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To the Graduate Council:

I am submitting herewith a dissertation written by David Joseph Perlman entitled "Transformative ethics consultation : a supplement to ethics facilitation for emotionally charged health care value conflicts." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this dissertation and recommend its acceptance:

John Hardwig, Julia Malia, Linda A. Rankin

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

To the Graduate Council:

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Glenn C. Graber, Ph.D.
Dissertation Director
Department of Philosophy

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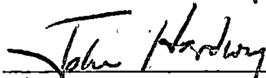

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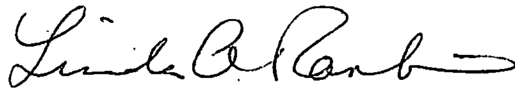

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Transformative Ethics Consultation

A Supplement to Ethics Facilitation for Emotionally Charged Health Care Value Conflicts

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

David Perlman
December 2000

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Dedication

I dedicate this dissertation to my late father, Herman "Perl" Perlman (1945-1993), perhaps the best natural mediator I have ever observed. "Blessed are the peacemakers."

I also dedicate this dissertation to my fiancée and best friend, Kristine Lydia Biggie. Love is perhaps the best mediator.

Acknowledgments

Many people have helped me achieve this stage of my education. My parents, who stressed the importance of education above all else, receive my highest acknowledgment. My fiancée and best friend, Krisy, deserves equal acknowledgment—she is the one I credit with keeping me focused on my task during my more "irrational" moments and for providing invaluable clinical guidance for the case studies.

This work would not have been possible without the advice and guidance of my dissertation committee, Glenn Graber, John Hardwig, Julia Malia, James Nelson (a former member), and Linda Rankin, and the support of the faculty and my graduate student colleagues in the Department of Philosophy. Special thanks to Jennifer Chassman, Chris Crittenden, Nancy Dumler, Lisa Eckenwiler, Terri Mellinger, James Okapal, and Barbara Russell. My dissertation reflects my interdisciplinary nature; Grayfred Gray, School of Law, and Steve Martin, Conflict Resolution Program Director, deserve acknowledgment.

The Leopold Schepp Foundation provided generous funding of my doctoral education, without which I would never have been able to produce this dissertation. Financial support from the Institute of Human Values and Health Care, where I was a Fellow and Fellowship Coordinator at the Medical University of South Carolina in Charleston, helped immensely. The Institute's Director, Dr. Robert Sade, provided invaluable advice, encouragement, and support, as did the Fellows (1998: Katherine

McGrath and Cynthia Haney and 1999: Hugh Lena, Jason Arnold, Angela Wasunna, Bob Blank, and Matt Stolick).

The quality of this dissertation is due in large part to a number of readers. I owe a great debt of gratitude to Mike Keene, the course director for Writing for Publication, and my dissertation coaches along the way, John Doggette, Sarah Townsend, Cynthia Haney, and Glenda Lee Thompson. Connie Perry and Eve DeVaro provided feedback for Chapter Seven.

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Finally, a debt of gratitude must go to Marie Horton and Ann Beardsley, the Department of Philosophy secretaries, who were always there with kind words and candy.

Abstract

An emotionally difficult case of withdrawing artificial food and water from a patient in persistent vegetative state prompts consideration of the role of empathy and emotion in health care ethics consultation. Rather than viewing ethics consultation purely in terms of consultant-initiated ethical and largely cognitive analysis followed by interpersonal facilitation of consensus, this dissertation seeks a process to address emotion early and to cultivate empathy as a collective responsibility among patients, surrogates, and clinicians.

Moral decision-making and thus ethics consultation must integrate the emotional and cognitive processing of value perceptions and judgments. Promoting integration during ethics consultation encourages participants to adopt a moral orientation of respect and concern that facilitates consensus-building in emotionally charged value conflicts. Phenomenologists Jürgen Habermas and Arne Vetlesen describe this process as overcoming one's own perspective in order to understand the interests and perspective of one's fellows. By adapting this phenomenological sequence to ethics consultation, the dissertation culminates in the presentation of a two-step process, transformative ethics consultation (TEC).

If consultants identify an emotional tension early, TEC can serve as a supplement to the identification and analysis of the value conflict or uncertainty. The first step of TEC allows consultation parties to explore, express, and have their emotions validated by the consultant as an initial empathy-building phase. The second step attempts to extend

empathy to all parties in such a way that each party understands the other. Extending empathy thus encourages shared moral ownership of the problem and the process for its resolution. To illustrate the two steps of TEC in action, I analyze the case that sparked the dissertation and present another to supplement the argument.

In the final chapter, I address two potential challenges to TEC—that it is equivalent to bioethics mediation and thus open to the pitfalls of bioethics mediation as a stand-alone consultation modality. I rebut both of these challenges. I overcome the first by arguing for a new understanding of impartiality in ethics consultation that comports with the spirit of ethics facilitation. I defend against the second by suggesting that TEC skills can be easily adapted for use outside of or after ethics consultation as a means to ameliorate the moral distress associated with emotionally charged value conflicts.

Preface

> "When all the hard work applied in one direction fails to produce results, the good thinker does not give up but starts over."
>
> —Sidney Callahan, 1991, p. 68.

This dissertation represents a personal and a professional achievement for me. It is a personal achievement because of my dedication to the practice of mediation and my desire to connect this area of interest to my professional training in philosophy and bioethics. Most important to me, however, was the fact that the dissertation process was a lesson in personal perseverance, since the early work on the dissertation yielded a first draft that was unacceptable. The latter fact helps connect the personal achievement to my professional development as a scholar.

It is fitting that the title for this section is 'preface.' While this dissertation represents an end product to my graduate career, the ideas examined, expressed, and promulgated in it are merely the beginning of the research I plan to do on the topic. Nevertheless, to defend the philosophical and bioethical relevance, timeliness, and the topic's contribution to the field, I provide a brief synopsis of how this work began and proceeded.

Bioethics is an interdisciplinary field. A graduate student friend once described doctoral education as a gourmet meal, whose individual courses were to be savored. With these two ideas in mind, I decided to take several classes outside of philosophy. Death, Dying, and Bereavement was a natural first choice, as much of bioethics deals with how to provide good quality end-of-life care. In an early class on clinical ethics, I became

interested in the role of the clinical ethics consultant—a person, perhaps with philosophical training, who, as one job requirement, would help resolve value conflicts and uncertainties in health care. A clinical ethics consultant would need not only bioethics and health care knowledge, but also interpersonal skills in facilitation, mediation, and conflict resolution, the literature collectively suggested. The next semester I enrolled in a mediation course with Dr. Julia Malia to gain initial competency in the skills needed to address health care conflicts. Upon seeing the almost universal application of the skills I was learning as a mediator, I became interested in whether mediation might be adapted for use as an ethics consultation modality.

This interest started as practical in nature, but soon grew to include scholarly fascination. As a philosopher, the scholarly challenge was to determine how such a practical conflict resolution process as mediation might pose interesting questions for philosophical analysis. An interesting confluence of factors helped in formulating such questions and in pointing to potential sources to consult for some answers. First, two of the major professional societies governing bioethics, the Society for Health and Human Values and the Society for Bioethics Consultation, formed a Task Force (the SHHV-SBC Task Force on Standards for Bioethics Consultation) to investigate and promulgate competencies for ethics consultants and a process for conducting consultations. The field of ethics consultation was in its infancy, and I recognized that my work in adapting mediation to ethics consultation might find room in the burgeoning discussions of what role and process would be appropriate for conducting consultations. Second, work by many ethics consultants in the field was leaning towards an approach that argued for the

integration of interpersonal skills with bioethics knowledge. The 1994 book edited by Françoise Baylis' is a good example in that it traces the evolution of ethics consultation from a largely cognitively-focused attempt to clarify values to a more balanced approach to moral problems combining clarification of values with interpersonal facilitation of differences. I detail this evolution in more detail in Chapter Two of the dissertation. Third, the feminist literature had sparked a renewed interest in the role of emotion and relationships in morality and moral decision-making. Why this factor became important in my work will become clear in a short time. And, finally, use of the concept, process, or word 'mediation' was increasingly being used to describe the activity of consultants conducting ethics consultations in everyday speech and in the bioethics literature. This confluence of factors was instrumental in helping define the philosophical questions that form the core of my dissertation.

Initial questions focused critically on what was ethically or morally significant about the mediation process and how its very strong process constraint of impartiality for the mediator would jibe with the more facilitative role cited for ethics consultation. This critical assessment seemed unproductive, for impartiality seemed so counter to the goals of ethics, and mediation without some form of impartiality was no longer really mediation. Rather than give up, I tried a different approach.

What was it about the mediation process that was so interesting and would prompt questions for philosophical investigation? Mediation seemed to require that parties relate to each other in a particular way—not as adversaries but as collaborative problem-solvers. How did mediators and/or the mediation process allow or facilitate the

transformation of what was usually a highly emotional and contentious issue into one that parties would willingly engage each other with civility and with dignity? Asking this question helped to abstract the early stages of mediation—which focused on building empathy and rapport and acknowledging strong emotions—away from the concern with impartiality and into a form for philosophical analysis.

If the early stages of mediation concentrate on building empathy—first between the mediator and the parties to facilitate party trust to the process, then later between the parties who must jointly collaborate in reaching an agreement, then several philosophical questions could be posed. What is empathy? How can it be developed? And what is the role of emotion in fostering empathy? These are epistemological questions, ones to which philosophers, especially phenomenologists and feminist philosophers and bioethicists, had interesting answers. Moreover, many of the ethics consultations I was involved with as a Fellow at the Medical University of South Carolina in 1998 involved a strong emotional component that ethics facilitation failed to resolve in a satisfactory manner. All of these things seemed to make interesting philosophical and bioethical topics for investigation.

Two cases in particular from my clinical fellowship experience were profoundly unsatisfying to me. At first, I did not know why I felt the way I did. By relying on the rich, interdisciplinary literature on ethics consultation, empathy theory, and the role of emotion in morality, I soon wondered whether ethics facilitation was generally unsatisfactory in cases of strong emotional components. I was a consultant in training, supervised by a veteran ethics consultant, when I observed and participated in these

cases. For use in this dissertation, I have changed many of the background features and the names of the participants to protect confidentiality.

Around this time, the SHHV-SBC Task Force finalized its work and produced a report, which was endorsed and published by the newly formed American Society for Bioethics and Humanities. The report, *Core Competencies for Health Care Ethics Consultation*, argued that ethics facilitation was the most appropriate process to use in conducting ethics consultations. It is fortunate that this process was the one the ethics consultants used in the two cases whose resolution was unsatisfying to me, for it could serve as starting point for exploring whether there might be substance to the way I felt about the cases.

My analysis of *Core Competencies* in relation to the two highly emotional cases revealed two potential shortcomings with ethics facilitation. The first is that much of the early work in ethics facilitation focuses—wrongly I would argue—on cognitive analysis of the ethical problem or uncertainty by the ethics consultants. What is often needed in such cases is acknowledgment of the emotions present and building of empathy between parties and consultants and then between the parties themselves. The second shortcoming builds on the first. *Core Competencies* endorses empathy as a skill that ethics consultants should possess to help parties deal with their feelings. However, the skill comes late in the process and does not capture recent philosophical and psychological understandings of empathy as a means of establishing dialogue between those who "own" a moral difficulty.

With these two shortcomings identified in relation to two cases with strong emotional components, I hypothesized that a more nuanced conception of empathy was needed in ethics consultation. The phenomenological literature on empathy and perception lent itself nicely to establish this claim and suggested the two steps that could act as a supplement to the shortcomings of ethics facilitation. Since these two steps concern the transformation of empathy into a collective responsibility between consultation parties, I termed my supplemental process transformative ethics consultation (TEC).

The first step should concentrate on establishing what phenomenologist Jürgen Habermas considered the collective will to engage in moral dialogue. When strong emotions threaten to polarize the attempt to engage in moral dialogue, attention to the emotions, their role in the emerging dialogue, and how to achieve integration of emotion with reason should be the first step. Several sources from the bioethics and mediation literature provided additional evidence for this claim. Self-reflection designed to facilitate the expression of emotion, followed by acknowledgment of emotion by others helps to reformulate strong emotional impulses in ethics consultation, authors argued. The ethicist's ability to establish empathy with the parties by acknowledging their feelings is antecedent to the ability and willingness of the parties to establish empathy, respect, and concern for each other later in the process, other authors argued.

Relying once again on Habermas and work by his student, Arne Vetlesen, after acknowledging emotion, the second step should concentrate on helping parties to overcome their own viewpoint and take the interests of others into account in the

emerging moral dialogue. Each participant must see the other as a person of value, deserving of equal respect and dignity. If unable or unwilling, the ability of consultants to help forge consensus will either result in hasty or unstable consensus or a complete breakdown in the ability of the parties to engage in the moral discourse needed to reach consensus. Thus, if consultants identify an emotional tension early in the consultation process, the two steps of TEC can serve as a supplement to the two shortcomings I identified with ethics facilitation. It is in the spirit of further elucidating and grounding these claims that I wrote the dissertation that follows.

