally, one of the final points of this analysis introduce existing efforts in implementing hospital-based ethics programs in Europe. By examining Renzo Pegoraro's attempts at assessing and establishing a hospital-based ethics program in Europe, the ASBH can learn a tremendous amount in their current efforts. Methods of extracting and assessing data regarding the demands of clinical ethics is an excellent way of beginning this process. Additionally, assessing the philosophical paradigms a program of this magnitude exemplifies aids the American effort by extracting effective methods of introducing ethics to an otherwise resistant system. However, the issues that accompany modeling an American model of hospital-based bioethics programs from Pegoraro's program lie in cultural differences in medicine and health care. While Pegoraro and the EHBP's efforts have proved to be effective in the ten participating European countries, establishing a clinical ethics residency program that accommodates the way in which health care is performed in the United States becomes an onerous process.

This analysis argues that the key curriculum components mentioned in this discussion are malleable and powerful enough to apply to both American and European bioethics programs. The adaptability of these components inherently contains the purpose and functionality of virtue-identification in clinical ethics. While the purpose of this discussion is not to establish a novel curriculum, nor is it to develop a school for ethics, it is intended to introduce a small, yet powerful educational component that ethicists must become familiar with in their training. Identifying the issues surrounding ethics consultation programs aids this process by examining if introducing these curriculum components are even tenable. However, this discussion argues that, despite the cultural issues surrounding clinical ethics, the key curriculum components mentioned

in this analysis inevitably bolster training programs for ethicists in a positive and pragmatic fashion.

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## Chapter 6: Conclusion

The purpose of this dissertation is to introduce key components for an ethics consultation curriculum. The otherwise lack of a professional standard of certification and accreditation for clinical ethics consultants presents a tremendous opportunity for clinical ethics programs to build formidable curriculums for budding ethicists. The dissertation addresses a lack of key curriculum points by presenting a critical account of professional ethics consultation which aids in developing a robust curriculum for certification and credentialing clinical ethics consultants in the United States. The curriculum for certification and credentialing clinical ethics consultants is one that requires structure, malleability with cultural paradigm shifts, and the ability to ethically accommodate technological advancements. However, rather than establishing a definitive lesson plan for clinical ethics consultants, this project emphasizes the key components of a curriculum with the core purpose of combining knowledge points with skills. In doing so, analytical reasoning for clinical ethics consultants becomes bolstered in a manner that meets accepted professional standards in other fields.

Chapter one outlines the project's argumentative road map by discussing the emergence of clinical ethics, outlining the methods & standards of clinical ethics consultation, providing instances of moral reasoning, demonstrating ethical facilitation and virtue techniques, and culminating with issues surrounding the implementation of the suggested key curriculum points. This final point is addressed in manner that additionally assesses the issues that surround developing residency requirements for clinical ethics consultants. The basis and need for the dissertation's thesis lies in the current lack of formal accreditation standards for ethics consultants. This lack devalues the quality and abilities of clinical ethicists. Additionally, the lack of accreditation standards diminishes clinical ethicists' expertise, credibility, and purpose

amongst a community of trained professionals, families, and patients. While the most formidable standard of clinical professionalism in ethics lies in the possession of academic degrees, these degrees do not always hold a firm basis in practical applications in relevant venues like hospitals. The chapters that follow the dissertation's introduction address the thesis by outlining the historical facets that surround the emergence of clinical ethics, the standards of clinical ethics consultation, the moral reasoning involved with ethics facilitation and virtue, and the venues in which the proposed dissertation's key components become implemented.

Chapter two provides a historical and contemporary analysis of health care ethics consultation. This introductory tactic justifies the establishment of a formidable and reliable curriculum that encourages and promotes the need for formal certification standards. While the history and development of clinical ethics has arrived at a practice that emphasizes facilitation, this dissertation possesses its foundation in a mutual relationship between the knowledge and skills involved in health care ethics and moral philosophy. The importance of a curriculum that focuses on knowledge and moral philosophy as prerequisite bases for ethical skill sets yields a stronger standard for professionalizing clinical ethicists. The project presents this historical analysis of clinical ethics by tracing a relevant history of moral philosophy and deriving the philosophical origins of autonomy, paternalism, and consent in contemporary American health care. The lineage of these themes demonstrates the foundations of moral theory in a manner that solidifies the importance of critical analysis in clinical ethics. The chapter subsequently discusses how relevant philosophical literature and theories have evolved into contemporary methods and theories for ethics consultation. These facets of the argument are expedited with a discussion surrounding clinical consent and emerging genetic technologies. This discussion serves as a

stepping stone that aids the argument by demonstrating the effectiveness of philosophical analyses in clinical ethics and further develops clinical ethics as a normative discipline.