Table of Contents

Transformative Ethics Consultation: A Supplement to Ethics Facilitation for Emotionally Charged Health Care Value Conflicts

Chapter One: An Introduction to and Rationale for Transformative Ethics Consultation

Introduction 1

Part I: The Rationale for Transformative Ethics Consultation 2

Chapter Two: Expanding the Role of Empathy in Ethics Consultation Modalities

Introduction 19

Part I: The Ethics Facilitation Approach 20

Part II: Jamie's Case 46

Part III: Analysis of Jamie's Case and the Need for Collective Empathy 54

Chapter Three: The Role and Nature of Emotion and its Implications for Ethics Facilitation: The Genesis of Transformative Ethics Consultation

Introduction 66

Part I: The Neurobiology and Psychology Literature on the Nature of Emotions 67

Part II: The Integrative Nature of Morality: A Brief Review of the Psychology Literature and its Relevance to Bioethics 76

Part III: The Psychological Role of Emotions in Morality: Callahan's Cycle of Conscience 81

Part IV: The Role of Emotions in Morality: Exploring the Connection between Psychology, Philosophy, and Bioethics 90

Part V: Jamie's Case and the Genesis of Transformative Ethics Consultation 98

Chapter Four: The Role of Empathy in the Interpersonal Integration of Emotion and Reason and its Implications for Ethics Consultation

Introduction 104

Part I: Empathy and its Connection to Interpersonal Integration of Emotion and Reason 105

Part II: Empathy and Phenomenology 110

Part III: The Integrative Nature of Empathy and Personhood 118

Part IV: Empathy as Second Personhood: A Feminist Response 126

Part V: Interpersonal Integration of Emotion and Reason 140

Part VI: Consultant-Directed Empathy and Jamie's Case 158

Chapter Five: Dialogue: An Authentic, Integrative Form of Interpersonal Interaction for Ethics Consultation

Introduction 167
Part I: Callahan, Authenticity, and Character 168
Part II: Interpersonal Authenticity or Bad Faith? Bridging the Gap between Bioethics, Existentialism, Callahan, Vetlesen, and Ethics Consultation 185
Part III: Interpersonal Authenticity and the Integration of Emotion and Reason in Ethics Consultation and in Jamie's Case—Three Tests 195

Chapter Six: From Intrapersonal Authenticity to its Interpersonal Counterpart: A Transformative Model for Ethics Consultation

Introduction 212
Part I: The First Step of TEC 214
Part II: TEC and Ethics Facilitation Compared 218
Part III: Exploring, Expressing, and Validating Emotion—The First Step in Ethics Consultations with a Strong Emotional Component 225
Part IV: The Case of Mr. Sullivan 242

Chapter Seven: Engendering Collective Empathy: The Second Step in Transformative Ethics Consultation

Introduction 253
Part I: Empathy as a Collective Responsibility—Motivating the Argument 253
Part II: Consensus and Its Preconditions—The Ethics of Discourse 256
Part III: Mediation, Empathy, and the Second Step of TEC 277
Part IV: The Conclusion of Jamie's Case and Use of Transformative Ethics Consultation 292

Chapter Eight: Transformative Ethics Consultation Skills and Process: Testing the Mediation Hypothesis

Introduction 298
Part I: Critiques of Bioethics Mediation 299
Part II: The Use of Norms in Ethics Consultation: Why TEC and Bioethics Mediation are Not Equivalent 306

Conclusion: Transformative Ethics Consultation, its Shortcomings, and Ways to Overcome Them

Conclusion 315

References 330

Vita 344

Chapter One

An Introduction to and Rationale for Transformative Ethics Consultation

"When persons prevent their emotions from overtaking their rationality, it is called reason. When persons prevent their rationality from overtaking their emotions, it is called compassion. When persons can do both, it is called wisdom."

—Ancient Chinese Saying

Introduction

"What do you mean?" Rev. Williams[1] shouted, slapping his palm on the conference room table. "You're going to starve Jamie to death!"

The ethics consultants looked at each other in disbelief. The attempt to inform Mrs. Jackson and her pastor of the grim prognosis of her 21-year-old son in persistent vegetative state and the team's wish to withdraw food and water had suddenly turned into an ethics consultant's nightmare.

The patient, Jamie Jackson, had acute bilateral pneumonia, which had not responded to several last-line antibiotics, and, most recently, he has developed an acute bowel obstruction that requires surgical intervention. However, the surgeons refused to operate on Jamie until his infections cleared. The consultants proceeded to tell Rev. Williams and Mrs. Jackson that Jamie would, in fact, not die from starvation, but by dehydration if the clinicians withdrew food and water.

[1]Both cases are based on an actual ethics consultation, and many of the background features of the case, as well as the names of the consultation parties, have been changed to protect confidentiality.

"If you don't get that patient on to the gurney, I will sedate him so he can't refuse next time," shouted the surgical resident to a nurse caring for a mildly demented 78-year-old man with a large, bleeding mass over his ear.

The resident stormed off and down the stairwell. The nurses on the unit had collectively decided not to force Mr. Sullivan to surgery against his will, despite his mild dementia. The resident's threat was surely unethical and illegal. The nurses requested the involvement of ethics consultants.

The ethics consultants praised the nurses for their moral courage in wishing to uphold the right of patients to refuse treatment. But, in this case, the surgery is in the best interest of the patient, and he is not capacitated to refuse, they explained. His legal and ethical surrogate, after weighing the benefits and burdens of surgery, determined that the surgery would proceed. A nurse decided to accompany Mr. Sullivan to surgery in an effort to keep him calm, and sedation was not ordered. A meeting between the surgeons and nurses was never arranged to address the highly emotive issue that sparked the case. Despite the lack of involvement from the surgeons, involvement by the ethics consultants helped resolve the underlying clinical difficulty.

Part I: The Rationale for Transformative Ethics Consultation

These two cases illustrate the complex interplay between cognitive and emotive factors in ethics consultation. The recent American Society for Bioethics and Humanities (ASBH) report *Core Competencies for Healthcare Ethics Consultation* (hereafter *Core Competencies*) acknowledges that such an interplay of factors is a common element of

ethics consulting. In order to address both dimensions effectively, ethics consultants will need knowledge and skills designed to first identify and analyze value conflicts and uncertainties, then forge moral consensus.

Ethics facilitation involves two stages: (1) the identification and analysis of value conflicts and uncertainties, followed by (2) the building of moral consensus regarding one of the options generated at the first stage. The first stage involves fact gathering and sharing, followed by consultant use of bioethics knowledge and concepts to generate a range of ethical options for resolving the conflict or uncertainty. The second stage allows parties to voice their concerns about the options. Ethics consultants then use interpersonal facilitation skills to clarify each party's values and views regarding the options to build consensus for the selection of one option.

A recent issue of the *Journal of Clinical Ethics* contained papers discussing the ASBH report and offering additional suggestions regarding potential problems or shortcomings with the ethics facilitation process. It is in this spirit that I make my argument that in particular cases involving strong emotional components, ethics facilitation has two major shortcomings and requires supplementation. The first is that much of the early work in many consultations wrongly involves cognitive analysis by the ethics consultants, when what is often needed is acknowledgment of the emotions present and building of empathy between parties and consultants and then between the parties themselves. The second shortcoming builds on the first. Although *Core Competencies* endorses empathy as a skill that ethics consultants should possess to help parties deal with their feelings, the skill comes late in the process and does not capture recent

philosophical and psychological understandings of empathy as a means of establishing dialogue between those who "own" a moral difficulty.

In the first example, "Jamie's Case," ethics facilitation's procedural shortcoming would have the ethics consultants address the emotionally-laden but factual misconception that withdrawing food and water will starve a person to death before ensuring that the emotions underlying such a misconception have been fully explored, expressed, and acknowledged. The clinical literature clearly shows that such patients will not starve to death, but will die from dehydration. Moreover, the symptoms associated with terminal dehydration can be managed to lessen the discomfort patients experience and the anguish surrogates feel when making such a decision. But these facts will do little to assuage the sense of moral frustration that Rev. Williams' outburst displays.

In Jamie's case, the emotional dimensions of the withdrawal and starvation issue should be explored and addressed before the cognitive dimensions occur in the first stage of ethics facilitation. Perhaps Rev. Williams and Mrs. Jackson are concerned that Jamie will be abandoned, that *caring* will be withdrawn at the same time as his *care*. And perhaps this feeling of moral distress manifests itself in Rev. Williams' supposedly highly emotional outburst. Another, equally plausible, interpretation of his outburst is to highlight the fact that the clinicians do not "see" the issue as one of abandonment. By not addressing these emotional concerns and attempting to help each party see how the other is interpreting the situation, the ethics consultants risk alienating the mother and pastor and appear to align themselves with the clinicians. Once established, this power dynamic

may cause the parties' positions to become entrenched, making it next to impossible for consensus to be forged later in the process.

In the second case of Mr. Sullivan, the underlying clinical issues that sparked the case have been resolved, but residual, unexplored, highly emotional professionalism issues may continue to cause moral distress among the nurses and resentment among the surgeons after the resolution of the case. These two groups of health professionals will need to work together in the future, and the emotional and moral strain between them, if unresolved, might likely cause future conflicts and interfere with providing quality patient care. On the basis of these two cases, the argument I wish to entertain is that by addressing emotional dimensions early in the ethics facilitation process, ethics consultants can more effectively help parties reach consensus later in the process.

In order to properly investigate this claim, much territory needs to be covered. What is an emotion, and how does emotion function in moral decision-making in general and in ethics consultation in particular? What is empathy? What role does emotion play in achieving empathy? And why is the conception of empathy endorsed in *Core Competencies* insufficient or incomplete? I devote entire chapters to these topics, but a summary of the answers will help to elucidate the rationale behind the claims I am trying to advance.

Sources from the psychology literature (Dafter, 1996; Callahan, 1991) suggest emotion should not be categorized as positive or negative in nature, as we often do in common parlance. Rather, emotions or feelings are neutral neurophysiological signals from oneself to oneself—what psychologist Sidney Callahan terms "vital signs" of one's

inner awareness. As psychologist Roger Dafter suggests, it is not the emotion itself that is positive or negative, but how we act on the information provided to us by our emotions—that is, how and whether we express what we feel. Thus, unlike the account of emotion we find in early philosophers like Plato or later philosophers like Kant, emotions are not something we passively endure and must set aside in moral decision-making. Emotions play a vital role in morality, often signaling the presence of a moral dilemma (Broom, 1991; Wocial, 1996; Fletcher, et al., 1998; Purtilo, 1999). For Callahan, the role of emotion in morality is tightly integrated with our directed and intuitive rational faculties of judgment and our capacity of human will. All three, she argues, are needed to make decisions in good conscience. Emotion tutors not only itself but also helps to monitor our more rational processes. Emotions may serve as the wellspring of our most authentic self-assessment of how we wish to act in particular situations. Thus, to not consult our emotive pull towards particular choices and combine it with directed, rational thinking of consequences is to make decisions in bad faith.

Philosophical accounts accord with this active and vital assessment of emotion and its role in morality. Nancy Sherman (1995) argues that emotions are "modes of sensitivity that record what is morally salient and...communicate those concerns to self and others" (p. 65). Thus, emotion serves as both a mode of perception that allows us to grasp the morally salient features of particular situations and an intrapersonal and interpersonal means by which to communicate these features to ourselves and others. As a mode of perception, emotion functions in concert with cognition as the genesis of moral occasions. According to Sherman (1995), "the report of the emotions may not be final or

decisive. But it is an important way to begin to mark a moral occasion" (p. 665). As a means of communication to ourselves, emotion provides a test for our initial evaluation of our perceptions. The fact that we "*feel* discomfort, anxiety, anger, or some other disturbing emotion" when encountering a moral problem suggests that emotion can function as an early warning system for moral difficulties (Purtilo, 1999, p. 25).

Emotion plays a central role in our faculties of perception—our ability to feel and sense; this fact helps make an immediate connection between emotion and the faculty of empathy. Rather than relying on the common notion of empathy as being able to put oneself in the shoes of another and to feel what another seems to be feeling, the conception of empathy I endorse involves the very same internal and external interplay that Sherman describes for emotion. This conception of empathy is derived from the phenomenological literature on perception and discourse ethics, so a brief examination of each is necessary.

The phenomenological method, first introduced by Edmund Husserl, asks us to suspend our existential claims about reality and, rather, focus on the perceptions present to our immediate grasping and subject them to rigorous analysis. Here is a brief summary of what such a method gives us regarding our perceptions. Our field of perception is an ever-shifting temporal horizon of possibilities. Objects appear, change configuration, shape, and constitution as our perceptual field shifts (i.e., we move our heads). Some objects seem inanimate, incapable of movement by their own will, whereas others appear to have this power. Moreover, our ability to focus perception allows us to bring certain objects more clearly into the foreground of our perceptual field for examination. Other

objects in our perceptual field recede into the background and become fuzzy and indistinct. Objects in our foreground are more perceptually distinct to us, whereas objects in the background are less so. Since I can manipulate many objects and will my perception to focus on particular objects, a phenomenological view of perception suggests that my acts of consciousness and perception are responsible (in the epistemological, not the moral sense) for the interaction of the objects within my perceptual field.

Yet one type of object in particular, the human being, seems to violate this dictum. Like me, other human beings appear to perceive a field of possibilities (phenomenological shorthand for "potentially knowable or graspable objects of one's perceptual faculties"), one in which I am a possibility to them, just as they are a possibility to me. To avoid the obvious problem of only one mind existing, phenomenology requires that human beings be accorded special status as other minds, as subjects, not objects. By attributing the same moral-ontological status to others as I posit for myself, not only is it possible to relate ethically to others, but such relations require that I treat other minds with the same respect and concern that Kant considered the most fundamental moral duty. According this status to other human beings is necessary to account for the fact that communication with others is possible and such communication involves verbal and non-verbal language and signs that seem intelligible to us.