Beginning with a formal historical analysis, part 2.1 discusses the lineage of clinical ethics. With clinical ethics' origin in the philosophy of Hippocrates, the discussion demonstrates the Hippocratic influence ancient moral theory has placed upon modern ethical thinkers like Thomas Percival, Richard Cabot, and Chauncey Leake. The adoption of ancient theories through these modern ethicists has historically developed into a pragmatic approach to health care ethics. However, while the pragmatic approach to clinical ethics aided the development toward formalized contemporary ethical standards, these standards require a philosophical approach that accommodate evolving medical technologies.

Part 2.2 addresses the historical demand for a clinical ethics methodology that accommodates the changing tides of technological developments in medicine. This task is accomplished by demonstrating the dangers that accompany man's relationship with medical technologies and the philosophical considerations that aid in facilitating moral judgments regarding technological advancements. The discussion elaborates this point by specifically addressing the dangers of modern genetic technologies under the framework of German phenomenologist Martin Heidegger. Though historically noted for his work in ontology, Heidegger's essay *The Question Concerning Technology* aids the historical analysis portion of the proposed dissertation by illustrating the effectiveness philosophical approaches possess in resolving modern ethical discrepancies. This discussion aids the dissertation's thesis by stressing the importance of a clinical ethics consultant's ability to analytically reason amidst value discrepancies and moral uncertainty.

Chapter three introduces the variety of clinical ethics consultation methods that possess

contemporary relevance. Part 3.1 begins this discussion by analyzing and amalgamating the beneficial aspects of various clinical consultation methods while simultaneously establishing a philosophical basis for these methods. This task begins by defining clinical ethics in a manner that effectively depicts the goals and functions of consultation methods. Part 3.1 further explains these points by framing a clinical case around the foremost contemporary clinical consultation approaches including Johnson's Four Topics method and Orr and Shelton's Process and format approach. In doing so, the discussion subsequently weaves beneficial aspects of existing consultation methods with thematic philosophical qualities.

Part 3.2 investigates the existing literature regarding the standards of consultation affairs and the state of accreditation methods for clinical ethics consultants. While part 3.1 of this chapter aids the discussion by tracing relevant ethical themes throughout contemporary consultation models, part 3.2 assesses efforts made to formalize clinical ethics consultation practice by the ASBH and its CECA subcommittee. The section explains the current demand for qualified clinical ethics consultants and the ways in which the ASBH and CECA have attempted to accommodate this demand. While the chapter also details the progress of formal certification efforts, the discussion also attempts to demonstrate skills and skill-based assessments required of clinical ethics consultants. In doing so, chapter three identifies lapses in contemporary efforts to professionalize clinical ethicists and indicates a need for a refined philosophical basis for the certification of clinical ethics consultants.

With the important aspects of clinical ethics consultation methods extracted and the state of contemporary certification efforts articulated, the proposed dissertation migrates to a discussion surrounding the importance of virtue-identification for clinical ethics consultants. Chapter four indicates the knowledge and skill-based facets of clinical ethics. Knowledge areas



such as informed consent, conflicts of interest, refusal to treat, and medical futility are all necessary knowledge components for clinical ethicists. However, these components, among others, must become understood by ethics consultants with an accompanying ability to philosophically deliberate with analytic moral reasoning skills. These skills aid a consultant's ability to mediate conflict and deescalate volatile situation. Chapter four indicates that analytic moral reasoning skills inherently develop by identifying virtue in practical instances.

Part 4.1 illustrates the importance of virtue-identification. Identifying virtue in health care reveals the philosophical underpinnings of moral decision-making and the proper methods of facilitation involved in health care ethics consultation. The discussion achieves this task by detailing moral accounts of Immanuel Kant's deontological structure and Aristotle's virtue theory. In doing so, philosophical methods of identifying virtue emerge and permeate the necessary facets of clinical ethics consultations.

Part 4.2 expands upon its preceding counterpart by implementing these moral accounts. This approach demonstrates the effectiveness of virtue identification in a research ethics context. Applying the knowledge and skillsets acquired by identifying virtue to a research ethics context aids the discussion by demonstrating the practicality of virtue identification. Additionally, analytic moral reasoning skills derived from virtue identification aid the discussion's goal of identifying key components in an ethics curriculum by indicating the importance of a clinical ethicist's understanding of research ethics. The project's emphasis on virtue identification and the inherently acquired moral reasoning skills promotes a clinical ethicist's ability to provide constructive recommendations amidst value-laden discrepancies in therapeutic and experimental research. Chapter four ultimately demonstrates the crux of the argument's goal by exposing the

key curriculum points that ought to be entailed within developing clinical ethics consultation training programs.