Husserl wondered what faculty of the mind allowed mediation between the inner worlds of two individuals, supposedly inaccessible to others. He argues that empathy makes translation of our inner mental world intelligible to others and theirs to us. In order

to accomplish such a feat, empathy involves a dynamic relationship between self and other. It involves a reaching out to the other in communication, but also a reaching inward to our experience of the world, translation of that experience into language, transmission of the language to the other through speech, and interpretation of the language by the other in terms of his or her own inner experience of the world. In this way, empathy bridges the world of our inner experience and our external world of perceived numerous others, all of whom have their own inner experiences, supposedly inaccessible to us.

Phenomenology is also helpful for understanding how interpersonal disagreement, a common feature of value conflicts in ethics consultations, arises and how discourse can help in its resolution. Perception depends on the perspective we take towards the objects or subjects of our perception. For Husserl, our perception of the external world is always incomplete. Although we may intuit that a desk has many different sides, we can only perceive at most three of its sides in one sweep of our perceptual faculties. Walking around the desk reveals many different angles from which to view the object. Our minds compute these different perspectives—what Husserl termed adumbrations—and we conclude that the desk has several sides, that it is one, distinct object. Thus, our perception of objects in the external world is always missing at least one perspective. This incompleteness can potentially account for why different persons seem to see things differently—objects, certainly, but also our interpretation of various moral events as well.

The dialogue with others that helps in building empathy and the respect for others that I must have in order to relate to others, however, can help in situations when

interpretations of a shared moral experience differ or the values used to describe it differ. This is the goal philosopher Jürgen Habermas sets for his discourse ethics. Habermas' discourse ethics starts with the assumption that sometimes agreement on particular moral decisions in a pluralistic democratic society cannot exist. In order to salvage ethics and moral theory from the relativism inherent in such a state, Habermas attempts to ground ethics by taking consensus to be the foundation of a moral theory that provides justification for decisions. For Habermas, consensus represents a moral equilibrium. Habermas critiques such thinkers as John Rawls, for whom equilibrium is a theoretical endpoint of abstract judgments made behind a veil of ignorance. Rather, according to Habermas, the discourse to reach such equilibrium is practical and immediate—between actual persons in dialogue, not ideally situated and objective persons stripped of social context in an "original position." Thus, rather than abstract rules of justice governing the deliberations, Habermas argues that rules of discourse or discourse ethics ought to govern the interaction between individuals intent on reaching agreement.

Discourse ethics has two rules, the simultaneous satisfaction of which facilitates the achievement of agreement. The first rule concerns equal respect for individuals, and the second involves concern for the common good. Habermas operationalizes equal respect for the integrity and dignity of each individual in terms of the ability of parties to consent to or veto particular interpretations of norms in question. Concern for the common good requires reciprocal perspective-taking very similar to the sort required by the concept of empathy I endorsed previously. Habermas characterizes such perspective-taking as overcoming one's viewpoint: "in seeking mutual agreement, each attempts to

get beyond an egocentric viewpoint by taking into account the interests of others and giving them equal weight to his or her own" (Habermas, 1990, p. x). When parties in discourse treat each other with respect and overcome their viewpoint, Habermas argues that consensus is possible through a process he terms moral argumentation.

Moral argumentation requires one of two endpoints, according to Habermas (1990): either the restoration of "intersubjective recognition of a validity claim after it has become controversial" or the assurance of "intersubjective recognition for a new validity claim that is a substitute for the old one" (p. 67). Moral argumentation, contrary to the connotation of a heated debate or argument, requires cooperation, respect, and empathy, according to Habermas. Habermas' understanding of empathy involves interplay between self and other. If I am to overcome my own perspective and take the interests of fellow decision-makers into account in an emerging consensus, I must not only be aware of what my interests are but also try to communicate with others regarding their interests.

Habermas' student, Arne Vetlesen, builds on his mentor's philosophical foundation and offers an account of moral decision-making that involves a highly nuanced version of empathy. Vetlesen is not so much concerned with establishing a process to justify the outcome of discourse ethics. Rather, his goal is to inquire into what preconditions must exist between people to behave morally towards one another. Vetlesen, like his mentor Habermas, bases his account on the faculties of moral perception. Vetlesen argues that sensitively attuned perception to the suffering or other emotional signals of others produces in us recognition that particular phenomena are morally significant. By consulting our own emotional and rational repertoire of previous

perceptions, we make a judgment that the other needs our help. By engaging the other in discourse as to how he or she is feeling, we can confirm or modify our moral assessment of the other's needs and construct interventions that are appropriate to the situation.

Vetlesen's sequence of moral perception and judgment involves an empathetic bond to the other. However, as Habermas and Husserl argue, establishing this bond requires that we first consult our own emotional and rational perceptions and judgments. Without the ability to tune into our feelings, Vetlesen asserts, we will fail to address the subject of our intervention in a moral manner that respects the unique personhood of the other. Thus, like the process endorsed by Habermas, the sequence of empathy is aimed at mutual emotional and intellectual understanding. If adapted to serve as a mechanism in ethics consultations with strong emotional tensions, the sequence Vetlesen outlines, combined with the components necessary for authentic discourse, suggests a two-step process to supplement the two stages of ethics facilitation. If consultants detect an underlying emotional component early in the consultation process, this two-step supplemental process should be triggered before proceeding to identify and analyze the value conflict or uncertainty.

The first step should concentrate on establishing what Habermas considered the collective will to engage in moral discourse. When strong emotional tensions threaten to polarize the attempt to engage in moral dialogue, attention to the emotions, their role in the emerging dialogue, and how to achieve integration of emotion with reason should be the first step. As Vetlesen suggests, our first moral perception of events may require re-evaluation. Perhaps anger, frustration, or fear colored our initial perception of the

situation. These emotions certainly seem to be present in the two cases with which I started. But, in practical terms, how is it possible to re-evaluate a moral perception once we have made a moral judgment? What techniques and procedures not supplied in *Core Competencies* would ethics consultants need?

Several sources in the bioethics literature suggest that self-reflection designed to facilitate the expression of emotion, followed by acknowledgment of emotion by others helps to reformulate strong emotional impulses in ethics consultation. Larry Churchill and Alan Cross (1986) consider the integration of emotive reactions with more rational faculties of moral judgment and evaluation as essential in reaching consensus on bioethical issues. Psychiatrist John Hayes (1986) argues that decisions made with conviction and emotion can often be avoided if consultants carefully guide a four-step process of moral dialogue based on the work of moral philosopher Henry David Aiken. Emotive appeals to metaethical principles like justice, integrity, and autonomy are usually taking place before exploration of the emotions in such cases, Hayes argues. For instance, the nurses and surgeons in Mr. Sullivan's case were making opposing claims to professional duties before adequately exploring how each side interpreted how such norms functioned. The nurses refused to sedate Mr. Sullivan because they perceived their duty to advocate for their vulnerable patient, whereas the surgeons believed they were acting beneficently by proceeding with surgery. These two different, role-defined appeals to professional duties only helped to polarize the situation. And the fact that a meeting was never convened to talk about how each side was interpreting the norms of their

respective professional codes of ethics means that consensus and its moral preconditions of respect, concern, and reciprocal empathy could not be established between the groups.

The ability to cultivate these preconditions of respect, concern, and reciprocal empathy depends largely on the exploration and expression of emotion, followed by the acknowledgment of emotion by others, authors who support a role for mediation in ethics consultation argue. *Core Competencies* includes the skills necessary to accomplish this, but not as an initial empathy-building step. *Core Competencies* suggests ethics consultants should show empathy, respect, and concern to the parties and their emotional needs. Thus, acknowledging emotion is an important component of ethics facilitation. However, it is not clear where in the process such acknowledgment should take place. Moreover, the fact that the acknowledgment of emotion helps to establish an empathetic link among the parties for each other is not described in *Core Competencies*. Bioethics mediation authors argue that the ethicist's ability to establish empathy with the parties is antecedent to the ability and willingness of the parties to establish empathy, respect, and concern for each other later in the process.

After the acknowledgment of the emotions present and their influence on the emerging dialogue, the second step should concentrate on helping the parties to overcome their own perspective and take the interests of others into account in the emerging moral discourse. One way to achieve this is by helping the parties to feel that they "own" the dialogue and the outcome of the consultation. Richard Zaner characterizes this approach in terms of the consultants concentrating more on listening than on telling. It is important for consultants to establish empathy, rapport, and respect with each party, but in this

second step, it is the time for the parties to develop these elements among themselves. Empathy directed from consultant to one of the parties needs to be extended into party-to-party-directed empathy. Each party needs to see the other as a person of value, deserving of equal respect and dignity. If the parties are unable or unwilling, the ability of the consultants to help forge consensus will either result in hasty or unstable consensus or in a complete breakdown in the ability of the parties to engage in the moral discourse needed to even reach consensus.

The central feature of the two-step supplemental process concerns extending empathy from each individual to a collective responsibility among the parties engaging in moral discourse. The extension of empathy helps the parties to transform their view of the situation into one of potential mutual understanding and resolution. Hence, I term the process transformative ethics consultation (TEC). Thus, before proceeding to cognitive analysis of Rev. Williams' outburst regarding withdrawal of food and water in Jamie's case, TEC would have the consultants first tune into and acknowledge the emotions present among the parties. In fact, there was substantial racial tension, mistrust, and moral distress present in that case—all features that the consultants did not address. By immediately embarking on trying to explain how Jamie would not "starve" to death, the consultants missed a crucial opportunity to show the parties that some of their emotions—mistrust on the one hand and moral frustration on the other—were manifesting themselves because each party had opposing interpretations of the norm 'to care'. Rev. Williams and Mrs. Jackson only wanted to provide the best possible care for Jamie, and they interpreted their religious perspective to mean that care should continue

to be provided regardless of how poor a prognosis Jamie had. For the health care team, providing the most humane care for Jamie meant that he would not have to be tortured into surviving for the few extra days if he were continuing to be fed and hydrated after his bowels obstructed.

One fortunate feature of TEC is that it can be used as an adjunct to ethics facilitation or as a stand-alone consultation modality for times when ethics facilitation fails or a formal consultation is not initiated. For example, the skills for building and extending empathy could have been used after the consultation formally ended with the nurses in Mr. Sullivan's case. Separate meetings to explore the underlying emotional tensions could be facilitated by consultants to acknowledge the feelings of each party. A joint meeting designed to explain these feelings, now more completely integrated with rational explanations of the ethical principles that were at stake in the case, could be scheduled. If the parties were willing to treat each other as moral equals, empathy might be cultivated and the integrity of the professional relationships that these two groups must maintain might have been preserved or at least mutually acknowledged.

Of course, as is inevitable with any process developed to serve as an ethics consultation modality, TEC has several criticisms and shortcomings. The concluding section, after Chapter Eight, will go into detail regarding each criticism, but each one points to future avenues of research on this topic. The first is that the process is untested as yet. True, TEC is merely at the point of conceptual argument, but it is possible to test its effectiveness by training ethics consultants in the techniques and seeing how they fare compared to colleagues without such training. The second concerns whether consensus is

even an appropriate goal of ethics consultation. I am not sure whether the bioethics community can ever reach consensus on consensus, but it is one reason why working in this field is so interesting. I take consensus to be at least one legitimate outcome among all possible outcomes for ethics consultation. A third criticism is that since TEC relies on mediation techniques and processes, it is open to criticisms of using that approach in bioethics. Mediation generally mandates the impartiality of the mediator, and that role is not compatible with the facilitative goals of ethics consultation. Thus, critics may charge TEC with being equivalent to bioethics mediation and thus open to the pitfalls of bioethics mediation as a stand-alone consultation modality. I rebut both of these challenges in Chapter Eight. I overcome the first by arguing for a new understanding of impartiality in ethics consultation that comports with the spirit of ethics facilitation. I defend against the second by suggesting that TEC skills can be easily adapted for use outside of or after ethics consultation as a means to ameliorate the moral distress associated with emotionally charged value conflicts.

The research underlying TEC has benefits of its own that could be translated to training programs for ethics consultants, health professions students, and students of ethics consultation. The skills could be offered as a certificate program in advanced interpersonal skills as recommended in *Core Competencies* or as a supplement to already existing courses in ethics consultation. The empathy theories underlying the process can help inform work in health care education. Programs specifically designed for physicians, such as Balint groups, can help physicians in training learn how to be more empathetic towards colleagues and patients. Nurses and allied health professionals can explore the

concept of moral distress, and forums can be designed to help empower them to overcome feelings of powerlessness due to the high level of personal responsibility they take as hands-on patient advocates but who often have little authority to oversee the decisions that are made.

Chapter Two

Expanding the Role of Empathy in Ethics Consultation Modalities

> Food and water are "perfect symbol[s] of the fact that human life is inescapably social and communal. We cannot live at all unless others are prepared to give us food and water when we need them. If the duty of parents towards infants provides a perfect example of inescapable moral obligation, the giving of nourishment is its first and most basic manifestation."
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> —Daniel Callahan, 1983, p. 22.

Introduction

Ethical conflicts and uncertainties abound in the delivery of health care services, and many, if not all, have both cognitive and emotional dimensions. Recent evidence from many disciplines suggests that moral resolution is not authentically effected unless both of these supposedly separate dimensions are addressed and integrated into moral problem-solving processes. Exclusive focus on cognitive elements of moral difficulties may address the normative questions underlying ethical conflicts and uncertainties—what ought to be done and why. But without equal attention to the uniquely human, emotional elements underlying moral difficulties, the resolutions reached will lack what Françoise Baylis (1994) has termed the uniquely human dimensions of ethical difficulties.

Ethics facilitation, the consensus approach recently promulgated by an American Society for Bioethics and Humanities (ASBH) report, represents one ethics consultation modality to address and hopefully resolve such conflicts and uncertainties. Moreover, ethics facilitation argues that interpersonal and process skills must work in concert with ethics-related knowledge in order to address effectively the dual cognitive-emotive nature

of such conflicts and uncertainties. One such interpersonal skill concerns the ability of the ethicist to show empathy to patients, surrogates, and clinicians involved in a consultation.

An ethics consultation involving the highly emotional issue of withdrawing artificial nutrition and hydration (ANH) from a patient in a persistent vegetative state (PVS) prompts consideration of the role of empathy in ethics facilitation. The case features an emotional tension that could, if not addressed early and appropriately, derail the ethics facilitation process. By analyzing what amounts to a shortcoming in construing empathy and its role in ethics, I argue that ethics facilitation requires supplementation with procedures designed to expand empathy from a consultant-directed activity to a collective responsibility. Expanding empathy thus can help resolve such impasses and their often associated emotionally charged sequelae—polarization of conflict, ethical uncertainty, miscommunication, misunderstanding, and misinterpretation of the facts and values at play in the consultation, and refusal to engage in constructive dialogue.

Part I: The Ethics Facilitation Approach

Since this dissertation deals specifically with ethics facilitation as endorsed by the ASBH, it is necessary to provide an overview of this approach. The best way to accomplish this goal is by placing ethics facilitation within the context of the many models and approaches promulgated for conducting ethics consultations and discerning what distinguishes ethics facilitation from these other approaches.

Ethics Facilitation within the Spectrum of Consultation Modalities. A relatively large and growing body of literature describes many models and approaches for

conducting ethics consultations and evaluating their success. Rather than arriving at consensus, the ethics consultation literature poses more questions than it answers. Who should do consultations—entire ethics committees, a small group of ethics committee members, or one consultant? What type of professional background provides the optimum balance of knowledge and skills for ethics consultation—clinicians with training in ethics, philosophers, theologians, and medical humanities scholars with training in health care delivery, or teams of consultants with representatives from these diverse backgrounds? What is the most appropriate role for the consultant—advisor, adjudicator, moral expert, mediator, consensus-builder, facilitator, educator, or some combination of these roles?

Recently, such questions (and others) have prompted bioethics as a discipline to form a task force devoted to articulating the core competencies and procedures for conducting ethics consultations (SHHV-SBC, 1997). The 1998 report of the ASBH *Core Competencies for Health Care Ethics Consultation* (hereafter *Core Competencies*) is the result of such an attempt. *Core Competencies* clearly argues that the most appropriate role for a consultant is to facilitate moral analysis and consensus. *Core Competencies* defines consensus as "agreement by all involved parties" regarding a course of action (ASBH, 1998, p. 7).

The rationale behind suggesting consensus as the outcome concerns the primacy ethics facilitation places on respect for autonomy. Within certain socially prescribed boundaries, patients, surrogates, and clinicians, with facilitative involvement of ethics consultants, must be able to jointly decide which ethical option(s) will be implemented.

Thus, although the consultant provides facilitation and ethics knowledge, it would be unethical for the consultant alone to determine the outcome of a consultation. Respect for autonomy requires that consultants refrain from engineering consultation outcomes and instead blend the values of all parties into a shared understanding or consensus.

According to *Core Competencies*, consensus represents an appropriate balance between two extremes—pure facilitation and pure consultant authoritarianism. Pure facilitation allows patients, surrogates, and clinicians to decide the outcome with little, if any, ethical guidance from a knowledgeable consultant, whereas pure authoritarianism features the consultant as a moral expert whose knowledge of ethics qualifies him or her to decide the morally appropriate course of action. Many other consultation modalities exist between these two extremes—mediation, patient advocacy, several varieties of facilitation, and education. Thinking of these consultation modalities as a spectrum and comparing whether the consultant has the moral authority to determine the outcome in each modality, *Core Competencies* suggests ethics facilitation occupies a middle ground.

At one extreme, pure facilitation is characterized by its focus on resolution of interpersonal conflicts, with little, if any, ethical analysis. The bioethics literature is rife with references to so-called ethical conflicts that involve largely interpersonal communication breakdowns. Some authors argue that the consultant's role is to facilitate discussion and agreement. The consultant has little moral authority to decide the outcome. Rather, the consultant facilitates communication among patients, surrogates, and clinicians and seeks agreement on a specific course of action.

Certainly ethics consultations can and often do include communication barriers and even breakdowns; however, it would be a hasty generalization to imply that all consultations can be resolved by mere communication facilitation. For example, not all consultations involve interpersonal conflicts sparked by failures to communicate. Some concern uncertainty—the patient, surrogate, and clinicians all agree on a course of action but request a consultation to discuss whether the course of action is morally justifiable. Moreover, without analysis regarding the ethical import of possible consultation outcomes, pure facilitation can sometimes override important moral values in the attempt to reach agreement. For instance, as *Core Competencies* points out, it is possible to facilitate an agreement between the surrogate of an incapacitated patient and a clinician to override the expressed wishes of the patient in an advance directive. Thus, this type of model is generally regarded as inappropriate.

Although mediation can have many characterizations, it usually employs the consultant as an outside, impartial third party, perhaps contracted by an institution or ethics committee to handle certain ethical quandaries. *Core Competencies* argues that mediation might be an appropriate consultation modality *after* ethics facilitation has failed. Moreover, training in mediation can provide attainment of several advanced process and interpersonal skills endorsed in *Core Competencies*. Mediation, like pure facilitation, withholds from the consultant the moral authority to decide the outcome. Moreover, mediation has received criticism that it is an inappropriate ethics consultation modality, namely because impartiality is an unachievable façade and perhaps an

undesirable, morally distancing stance, antithetical to the democratic goals of ethics consultation.[2]

Some ethics consultants argue that the goal of their work is not to help reach resolution or agreement but to act as the moral voice of patients or surrogates and uphold their autonomy when it is threatened. This patient advocacy model of ethics consultation places considerable moral authority in the consultant, since the consultant speaks for the patient or surrogate and acts as an active participant in shaping the outcome of the consultation. Despite its emphasis on patient autonomy, it is possible that such a model of ethics consultation places consultants in a conflict of interest if they will simultaneously provide patient advocacy as well as ethical guidance, education, and analysis. Especially in cases featuring ethical conflict, upholding the autonomy of the patient may polarize the conflict and result in clinician distrust of the consultant to also guide ethical analysis and resolution. *Core Competencies* emphasizes the need for consultants to disclose any conflicts of interest they have or to be free from such conflicts in order to respect the autonomy of patients, surrogates, and clinicians. Including a patient advocate, ombudsperson, or patient representative in the place of the ethics consultant-as-advocate remedies the inherent conflict of interest in having the consultant play these competing roles.

Following the medical model of seeking clinical consultations from colleagues, some authors argue that ethics consultation is no different than clinical consultation—the

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[2]Since the process to supplement ethics facilitation that this dissertation eventually endorses involves the beginning stages of mediation, it will be necessary to determine whether the supplemental process is open to these criticisms. I argue in Chapter Eight that the supplemental process is not amenable to these criticisms.

goal of which is an expert opinion on a particular matter. *Core Competencies* has judged variations of this model as authoritarian. The consultant is viewed as a moral expert whose judgments and opinions have the weight of moral pronouncements, and there is often little patient or surrogate involvement in determining an ethically appropriate course of action. Such a model thus violates the spirit of autonomy for patients or surrogates to make the decision, and *Core Competencies* argues against consultant authoritarianism in any form.

An education model of ethics consultation views the consultant as an ethics advisor—someone who can help clarify questions to be asked, principles, theories, and approaches to be used, but who offers little, if any, moral advice as to how best to resolve the ethical difficulty in question. The underlying belief of the education model is that guiding a process of critical self-reflection educates patients, surrogates, and clinicians regarding what values are at play and at stake in particular cases. Thus, it is inappropriate for an ethics educator to attempt to direct the outcome of a prospective consultation. Ethics facilitation incorporates a strong educational component within its stages, but it expands the pure educational role of the consultant to that of an active, albeit facilitative, participant in the process.

Since facilitation attempts to balance competing claims of patient and clinician autonomy, it has long been advanced as the most appropriate goal for ethics consultation. The bioethics literature reflects several variations of this basic approach, including its most recent incarnation, ethics facilitation. Specifically, facilitation models show an interesting evolution from early models designed to facilitate ethical analysis, a

predominantly intellectual activity, to later models designed to facilitate both ethical analysis and interpersonal communication, intellectual facilitation's more emotional counterpart. A more targeted analysis of this literature shows this evolving trend and confirms the recent assertion in *Core Competencies* that ethics consultations clearly have both cognitive and emotive dimensions and involve intellectual and interpersonal components. It is important to show this evolution, because at its culmination, authors suggest that empathy is one of the interpersonal skills ethics consultants ought to have. However, I will argue that this conception of empathy has two shortcomings, and subsequent chapters of the dissertation will attempt to provide a more nuanced conception of empathy to overcome these shortcomings.

The Evolution of Interpersonal and Intellectual Facilitation. Numerous authors reference facilitation as a skill or ability necessary to conduct ethics consultations (Glover, Ozar, & Thomasma, 1986; Ackerman, 1987; Moreno, 1991b; Zaner, 1993; Baylis, 1994; Lynch, 1994; SHHV-SBC Task Force, 1997; ASBH, 1998). Contrasting Terrence Ackerman's early facilitation model and its emphasis on intellectual activities with later models illustrates the evolution of facilitation into intellectual and interpersonal components. Ackerman acknowledges that emotion is important,[3] and perhaps even certain indirect psychological benefits result from the involvement of ethicists in health

[3]Ackerman (1987) argues that ethicists need adaptive professional skills to facilitate moral reflection in atmospheres "that may be emotionally charged for members of the health care team" (p. 318). Despite this acknowledgment of an emotional dimension to ethics consultation, Ackerman (1987) suggests that rather than skills designed to explore emotional facets of ethical difficulties, ethicists need abilities in defusing "emotional factors" and must "provide cool, deliberate moral analysis of the issues" (p. 318). Moreover, the characterization that the consultation may involve emotionally charged issues for the health care team neglects the fact that patients and surrogates may feel similarly so.

care settings.[4] Nevertheless, the overriding concern of the ethicist must be facilitation of "cognitive analysis and resolution of a moral problem," an activity that Ackerman (1989) labels as "predominantly intellectual" (p. 316).

Despite its publication three years earlier than Ackerman's 1989 article, Jacqueline Glover, David Ozar, and David Thomasma's article on the ethicist as a decision facilitator recognizes that ethicists need more than technical skills in ethical analysis in order to fulfill their complementary roles as teachers and consultants. Not only is the hospital an unfamiliar setting for many ethicists trained in the humanities, but this unfamiliarity is compounded by a lack of training beyond so-called professional skills in ethics. Glover and colleagues (1986), in reaction to the many "personal tragedies and emotions" that ethicists encounter on rounds and in consultations, recognize the impossibility of confronting "life's essential questions and values with only 'professional' skills" in ethics (pp. 29-30). They suggest that life has many levels beyond the objective, professional, and sometimes distancing type of cognitive skills that characterize "professional" skills in ethics. Part of the richness of life concerns a highly emotional attachment to what each of us holds dear, the very meaning behind the word 'value'—the moral currency and substratum of ethical discourse.

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[4]In his attempt to justify the role of the ethicist, Ackerman clearly emphasizes the cognitive over the emotive. He argues against the consultant playing the role of secular clergy, who "encourage attitudinal changes making persons more disposed toward morally appropriate behavior," or psychological counselors, who "assist persons in understanding and resolving their own emotional problems," misunderstands and misconstrues the role of the ethicist as a facilitator of "the analytic procedures of moral reflection" (Ackerman, 1987, p. 316).

Despite Glover and colleagues' acknowledgment of the need for more than "professional" skills in ethical analysis, the need for training in interpersonal communication techniques does not achieve full recognition until Jonathan Moreno's two 1991 articles on ethics consultation. In "Ethics Consultation as Moral Engagement" Moreno (1991a) identifies ethical analysis as a skill that ethics consultants should possess. In addition to this analytic ability to identify and analyze ethical problems, Moreno (1991a) suggests that ethics consultants also need a more intuitive skill, ethical insight, as well as the moral perseverance "not to take the easy way out" (p. 47). Moreno's discussion of ethical insight and strength of will lead him to add to the list of skills ethicists need. In addition to ethical expertise, ethicists must have the ability to discern social and power dynamics and their role in them, including small group dynamics and their possible outcomes. Moreno (1991a) argues that these abilities depend on the ethicist possessing competent interpersonal skills in mediation and negotiation strategies (p. 55).

In a follow-up article, Moreno (1991b) presents a similar dichotomy between analytical abilities (in health law, health care financing, and health policy) and more interpersonal skills, "particularly tactfulness and the ability to mediate among deeply felt differences while honoring them" (pp. 154-155). The ability to mediate such differences and simultaneously respect them requires an ability to respect the autonomy of others but also the ability to address and ameliorate deeper issues of an emotional nature. The interpersonal skills in showing respect and empathy required for this form of ethics consultation find their most eloquent expression in subsequent facilitation authors

Françoise Baylis and Abbyann Lynch, who embrace them as central to good practice in ethics consultation.

Abbyann Lynch (1994) splits facilitation into two complementary subtypes—intellectual facilitation and interpersonal facilitation. Intellectual facilitation concerns the consultant's ability to help patients, surrogates, and clinicians identify ethical issues and use bioethical knowledge to facilitate a resolution to a presenting ethical problem. Interpersonal facilitation concerns the consultant's ability to "communicate with angry, frustrated people," to "empathize with those who feel pain and require emotional support, while also moving the ongoing discussion...to conclusion" (Lynch, 1994, p. 58). This ability is similar to Moreno's emphasis on simultaneously mediating and honoring deeply felt differences. Thus, without skills at facilitating interpersonal dynamics, emotions, and feelings, Lynch (1994) argues the consultant may fail to assist patients, surrogates, and clinicians in resolving an ethical difficulty they "own" (pp. 57-58).