Chapter five applies the key components identified in chapter four to a venue in which budding clinical ethicists may hone analytic moral reasoning skills. The chapter argues that formalized certification programs, that include the proposed curriculum components, are possible if the practical skills established by the ASBH and CECA are amalgamated with the analytic moral reasoning skills derived from virtue identification. Part 5.1 begins with a discussion surrounding the practicality of merging a virtue-based curriculum with a residency program for clinical ethics consultants. This task is achieved by examining the proposed dissertation's task through an organizational ethics lens. Part 5.1 also emphasizes the importance of a clinical ethics consultant's knowledge regarding institutional ethics by discussing the interdisciplinary function of ethics across various hospital departments. While bed-side departments require clinical knowledge, the proposed curriculum points that manifest in a residency program also apply to departments like spiritual care, care coordination, and risk management. In doing so, part 5.1 describes the practicality of implemented virtue-based curriculum points into educational venues like residency programs for clinical ethicists. The argument in part 5.1 concludes with the way the key components described in this analysis manifest and how a philosophical basis in virtue benefits the overall goals of clinical ethics consultations.

Part 5.2 further explains the criteria of a residency program for clinical ethicists by expanding upon the practical aspects of the project as well as the difficulties that accompany this approach. Specifically, chapter five emphasizes the issues that accompany both the establishment of a credentialing program for clinical ethicists and the way in which the proposed key curriculum components can become implemented into said programs. Since there are literally

hundreds of residency programs throughout the United States, each residency program inevitably requires modification to accommodate a virtue-based curriculum component for ethicists.

Additionally, each residency program that adopts this approach must structure these new elemental aspects of a curriculum around an individual hospital's guidelines and certification standards. The project discusses the practical instances where the proposed curriculum points may manifest in section 5.1, including written exams, portfolios, and bedside charting, all of which are accessible to training programs for other health care professionals. However, the issues mentioned in 5.2 demonstrate the difficulties that accompany the proposed venues in which the key curriculum points may become implemented into a certification program. Issues surrounding the cultural acceptance of clinical ethicists in hospital medicine, viewing ethics consultation as a service, and identifying the extent of ethical utility throughout a multitude of health care departments aids the discussion's goal of implementing curriculum components.

Section 5.2 discusses the importance of examining existing efforts of establishing an ethics consultation curriculum in hospital-based medicine. The section details the efforts of Renzo Pegoraro, Giovanni Putoto, and Emma Wray, and the establishment of the EHBP. By examining a rather successful attempt at developing a hospital-based ethics training program in Europe, the analysis can assess the issues of translating this effort to American bioethics programs. While the European model is effective, especially regarding the shift from standard deontological methods, a hospital-based bioethics program is only as effective as the skill and knowledge points it attempts to teach. This analysis asserts that the virtue curriculum points identified in this discussion are applicable to any bioethics program that attempts to educate clinical ethicists. While Pegoraro, Putoto, and Wray's approach demonstrates an effective means of delivering information to clinical ethicists, their program has the potential to flourish further

by implementing elements of virtue identification and subsequent analytic moral reasoning skills.

Despite the difficulties that accompany a residency program for ethicists, the dissertation asserts that a residency program for clinical ethicists that is rooted in analytic moral reasoning and virtue ensures proper educational aspects of clinical ethics. Although issues like cost, resource allocation, employment, cultural acceptance, and continuing education are still present, this dissertation indicates the possibility of a residency program for ethicists that is rich in moral theory. This type of residency program is rooted in a curriculum that contains necessary knowledge and skill components that an ethicist must possess if he seeks to perform consultations, clinical meetings, and institutional facilitation effectively. Furthermore, unlike other attempts at establishing professional training programs for clinical ethicists, the dissertation presents a unique approach by introducing specific educational points. If clinical ethicists intend to receive a proper education that aids in their universal acceptance as professionals, ethicists must become moral stewards in their practice. By training clinical ethicists to become moral stewards with the proposed key curriculum components, any existing or future credential program that aims to professionalize clinical ethicists inevitably possesses educational components that ensure the proper development and practice of moral facilitation, ethical leadership, and analytic moral reasoning.

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