Baylis (1994) enriches the evolving focus on interpersonal skills in facilitation by arguing that ethics consultants need not only "dispositions of the mind" but also "dispositions of the heart"—namely, traits of character and consideration of the emotive nature of ethical problems (p. 26). Baylis, like Moreno and Lynch, splits the competencies into two categories—knowledge requirements and requisite abilities. Even in the more analytic or intellectual knowledge requirements, Baylis (1994) suggests that knowledge "of the human dimension(s) of ethical problem-solving" is necessary (p. 31). This knowledge "includes an understanding of the social and cultural circumstances that

affect the patients' and caregivers' emotional responses to a health problem" (Baylis, 1994, p. 31).

Lynch links emotional facilitation skills with empathy. Baylis describes empathy in terms of compassion and caring. Empathy is the consultant's ability "to…show genuine concern for…those who are suffering. S/he should not distance her/himself from the emotional aspects of the presenting ethical problem, but should strive to understand the anguish of those…suffering, and their need for comfort and help" (Baylis, 1994, p. 39). Interestingly, *Core Competencies* mirrors Baylis' description of empathy as showing compassion: "Compassion helps the consultant to work constructively with feelings in sometimes tragic situations" (ASBH, 1998, p. 22). In addition, *Core Competencies* posits showing empathy as one of the interpersonal skills designed to help consultants communicate with patients, surrogates, and clinicians and thus reach the ultimate goal of ethics facilitation, consensus.

The Goals of Ethics Facilitation. Moreno's claim that ethicists must maintain a balance between their ability to mediate deep differences in values while also honoring them illustrates a central tension in facilitation models of ethics consultation—one that *Core Competencies* addresses by positing an interesting and controversial outcome for ethics facilitation. In terms of interpersonal decision-making, autonomy can be a double-edged sword. Patients and surrogates have the moral right to have their autonomy respected within certain ethical and legal boundaries. So do clinicians, who have the right to protect their own personal and professional integrity.

These two different, role-defined interpretations of the principle of respect for autonomy are often at the heart of value conflicts that spark ethical difficulties. Since the overriding obligation of the ethics facilitator is to respect autonomy, *Core Competencies* proposes that the most appropriate outcome in such cases is a consensual blend, or a shared moral understanding, of the values at play. Achieving this consensus is perhaps the most difficult task for the ethics facilitator because, when diametrically opposed value claims to autonomy are present, it may be impossible to uphold one set of values without trampling the other. Extremely polarized emotional tensions, unwillingness to engage in the moral dialogue necessary to reach such shared moral understandings, and parties inability to understand and process deep differences in values represent difficult challenges to ethics facilitators and consensus.

It is beyond the scope of this dissertation to analyze the validity of using consensus as *the* outcome of ethics consultation.[5] As a distinctive form of interpersonal communicative or discourse ethics, consensus certainly is one of perhaps many valid outcomes for ethics consultation despite its inherent tension (Casarett, Daskal, & Lantos, 1998). *Core Competencies* includes specific interpersonal skills to help in resolving this central tension between the stability and validity of consensus and competing conceptions of autonomy. Its authors suggest that consultants' show of respect and empathy can help in building morally shared commitments. I wish to leave aside critiques and justifications

[5]An interesting literature has emerged regarding whether consensus is properly understood as a process of reaching resolution or a goal or endpoint (Moreno, 1988, 1989, 1991c; Perlman, 1994; Moreno, 1995; Burstein, 1997). Emphasis on which conception underlies ethics consultation might help prevent hasty consensus (Burstein, 1997) or inappropriate consensus—what Bernard Lo (1987) terms "groupthink," an Orwellian term describing ethics committee decisions supposedly reached by consensus when not all members have given assent to or expressed their thoughts regarding a decision.

for consensus and analyze the previous claim in more detail because I wonder whether a more stable consensus in times of strongly polarizing emotions can be achieved by expanding the notion of empathy endorsed in *Core Competencies*.

The facilitation literature, including *Core Competencies*, does an excellent job of illustrating the usefulness and necessity of empathy as an interpersonal skill. Surely ethics consultants need compassion, and showing empathy represents one way to display compassion. The focus, however, is on how empathy relates to the consultant's work. Baylis suggests that empathy shows that the consultant recognizes the human dimensions of ethical difficulties. And, *Core Competencies*, after all, is a document detailing what competencies consultants need. However, I want to expand the scope of this one interpersonal skill and determine what might happen if empathy were to be cultivated not only between consultants and patients, surrogates, and clinicians, but also collectively between and among the patients, surrogates, and clinicians.

I hope to show that expanding empathy beyond a skill only consultants must possess or show increases opportunities for reaching consensus in times of emotionally charged conflicts. Consultants showing empathy at such times is valuable, for it can help each party acknowledge their emotions and incorporate them in the cognitive processing of moral difficulties rather than simply leaving such emotions behind. But, if empathy can be expanded to include the sort of mutuality consensus requires, then ethics consultations with strong emotional tensions should utilize procedures to expand empathy from a consultant-directed activity to a collective activity in which patients, surrogates, and clinicians engage.

As I will later detail in Chapters Four and Five, recent phenomenological investigations of empathy emphasize the dual nature of empathy as both an intrapersonal means of moral self-reflection and -analysis and an interpersonal means of achieving respect for persons. Hence, if properly cultivated, empathy allows patients, surrogates, and clinicians to simultaneously acknowledge deep value differences while also respecting them in others. This phenomenological understanding has correlates in the psychiatry, philosophy, and psychology literature on moral development and ethical decision-making processes. Thus, it is my hope that such an understanding might help to more clearly provide a process and a rationale for reaching resolution in particular ethics consultations with strong emotional tensions. I substitute the word 'resolution' for 'consensus' to acknowledge that consensus may not be possible or desirable in some cases.

First, however, it will be necessary to define some key concepts, including what role strong emotions play in ethics consultation and how empathy functions on the level of the individual (the intrapersonal) and the level of the group (the interpersonal). I address these issues in more detail in the next two chapters, but a sketch of the argument is necessary here. As an introductory foray to the former discussion, the historical evolution of the interpersonal and intellectual distinction in facilitation becomes instructive, since it finds its most compelling expression in *Core Competencies* and the stages of ethics facilitation. The latter discussion requires a more extensive treatment of the phenomenological literature on empathy and its correlates in psychiatry, philosophy, and psychology, but the basic argument must be outlined as well. Fortunately, such an

outline is also possible on the basis of the distinction between the cognitive and the emotive dimensions of ethics consultation that *Core Competencies* identifies.

The Stages of Ethics Facilitation: The Affective and the Cognitive. *Core Competencies* begins by acknowledging that value-laden conflict and uncertainty exist in providing health care to patients and that ethics consultation has evolved as one mechanism to address such conflict or uncertainty. Especially when the value dimensions of health care clash or reveal uncertainties, *Core Competencies* argues that ethics consultants can help identify and resolve value conflicts, provide education and facilitation to remove value uncertainty, and forge moral consensus.

As human beings providing highly technological and scientific health care to often vulnerable patients or involving their often less scientifically knowledgeable surrogates, value conflicts or uncertainties can "have both cognitive and affective dimensions" (ASBH, 1998, p. 3). As an example of the former, differences in education level can produce knowledge and power differentials among patients, surrogates, and clinicians. Such differences can lead to misunderstanding, miscommunication, and misinterpretation of clinical diagnoses, prognoses, and treatments and the values that underlie them. In their concentration on the scientific values of health care, clinicians can sometimes dismiss, misconstrue, or undervalue the relevance of important patient or surrogate values, especially religious or cultural values. This latter example shows how a cognitive focus can lead to a failure to appreciate fully the affective dimension of ethics consultation. Separately and together, these cognitive and affective dimensions can produce anger and resentment among patients, surrogates, and clinicians, resulting in

patient failures to comply with recommended treatments, which, in turn, can produce frustration and ill-will among clinicians caring for such patients.

Moreover, *Core Competencies* suggests that the dual cognitive-affective dimensions of value conflicts or uncertainties can have interpersonal and intrapersonal elements. For instance, the parties to a consultation might already know the morally right course of action but have difficulty voicing the decision. Perhaps the decision is personally "daunting," such as disconnecting a loved one from life support (ASBH, 1998, p. 3). Or perhaps emotions such as "guilt over a loved one's sickness or impending death" prevent the analysis and acceptance of certain moral options (ASBH, 1998, p. 3). Alternatively, patients or surrogates might feel intimidated or distrustful of the medical team or the entire health care delivery system. These and other affective barriers prevent both the identification and analysis of value conflicts or uncertainties and the facilitation of moral consensus. If not addressed, such barriers can result in impasses to ethics consultation. The involvement of an ethics consultant might lend authority to parties' decisions or provide them with the necessary moral fortitude to voice their concerns.

The distinctions between the cognitive and affective dimensions of ethics consultation and their corresponding intrapersonal and interpersonal components are reflected in the skills *Core Competencies* endorses to address each of these areas. *Core Competencies* separates ethics facilitation into two stages—the identification and analysis of value uncertainty or conflict, followed by the forging of moral consensus. Such a separation of stages represents an attempt to operationalize the work of the consultants in

addressing the often combined nature of the different dimensions present in ethics consultation—intrapersonal and/or interpersonal emotive and cognitive difficulties.

The first stage involves three components designed to help generate a range of ethically acceptable options. Ethics consultants gather factual information, clarify bioethical concepts at stake in the case, and explain the relevance of ethical norms needed to resolve the case. Fact gathering can include inspection of the patient's medical records and interviews with relevant parties. Basing their efforts on the facts gathered, ethics consultants identify the value conflict or uncertainty by introducing and defining relevant bioethical concepts. Most cases involve truth-telling, informed consent, surrogate decision-making, best interests, confidentiality, medical futility, or some combination of these and other bioethical and/or medico-legal concepts. The next step involves infusing the discussion with norms (taken from the bioethics literature, socially consensual values, health law, and/or institutional policies) that can help parties apply the bioethical concepts to the generation of options for resolving the case.

Core Competencies emphasizes cognitive processing skills for this first stage of ethics facilitation. In order to identify and analyze the nature of the value conflict or uncertainty, ethics consultants must gather relevant information, clarify pertinent bioethical concepts and normative issues, and assist in developing several morally acceptable options. While interpersonal skills might indeed facilitate this process, the activities revolve around the ability of the consultant to cognitively identify, assess, and analyze complex ideas and communicate them to patients, surrogates, and clinicians. The

traditional intellectual function of facilitation, as reflected in Ackerman's early model, best approximates the goals of the first stage of ethics facilitation, I argue.

The second stage of ethics facilitation attempts to build consensus regarding one option identified in the first stage.[6] The ethics consultants should help the parties explore the rationale for each option identified at the preceding stage, clarify the values underlying it, and provide each party an opportunity to voice concerns about the option. Helping to clarify each party's own values and views should provide the ethics consultants with enough congruence between values and options to help build consensus regarding one or two of them. The ethics consultants should focus the parties on selecting the one option that most approximates their shared moral commitments or mutual understandings.

Based on the separation of stages, I argue that it is after the first stage has yielded several options that the more interpersonal portion of ethics facilitation becomes prominent. The building of consensus for one option within the range of moral acceptability requires "softer" skills in facilitating communication and mediation as compared to the more "analytically harder" skills in ethical assessment and analysis the first stage requires. Such interpersonal skills are necessary to ensure the following process goals of ethics facilitation: (1) that parties have voiced their concerns and been heard (by whom, however, is not specified); (2) that parties have identified the presence

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[6]It is not clear precisely who should identify such options. *Core Competencies* posits skills and processes for the ethics consultants, but offers few examples of corresponding responsibilities for patients, surrogates, and clinicians. If respect for autonomy is the guiding ethical principle of ethics facilitation, then the argument could be made that after the consultant provides and clarifies bioethics language and concepts, option generation should be the job of the patients, surrogates, and clinicians.

and influence of their own values in the options; and (3) that parties receive assistance in developing consensus by ensuring the existence of "morally acceptable shared commitments or understandings within the context" (ASBH, 1998, p. 7).

If early in the process, during the first stage, for instance, the parties exhibit strong affective reactions—if they are angry at, frustrated with, or indifferent to each other—then, as Abbyann Lynch argues, intellectual facilitation may not help. In such cases, patients, surrogates, and clinicians must "buy into" the process on an emotional level before the first stage of ethics facilitation can succeed. As physician Julia Connelly (1998) has suggested, when "an emotional tone predominates," as it does in emotionally charged ethics consultations, "attention to the emotion is generally more effective than pursuing an intellectual discussion" (p. 228).

Certainly, building trust, developing rapport, and showing empathy are steps that can accomplish initial party "buy in" for ethics facilitation. As Connelly (1998) suggests: "it is helpful to work toward emotions that facilitate trust, such as caring, interest, compassion. Anger and frustration are examples of emotions that may disrupt relationships unless attempts are made to understand their origins" (p. 227). *Core Competencies* acknowledges this fact. The two stages of ethics facilitation require consultants to possess numerous skills designed to facilitate the stages of the process and the interpersonal dynamics of the decision-makers. The bulk of *Core Competencies* identifies and justifies these many knowledge, interpersonal, process, and characterological competencies. Ethics facilitation requires cognitive skills related to identifying and analyzing the values underlying moral conflicts and uncertainties. Skills

in ethical analysis, coupled with knowledge of ethical theory, the bioethics literature, health law, and health policy provide these cognitive competencies.

However, by including an affective dimension to ethics consultation *Core Competencies* acknowledges that conflicts and uncertainties rarely involve only cognitive applications of knowledge to the presenting ethical difficulty. Interpersonal dynamics, strong emotions, assumptions about facts and values, and personality conflicts can spark or exacerbate value uncertainties or conflicts. *Core Competencies* divides the knowledge-based aptitudes from those designed to address the so-called affective dimension of ethics consultation. Skills in mediating communication coupled with particular character traits provide consultants with the tools needed to address the affective facets of ethics consultation. In particular, *Core Competencies* suggests that the ability to "listen well and to communicate interest, respect, support, and empathy to involved parties" is an important interpersonal skill for ethics consultants to have (ASBH, 1998, p. 14).

It is not clear, though, where in the ethics facilitation process empathy should be developed. If ethics consultants recognize an emotional tension during the early stages of ethics facilitation, then delaying resolution of the tension until after the first stage of facilitation might weaken the foundation for achieving consensus. Such emotional tensions, if not dealt with immediately, can cause reluctance to engage in moral dialogue, polarize conflict, and even prematurely terminate the consultation. Revamping the stages of ethics facilitation so that emotional "buy in" can be specifically developed before identification and analysis of the value conflict or uncertainty would seem to be in order for such cases.

Ethics Facilitation, Emotional Tensions, and Empathy. Ethics facilitation advances the principle of respect for autonomy as a core value to be upheld during consultation. Although the role of the consultant is as a facilitator among the patient, surrogate, and clinicians, ethics facilitation seeks a consensus that blends the values and perspective of the patient or surrogate with the professional values of the clinicians. Thus, autonomy is not an absolute value in ethics facilitation—it is not always the autonomy of the patient that should determine the outcome, but rather a consensual blend of patient and clinician autonomy.

Given this view of the principle of respect for autonomy endorsed by ethics facilitation, patients, surrogates, and clinicians should shoulder considerable moral responsibilities to each other as consultation participants. *Core Competencies,* since its goal is to delineate the skills ethicists need, does not focus on the responsibilities of parties other than the consultants. However, other facilitation authors, especially Glover and colleagues, suggest such responsibilities in attempting to justify the necessity for shared decision-making in ethics consultation.

Glover and colleagues identify three benefits of joint decision-making in ethics consultation. First, involving all those affected by an ethical decision will reduce the tendency to overlook certain central values, perspectives, or positions. Second, joint decision-making reduces the potential for miscommunication or misinterpretation of relevant information and ensures its accuracy. And, building on enhancement of communication, Glover and colleagues (1986) argue that "a shared decision-making process is more likely to result in effective action" (p. 25). The reason why concerns the

fact that shared decision-making requires joint responsibility for the outcome, its implementation, and the process used to reach it.

Several bioethicists affirm that shared decision-making imposes significant moral responsibilities on patients, surrogates, and clinicians. Françoise Baylis and Abbyann Lynch term this joint responsibility 'moral ownership'—the patients, surrogates, and clinicians must "own" the presenting ethical challenge, for they will live with the consequences of the decision in a way ethics consultants will not. Edmund Pellegrino (1999) argues that ethics consultation requires collective decisions, which entail shared decision-making responsibilities.

A commitment to the virtue of what is right and good for the patient must guide the consultation, Pellegrino argues. For him, this virtue binds all participants collectively—the consultants, the patient or surrogate, and clinicians.[7] Thus, consensus, which requires much give-and-take, must represent a genuine or *authentic* attempt to engage in moral dialogue. Regarding others as subjects of moral respect and concern connotes this sense of commitment to the same goal—a decision that maximizes patient welfare. After all, the very etymology of the word 'consensus'[8] suggests a "feeling together," a shared feeling of "this is our disagreement or difficulty, we're in this

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[7]Throughout this dissertation I use Pellegrino's term "collective" to refer to all consultation participants (the consultants, the patient or surrogate, and the clinicians) and their respective shared moral responsibilities. I use the term "consultant" to restrict responsibilities or activities to the ethics consultants. Given this distinction in terminology, it should be clear that I am including the ethics consultant as a participant in the process, although his or her participation is limited to facilitating the appropriate atmosphere and encouraging resolution.

[8]The word 'consensus' comes from combining the Latin verb '*sentire*'—to feel—with the prefix 'con,' which denotes 'togetherness.' It is interesting that the word 'sentience,' which we normally equate with intelligence, the ability to consciously think independently, or to reason, actually means the ability to perceive, to feel. Thus, the word 'consensus' clearly denotes a "feeling together" as opposed to "thinking together."

together, and it depends on us reaching a joint decision to resolve it to our mutual satisfaction."

The ability of patients, surrogates, and clinicians to achieve consensus turns on their ability *and* willingness to achieve respect and concern for their fellow decision-makers. Respecting autonomy is a two-way street. Not only must others respect our values, but seeking that respect from others requires us to shoulder the moral responsibility of authenticity—not to take the easy way out, as Moreno suggests. Thus, echoing the title of Moreno's essay, ethics consultation is indeed a form of moral engagement, but not only for the consultants. All participants—consultants, patients, surrogates, and clinicians—must affirm a commitment to engage each other as moral agents of value, each of whom is worthy of respect and concern. Communication of empathy from consultant to patient, surrogate, or clinician affirms such respect and concern. However, it is equally incumbent on the patient, surrogate, and clinicians to communicate such empathy to each other as well. In Chapter Four, I examine this argument in greater detail by suggesting empathy represents a fundamental and appropriate ethical stance for individuals to take to one another when a joint decision must be reached.

Showing respect for another's autonomy requires understanding one's own values and how they differ from those of fellow decision-makers. As Pellegrino (1999) asserts, the "external appearance of virtuous action must also be matched by internal virtuous motivation" (p. 7). It is not enough to give lip service to respect and concern for another person's values. The effort to engage in empathetic concern must be authentic. It requires

a sequence of morally reflective self-understanding followed by an attempt to understand the other with whom we must make a decision. If strong emotions overpower our ability to adopt the orientation of understanding of others or if we only see others in purely objective, intellectual terms, a mismatch exists between what Pellegrino calls our internal motivation and our external action.

This notion of collective virtue, in contrast to the focus of *Core Competencies*—the individual virtues, abilities, and knowledge consultants need—provides the impetus for my discussion of ethics facilitation. Essentially, my dissertation is an attempt to expand one particular trait mentioned in *Core Competencies*—empathy—from an individual, consultant-directed activity to a collective one. I argue that an expanded, phenomenological understanding of empathy helps consultation parties realize their collective responsibilities to each other because empathy requires two elements—(1) authenticity and (2) integration of cognitive and emotive faculties of perception and judgment. Both elements ensure the sincerity and collective will of each party to engage in moral dialogue *because* joint moral ownership requires that I treat others as subjects of respect and concern and that others genuinely reciprocate this moral orientation.

The notion of empathy on which I rely is distinctly phenomenological and, as such, concerns how to achieve authentic integration of emotion and cognition and perception and judgment. It is important to distinguish this nuanced conception of empathy from the ordinary conception as the ability to adopt the emotional state of another and indirectly experience what they feel. Rather, a phenomenological conception of empathy concerns how it is that we morally interact with others despite not being able

to fully understand them in all their dimensions. Communication is necessary, as is the proper moral attitude of mutual respect and concern.

Philosopher Arne Vetlesen (1994) develops such a phenomenological conception of empathy in his book *Perception, Empathy, and Judgment: An Inquiry into the Preconditions of Moral Performance*. Vetlesen argues that empathy and the moral ability to recognize the physical suffering of another—what he terms moral perception—produces in us a similar feeling of suffering—a "suffering with" the other. Social roles, such as parent or care-giver, including health care giver, reinforce this role and create a healing impulse within us to minimize the amount of suffering others experience.

Vetlesen argues that moral action is our primary human responsibility. However, in order to respond appropriately to a moral situation, such as the suffering of another, Vetlesen maintains that our moral grasp of a situation, our moral perception of it, must be examined and cognitively evaluated. Empathy provides only an incomplete picture of the situation and generates in us a corresponding moral sentiment that may not accurately reflect the lived experience and emotions of the other, the subject of our perception. Thus, we must cognitively process, evaluate, and interpret our initial moral perception. Only a thorough examination of our perception of the situation can supply us with an appropriately balanced moral judgment and guide for action.

Moral perception and judgment function in concert, according to Vetlesen, blending emotional and cognitive faculties into one process for moral action. Recognition of another's suffering is only the first step. Acting on our first, intuitive, empathetic assessment may not respect the personhood of the one suffering. Through self-

reflection—"Why is it that I feel the suffering of this other?"—followed by interpersonal dialogue with the other, if possible, we can come to understand how the other is experiencing suffering and devise appropriate strategies to help the other overcome it.

As shorthand to describe the empathetic grasp of another's suffering, followed by an assessment of how the other experiences suffering, Vetlesen terms his integrative moral procedure empathetic understanding. If cultivated by all individuals in an ethics consultation, empathetic understanding facilitates the achievement of collective empathy, the moral standpoint I argue is necessary to help overcome emotionally charged value conflicts. In Chapter Four, I discuss the intricacies of Vetlesen's conception of empathy and its relationship to morality and ethics consultation in greater detail.

Authentic decisions are those that we make *our own* by consciously reflecting on the decision to be made and consciously authorizing it. In order to achieve authenticity, our emotive and cognitive faculties of perception and judgment must be actively integrated. Empathy, which has both inward, intrapersonal and outward, interpersonal components, provides the link between authenticity and integration. If empathy can be generated first between a patient, surrogate, or clinician and the consultant, then collectively among the parties, collective moral responsibilities bind the parties. One such responsibility is for partiesto regard one another as subjects of moral respect and concern, which, in turn, engenders a shared willingness to engage in moral dialogue. Since *Core Competencies* focuses exclusively on empathy as a consultant-driven activity, an expanded conception of empathy and procedures for engendering it are required. In this regard, ethics facilitation requires supplementation.

Empathy, to borrow from Pellegrino, must be a collective virtue, and ethics consultants can play an important role in modeling empathy and in helping to generate and maintain collective empathy. Collective empathy becomes most challenging to engender and sustain in ethics consultations when emotional tensions between or among patients, surrogates, or clinicians erupt into emotionally charged impasses. These impasses are characterized by many phenomena: a direct conflict between values or proposed options; when situations seem intractable because emotion and/or reason are not integrated on a multitude of levels; and when communication has broken down or communication barriers hinder the development of engaging in dialogue.

Such impasses can have intrapersonal and/or interpersonal elements. For instance, a patient, surrogate, or clinician may have a strong emotional reaction to one of the proposed options (an intrapersonal element), thus causing a breakdown in communication (an interpersonal element). As an example, I offer the emotional case of withdrawing artificial nutrition and hydration (ANH) from a patient in persistent vegetative state (PVS). This case, which features an emotional impasse, and its analysis in this and subsequent chapters illustrates the need for supplementing ethics facilitation with an expanded, phenomenological conception of empathy and procedures designed to enshrine such a form of empathy in the ethics consultation process.

Part II: Jamie's Case

An intern, Dr. Jessica Cassidy, describes the case history of one of her patients. "Jamie Jackson, a 21-year-old man in a persistent vegetative state with acute bilateral

aspiration pneumonia, is not responding to increasingly stronger trials of antibiotics, and now he has developed an acute bowel obstruction."

A group of clinicians sit around Dr. Cassidy, listening to her description. The purpose, however, is not to provide advice on clinical management or to ensure that Dr. Cassidy's assessment and plan are adequate, but to provide the two ethics consultants, pediatrician Kendra Davidson and bioethicist Dennis McCullough, background information on Jamie's case.[9] It is the third of April, and Dr. Cassidy and her attending physician, Dr. Roger Nemo, are relatively new to the care of Jamie Jackson. Dr. Cassidy explains that the team agrees that withdrawing Jamie's food and water is in his best interests not to suffer, but they want help from the ethics consultants in facilitating their meeting with Jamie's mother where that discussion would take place.

Dr. Cassidy recounts information she gleaned from the chart. "Jamie was involved in an accident three years ago when a truck sideswiped his bicycle. Neurosurgeons diagnosed a severe closed head injury and transferred him to the neurological intensive care unit. Six weeks[10] after monitoring his intracranial pressures and providing supportive care, neurosurgeons pronounced Jamie in a PVS and informed his mother, Mrs. Evelyn Jackson, that he would probably not regain meaningful existence."

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[9]Although based on an actual ethics consultation, many of the background features of the case, as well as the names of the consultation participants, have been changed to protect confidentiality.

[10]A lack of consensus exists in the clinical literature as to what amount of time constitutes an appropriate timeframe for diagnosing PVS. Some argue that one month is sufficient time for diagnosis, but others disagree, positing three months and six months as alternative timeframes for establishing a diagnosis of PVS.

"Social workers were involved from the beginning," Dr. Cassidy relates, "but to no avail it seems. A note in the chart from the hospital social worker indicates that Mrs. Jackson had also lost her eldest son, Devon, in gang-related violence a few years before Jamie's accident. She is divorced from Jamie's father, who lives in another state. The note suggests that Jamie was a difficult child—often acting out at school, getting into fights, causing disturbances in the classroom, and ditching school. The social worker notes that Jamie was close to his father, and that Mrs. Jackson thought that Jamie held a grudge against her for seeking custody, and somehow that explained his behavior at school. After the divorce, Mrs. Jackson had to take a night job, so she rarely got to spend quality time with Jamie. The social worker recommended that Mrs. Jackson be referred for supportive counseling to overcome the tremendous amount of guilt she was experiencing. That referral was never made, a later note indicates. Instead, Mrs. Jackson told the social worker that she would see her pastor for counseling, Rev. Maurice Williams, at the Bethel African Methodist Episcopal Church."

Dr. Cassidy closes the thick chart and gestures to Doris Evans. "Doris was the nurse manager here three years ago when Jamie had his accident and was brought to this hospital. She could probably tell you other details that are not in the chart."

Nurse Evans relates what she remembers, both from her personal experience and in her follow-up with the various social workers and case managers involved in Jamie's care. She confirms that Dr. Cassidy's medical and psychosocial account is accurate, but adds much background to the situation. "When the neurosurgeons felt confident that Jamie was in PVS, they set up a meeting with Jamie's mother to discuss his prognosis.

They informed her that they wanted to transfer him to a long-term care facility, and that in order to facilitate that, Jamie needed the surgeons to insert a permanent feeding tube. They also informed Mrs. Jackson that although Jamie's bodily functions could be artificially maintained through tube feedings and nursing care, his condition could worsen quickly if he caught pneumonia, his bowels obstructed, or he experienced other medical complications associated with invasive life-support technology. They told her that the physicians at the long-term care facility would most likely want to write a DNR order for Jamie given the likelihood that successful resuscitation would leave Jamie worse off than he was. The surgeons explained the invasive nature of CPR—pounding on Jamie's chest, injecting him with huge cardiac needles, and shocking him with electricity to restart his heart. They also told Mrs. Jackson that performing CPR on Jamie would not benefit him and might cause him additional harm and make the clinicians having to perform it feel like they were only causing Jamie suffering."

"Although Mrs. Jackson consented to the feeding tube, she emphatically told the neurosurgeons that she would not agree to any measures that might shorten Jamie's life. She explained that her family was very religious and that only God had the power to take human life. Mrs. Jackson said the one thing Jamie enjoyed most despite his behavior at school was singing in the Church choir. He was planning to go to a gospel music summer camp sponsored by their church. The neurosurgeons decided not to press the issue regarding Jamie's resuscitation status. They figured that the physicians at the long-term care facility could counsel Mrs. Jackson about Jamie's DNR status after establishing a

relationship with her. So, Jamie was transferred to a long-term care facility as his mother requested—a full code."

"Unfortunately, Jamie's DNR status was only the first problem associated with his long-term care." Nurse Evans recounted the health insurance problems that also plagued Jamie's care. "When Jamie turned 19 years old, Mrs. Jackson received a letter from her private insurance provider. Since Jamie was not a full-time student, the insurance company was dropping him as a dependent from her policy. Child support barely covered Jamie's basic necessities before the accident. It would not begin to cover the enormous medical expenses he was incurring at the long-term care facility. Without continued insurance coverage, the long-term care facility would not provide care for Jamie. The social worker at the facility told Mrs. Jackson that she could apply for Medicare coverage for Jamie, and once approved, another facility with 'Medicare beds' could be found to take over his care. Mrs. Jackson, angry and frustrated, yelled at the social worker that she and the staff did not care what happened to Jamie as long as they got paid. The social worker tried to explain that they did not have any available Medicare beds, but Mrs. Jackson yelled at her that she wanted her son discharged to home health. One of the nurses at the facility overheard the heated exchange, called security, and had Mrs. Jackson escorted out of the building."

"Mrs. Jackson's frustration at this point was understandable," Nurse Evans remarks. "Jamie was the unfortunate victim of health care bureaucracy at its worst, and his mother was caught in the middle. The long-term facility's social worker phoned me recently and told me some additional background that might provide insight into the

present situation. In response to her frustration and her fear that Jamie would be transferred again once he was approved for Medicare, Mrs. Jackson enlisted the support of her pastor, Rev. Williams, to start a community collection fund to provide home care for Jamie during the interim. It seems she was intent on hiring a private duty nurse to care for Jamie until Medicare approved home health visits," Nurse Evans concludes. "To help Jamie's cause, Rev. Williams enlisted a local newspaper to do a story on Jamie's plight and a local TV show aired one of Rev. Williams' emotional sermons on Sunday as the collection plate made its way around his congregation."

"The plan was working," Nurse Evans says. "Rev. Williams' efforts raised six months worth of funds to provide home care for Jamie—just enough to allow Mrs. Jackson to hire a private duty nurse and rent the equipment needed until Medicare and home health could take over his care. Just as Mrs. Jackson was preparing to provide home care for Jamie, he was diagnosed with pneumonia. The physicians at the facility decided to admit him to our service for intravenous antibiotic treatment. Jamie has been with us for two months. Unfortunately, his pneumonia is not responding to several trials of different and increasingly more powerful antibiotics, and Dr. Cassidy and Dr. Nemo detected a blockage in his intestines this morning after a routine X-ray."

"Just as a precaution we've asked a security guard to be present given Mrs. Jackson's history," Nurse Evans adds, pointing to the wooden sliding door behind the ethics consultants. "The guard is sitting in the attached break room, within earshot of the meeting should he be needed, but hidden from view." The phone rings, and Nurse Evans

picks it up. Mrs. Jackson is waiting in the lobby. The ethics consultants leave to bring her to the meeting.

Mrs. Jackson, a slender black woman, enters the conference room accompanied by a tall, black man in a suit with a pastor's white collar. All the clinicians stand up and go to greet them. The ethics consultants sit down at one end of the long conference table, and the clinicians, all white and wearing their long, white coats, cluster around the consultants.[11] Mrs. Jackson and Rev. Williams sit at the other end of the table. This seating arrangement only accentuates the noticeable differences in power and race between the parties.

After the introductions, Dr. Davidson, the attending ethics consultant, turns to Dr. Cassidy and asks her to start.

"Mrs. Jackson, we have been taking care of your son, Jamie, for several months," Dr. Cassidy explains. "His pneumonia has progressed beyond the point where antibiotics can cure him, so we have stopped them." Mrs. Jackson, a thick folder of notes from similar meetings spread before her, nods her understanding.

"It is quite common for patients like Jamie to develop pneumonia. Jamie cannot swallow, so his own saliva or his nutritional supplement can seep into his lungs, which produces infections like the pneumonia he has now. However, we cannot cure this pneumonia—several trials of increasingly stronger antibiotics have not worked. The blockage in his intestines we told you about this morning is even more troubling. The

[11]The consultants at the particular institution where this case was taken from had an explicit policy of not wearing clinical attire (white jackets, scrubs, stethoscopes, etc.) while conducting ethics consultations. Special badges, with the consultant's name, degree, and the words 'Ethics Consultation Service,' were worn instead of hospital picture badges during consultations.

surgeons say it's too risky to perform surgery on Jamie because of his lung infections, and even if they would perform the surgery, he would still have pneumonia, which would, untreated, kill him in a matter of days or weeks. But if we can't fix his bowel obstruction, he won't survive that long. I'm sorry, Mrs. Jackson, we've done everything we can."

Dr. Cassidy pauses for a moment, letting the silence dwell for a moment. "Given that we cannot cure his pneumonia and the surgeons will not perform surgery to fix his bowel obstruction, continuing to provide Jamie nutrition will only prolong his dying. Thus, we think it is best if we stop the feedings as well as the antibiotics."

Mrs. Jackson begins to cry loudly. The nurse manager looks nervously at the wooden door separating the conference room from the nurses' break room where the security guard waits. Rev. Williams attempts to comfort Mrs. Jackson, while he glares at the physicians. "What do you mean?" he shouts, slapping his palm on the table. "You're going to starve Jamie to death!"

The ethics consultants look at each other in disbelief. What started out as an attempt to help the team explain Jamie's grim clinical situation and review the options available suddenly turned into an ethics consultant's nightmare. How would they be able to bridge the gulf between the medical team's understanding of the facts and Rev. Williams' highly emotional state of mind and Mrs. Jackson's religious values in order to engage the parties in a constructive dialogue?

Part III: Analysis of Jamie's Case and the Need for Collective Empathy

As *Core Competencies* and many other ethics consultation modalities suggest, good ethics start with good facts. The numerous meetings that have been held between various clinicians and Mrs. Jackson suggest one of three things. Perhaps she has not been able to understand the serious nature of Jamie's clinical condition or maybe she has understood it but her belief system is such that life is an absolute value and Jamie must be kept alive regardless of how poor his prognosis. A third option is that Mrs. Jackson is in denial.

The real question, however, is whether it can be determined if Jamie shared or would have shared that moral outlook. If not, the parties must collectively determine whether Jamie's continued treatment represents more of a benefit than a harm to him. By introducing and reinforcing such bioethical concepts as surrogate decision-making, substituted judgment, and best interests, the ethics consultants can help determine if treatment should be continued or withdrawn. Moreover, their ability to foster dialogue might help in generating yet additional options that match the stated values of each party. To accomplish these tasks, however, it is necessary, as both Moreno and Lynch argue, to move the discussion forward while simultaneously acknowledging the value differences between Rev. Williams, Mrs. Jackson, and the team.

However, such discussion cannot take place until the emotional issues—Rev. Williams' outburst, Mrs. Jackson's level of mistrust, and the team's sense of moral frustration—have been addressed. After building trust and rapport by showing empathy and acknowledging the emotions present, it should be possible to discuss whether

removing Jamie's feeding tube will starve him to death. The most effective way to approach this highly emotional issue *after acknowledging the emotions present* is to provide Rev. Williams and Mrs. Jackson with a complete explanation of Jamie's underlying condition and explore current clinical understandings of withdrawing ANH and their ethical implications.

PVS patients like Jamie are alive—they have sleep-wake cycles, blink their eyes, exhibit rudimentary reflexes such as squeezing a hand placed in their own—but they lack higher cortex functions, activities such as speech that mark human interaction and impart meaning to existence. These basic signs of life can often confuse surrogates into thinking that their loved one will someday recover some neurological function. It is not known whether PVS patients feel pain or suffer, and this lack of knowledge compounds withdrawal decisions for them.

PVS patients may be medically maintained for many years with proper and constant supportive care. Some people view PVS as a sort of limbo between life and death. Depending on deeply cherished values about the meaning and sanctity of human life, keeping a PVS patient alive can allow hope to remain or it can prevent grief from beginning.[12] Moreover, the clinical literature has not reached consensus as to when a diagnosis of PVS can be firmly established (after one month, three months, or six

[12]The epitaph on Nancy Cruzan's gravestone is a telling example of how PVS can forestall the dying process for the patient and the grieving process for the family (Fletcher, et al., 1998, p. 130):

NANCY BETH CRUZAN
MOST LOVED
DAUGHTER – SISTER – AUNT
Born, July 20, 1957
Departed, Jan 11, 1983
At Peace, Dec 26, 1990

months). Neurosurgeons initially diagnosed Jamie after six weeks—a diagnosis that could reinforce Mrs. Jackson's mistrust if the lack of medical consensus were revealed to her. Nevertheless, three years represents a long enough time to be certain Jamie is in PVS (The Multi-Society Task Force of PVS, 1994; Payne, et al., 1996). Given these difficulties, the clinicians involved in Jamie's care should have: (1) developed a relationship with Mrs. Jackson early on; (2) provided her with information regarding substituted judgment and surrogate decision-making and reinforced this education on numerous occasions; and (3) fostered an environment for open discussion of the possible end-of-life decisions to be made in the future. These opportunities appear to have been missed or sidestepped in Jamie's case and may have exacerbated the level of distrust Mrs. Jackson and Rev. Williams now feel.

To further complicate matters, the ethics consultants should explain that a myth exists (among clinicians and surrogates alike) that withdrawing food and water from certain patients will "starve" them to death—a morally and emotionally repugnant scenario given the universal emotional significance of food and water. In normal circumstances, providing food and water to patients represents the pinnacle of caring. To withdraw these vital necessities somehow implies that care and caring will also be withdrawn. Despite how common such a sentiment seems to be, ethics consultants should explain that this myth about withdrawing ANH is based on a misunderstanding of human physiology.

First, the ethics consultants should explain that patients from whom ANH has been withdrawn will die from dehydration before any of the effects from malnourishment

or starvation occur. Thus, "starving" Jamie is not a possibility. Moreover, recent investigations in end-of-life care suggest that dying patients do not often suffer thirst when they or others decide to withdraw ANH (Brody, Campbell, Faber-Langendoen, & Ogle, 1997; Jackonen, 1997). Limiting nutritional intake is seen as a natural part of the dying process (McCue, 1995). Furthermore, if patients do experience thirst, there are interventions to alleviate the physical symptoms of dehydration and the emotional toll such experiences can cause for family and loved ones (Brody, et al., 1997). In Jamie's case, purposefully hydrating him will unnecessarily prolong his dying process, since surgeons have refused to repair his bowel obstruction. If ANH is continued and nothing is done about his bowel obstruction, Jamie's abdomen will swell from fluid overload, he could vomit, and the high fever from sepsis will most likely produce agony and agitation.

Sometimes decisions to withdraw ANH are medically indicated—as in the case of the terminal stage of an illness like cancer—but still very emotionally difficult. The misperception that withholding or withdrawing treatment also means that care and caring will also be withheld or withdrawn needlessly compounds the emotional difficulty of such decisions. Moreover, the emotional agony increases when such decisions involve medical uncertainty—as in the case of neurological trauma, where doctors do not know if a patient experiences pain or what the chances are for any level of recovery. Respecting religious and cultural values, such as those that emphasize the sanctity of life, add another level of complexity to these already difficult decisions.

After assessing Jamie's clinical situation and explaining that he will not starve to death, but continuing to hydrate him will prolong his dying, the ethics consultants should

introduce a discussion regarding decision-making standards. As his surrogate, Mrs. Jackson needs to make decisions for Jamie that incorporate his own value system. Did Jamie in fact share the same moral and religious outlook that Mrs. Jackson has espoused? There is *some* evidence he *may* have, given his interest in gospel music and his attendance and participation in church activities. Does that automatically, however, mean that he would want ANH continued? Perhaps Jamie's religious views were not as absolutist regarding the sanctity of life as Mrs. Jackson's seem to be. Perhaps he viewed life as precious only if he could sing. Did Jamie ever talk about such a situation with anyone—his mother, his father, his friends, or his pastor? If Mrs. Jackson is making decisions on the basis of what she wants or if her decisions contradict what Jamie would have wanted, she is not appropriately acting as his surrogate.

If a substituted judgment cannot be made because the decision-makers lack crucial knowledge to determine what Jamie's values were or if it is being improperly made, another decision-making standard, best interests, must be applied. Given Jamie's clinical situation, a strong argument could be made that withdrawing his food and water is in his best interests. Bowel obstructions require acute surgical intervention (and Jamie's case occurred before the drug octeotride, which provides a non-surgical method to correct bowel obstructions, was clinically available), and surgery will not be performed due to the additional risks Jamie's infections pose. Moreover, given that Jamie cannot swallow or protect his airway, performing surgery seems without long-term benefit because sooner rather than later he will develop another infection.

Feeding him intravenously (total parenteral nutrition, TPN) only postpones the same emotionally difficult decisions. If a surgeon could be found to perform the risky procedure to successfully remove Jamie's obstruction, TPN may keep him alive for a few more months, but placing a central arterial line for the TPN has its own risks and burdens—infections, infiltration, routine IV care—as does providing TPN. TPN is most often a temporary, last resort for nutrition; it can lead to electrolyte imbalances, spiked sugar levels, and is so toxic to the liver as to require eventual withdrawal.

In addition, since Jamie has developed some form of multi-resistant pneumonia, the likelihood of it resolving on its own is slim, since good immune reactions require adequate nutrition. Moreover, if Jamie overcame this bout of pneumonia, future infections are an inevitable part of his clinical condition, and he would be unlikely to survive another one. Furthermore, given that the symptoms of withdrawing food and water can be treated and Jamie provided a more comfortable death by withdrawing ANH rather than letting his obstruction rupture and cause sepsis, high fever, and agitation, withdrawing ANH would be one ethically justifiable option. Furthermore, Jamie's mother and Rev. Williams can partake in providing Jamie a comfortable death by using glycerin swabs and ice chips to keep his mouth and lips moist and providing physical comfort and prayer as he dies.

That this assessment seems so clear points to several missed opportunities in the early stages of Jamie's care to lay the groundwork for these emotionally difficult end-of-life decisions. A pro-active model of addressing ethical concerns would involve developing an open relationship to facilitate communication about such emotionally

laden issues (Karlawish, Quill, & Meier, 1999) and early discussion and consistent reinforcement of the decision-making standards to be used (Dowdy, Robertson, & Bander, 1998). Some failures are systemic, whereas others involve sidestepping of difficult, yet important, issues.

The fragmented nature of Jamie's care after his accident represents a systemic failure. Perhaps the social worker should have either insisted that Mrs. Jackson see a professional bereavement expert in addition to her pastor or ascertained Rev. Williams' expertise in this area. The failure of the neurosurgeons to adequately prepare Mrs. Jackson regarding the difficult decisions ahead or determine what Jamie's values were and record them as a baseline to compare against Mrs. Jackson's represent sidestepping or "turfing" issues to the long-term care facility, not a failure of the system. The pro-active ethics model of Dowdy and colleagues (1998) emphasizes the need to address questions such as resuscitation status and values history before discharge. Early intervention, even if Mrs. Jackson insisted on a full code for Jamie on religious grounds, is the professional responsibility of the health care team. It helps to establish an ongoing relationship with the surrogate so that future discussions about surrogate decision-making are consistent and reinforce the need to make decisions using the appropriate standards.

Provider discomfort, sometimes deceptively phrased in the language of the therapeutic benefit for the surrogate not to engage in end-of-life discussions, does not remove the obligation for disclosure and discussion. Perhaps the neurosurgeons should have involved ethics consultants to facilitate the meeting where Jamie's resuscitation status and values history were first broached. The fact that Mrs. Jackson's assumption

that a DNR would, by definition, shorten Jamie's life should have been reframed and the rationale behind the order explained more clearly so that if she still wanted to refuse, the decision was an informed one, not based on a misconception that a DNR is equivalent to withdrawing care.

It is not ethically or legally appropriate to evaluate the validity of religious values in certain treatment decisions (*United States v. Ballard*, 1944), especially withdrawal of treatment. The converse—using religious values to demand continued treatment that is, in the medical opinion of the team, not beneficial—is less clear legally and ethically. Nevertheless, it is necessary to ensure an adequate level of understanding for the various options so that religious values do not act as an automatic trump before receiving enough information to make an informed decision.

The emotional difficulty in end-of-life discussions often presents patients, surrogates, and clinicians with a multitude of challenges. Nevertheless, by the time Jamie had developed a bowel obstruction, he had been on the medicine service for two months. What were the goals of his treatment? Were these goals ever discussed with, agreed to, or communicated to Mrs. Jackson? Early discussion of the clinical goals for Jamie might have alerted the team that Mrs. Jackson had perhaps unrealistic expectations, allowing them time to explore the options with Mrs. Jackson and provide early intervention by ethics consultants, if necessary, to complement the information and discussion from the team (Fine, 1991).

Instead, the decision-making has reached a crisis, and strangers to his care—the clinicians, who feel moral frustration from past systematic failures and sidestepping of

end-of-life discussions, and the ethics consultants—must now help Mrs. Jackson make decisions under the worst of circumstances. The earlier windows of opportunity for discussion and exploration of options, which might have allowed Mrs. Jackson to take a pro-active role in making treatment decisions, have passed or been slammed shut. The choice seems now all or nothing, and the clinicians feel forced into withdrawing not only to protect their own sense of professional integrity but also to minimize Jamie's and Mrs. Jackson's suffering.

Bioethicists Larry Churchill and Alan Cross (1986) have suggested an illuminating concept for situations like Jamie's case that seem to involve "all or nothing" ethical choices. They term such situations instances of "either/or" ethical thinking (Churchill & Cross, 1986, p. 9). The perceived lack of options—that the only avenue of resolution is the choice between two extreme options—often leads frustrated, guilty, or angry persons to acquiesce to the will of the stronger or to resign themselves to choosing "the lesser of two evils."

One reason why choices seem constrained in such highly emotive cases is because both sides are experiencing the negative disequilibrium associated with prolonged moral distress. While largely explicated in the nursing literature, the experience of moral distress and its associated negative disequilibrium occurs whenever a person feels they know the right decision but institutional constraints make the implementation of such decisions nearly impossible (Jameton, 1984). Rev. Williams and Mrs. Jackson share a religious worldview that makes their preferred choice for Jamie's continued care conflict

with the values of the clinicians. Their protracted and pervasive experience of this form of negative disequilibrium has made their moral distress quite acute.

Nursing researcher Judith Wilkinson has identified two coping strategies for persons experiencing moral distress. Wilkinson reports that the usual sequence of subjects' experience of moral distress results from particular situations where a subject cognitively believes that she knows the morally proper course of action, but her inability to implement the action results in feelings of anger, frustration, or guilt. According to Wilkinson, the accumulated evidence from similarities in a number of interviews illuminated a model of moral distress. The model suggests two outcomes of prolonged moral distress—a negative coping strategy (characterized by loss of self-esteem and withdrawal from particular instances that might spark moral conflict) or an effective coping strategy. An effective coping strategy would have to address each dimension of moral distress—situations that cause the feeling of distress, the cognitive and affective aspects of the feeling, and the experience of not being able to act on those feelings. In light of this analysis of moral distress, the lack of participation from Mrs. Jackson and the strong reaction from Rev. Williams make psychological and moral sense. The question is what the ethics consultants can do to help move dialogue forward.

Churchill and Cross, who equate the experience of moral distress with the foreclosing of ethical options and creative moral problem-solving, might help provide a remedy. They describe a sequence of moral evaluation that involves describing one's moral experience (of distress, in this case), eliciting assumptions, considering multiple alternatives, and justifying choices that could serve as a mechanism for ethicists to use

when distress occurs in an ethics consultation. The mere articulation of the negative disequilibrium one feels when experiencing moral distress can be cathartic.

Part of achieving a deeper understanding of the problem involves examining one's description of a moral experience in order to determine what assumptions are being made. The next step is to devise ways to either gather more "data" to fill in the gaps or to acknowledge a certain element of moral uncertainty is present in the problem-solving process. Once we understand what we are assuming, a skilled ethicist can help foster creative moral problem-solving. Creativity is necessary when approaching moral problems, for we have a tendency to see options in terms of "black-and-white" solutions. It is either remove Jamie's feeding tube and let him die from dehydration or not. The tendency to see the resolution of moral dilemmas in terms of this either/or thinking can forestall the process of moral deliberation. Posing multiple alternatives can often lead to a reformulation of the original problem in terms of a richer description of the moral motives, assumptions, and feelings present in the situation. Seeing the broader landscape into which one's own moral experience fits as a piece or a specific passage helps persons experiencing moral distress overcome their own viewpoint or to feel morally empowered to make a decision.

Thus, despite their best efforts at ethics facilitation, without some way to acknowledge the host of affective dimensions in this ethics consultation first, followed by an attempt to foster collective, empathetic understanding, the consultants may fail in their task. Thus, at the interpersonal level, Mrs. Jackson, Rev. Williams, and the clinicians require a way to understand each other's moral perception of the situation. This

understanding cannot occur without each acknowledging and expressing their intrapersonal frustration, mistrust, and anger first, followed by integrating these emotions with cognitive processing of Jamie's clinical situation and the realistic options available. At a practical level, the ethics consultants require both skills and procedures to supplement ethics facilitation to achieve this integration. This dissertation attempts to provide both.

Chapter Three

The Role and Nature of Emotion and its Implications for Ethics Facilitation: The Genesis of Transformative Ethics Consultation

Emotions are "modes of sensitivity that record what is morally salient and... communicate those concerns to self and others."

—Nancy Sherman, 1995, p. 65

Introduction

I ended Chapter Two by outlining the topics to be covered in the remainder of this dissertation. These topics included: (1) the nature and role of emotion in morality in general and ethics consultation in particular; (2) the integrative nature of moral decision-making; and the nature and role of empathy in achieving (3) moral integration and (4) authenticity. The goal of this chapter is to discuss the first two elements from the argument initiated in Chapter Two. To reiterate, the argument consisted of the following statements: Cases like Jamie's, which involve strong emotional tensions, represent a challenge to ethics facilitation; and the challenge can be overcome by introducing an ancillary process to ethics facilitation that expands the role of empathy from a consultant-directed activity to a collective activity in which all parties engage.

In Chapter Two I concentrated on outlining several ethics consultation modalities, focusing in particular on ethics facilitation and how its core competencies function in the resolution of difficult cases like Jamie's. One of the core competencies includes empathy, which should help reconcile the affective or emotional dimensions present in some ethics consultations. Empathy and emotion are linked, for emotion plays a central role in establishing and maintaining empathy. In this chapter I explore the role of emotion in

ethical decision-making, and in the next I analyze empathy. After presenting overviews of the four central concepts underlying the argument initiated in Chapter Two, it will be possible to use the discussion of these concepts to synthesize the steps needed to overcome emotional impasses in ethics facilitation. Since Jamie's case provides an excellent backdrop against which to judge the appropriateness of the conclusions of this chapter, it will end with additional case analysis as the means to illustrate some of the elements necessary to supplement ethics facilitation.

Part I: The Neurobiology and Psychology Literature on the Nature of Emotions

Much of the history of philosophy has tended to either minimize the value of emotion in moral decision-making or suggest it negatively impacts the ability to make rational moral decisions. This received view has been intensely criticized lately, largely because of a renewed interest in the role of emotion in morality, sparked most recently by the pioneering work of psychologist Carol Gilligan and increased understanding of the neurobiological mechanisms of emotion. The combined evidence from these diverse areas of thought refutes the so-called "negativity" traditionally associated with emotions and their role in morality and posits emotion as an essential component of competent moral decision-making.

Like much of the history of philosophy, much of the scientific literature up until recent years misconstrued the role and nature of emotion. The impact of emotion on health and illness, such as the discovery of the stress, or fight-or-flight, response and its associated relaxation response some 40 years ago, prompted polarization of emotions into

negative and positive categories. Thus, emotions like anger, fear, grief, helplessness, and sadness were implicated in raising the risk of certain illnesses or being harmful to physical well-being, whereas peace, love, hope, humor, and trust were imputed to improve health and our immunological response to certain illnesses like cancer.

Evidence seemed to support the hypothesis regarding the negative effects of emotion on health. Early animal experiments demonstrated that stress increased the incidence of several disease processes. Research on humans (psychophysiological response tests to a variety of stressors and epidemiological studies of behavior types) seemed to link stress to disease processes in humans. The most notable studies suggested that certain personality types—type A and B personalities—influenced risk of coronary artery disease.

Based on this evidence, researchers hypothesized that if stress leads to disease, an opposite response, relaxation, might improve health and physical well-being. Extensive research suggests that relaxation techniques like imagery and meditation do indeed relieve certain ailments like certain types of headaches, chronic pain, and gastrointestinal disorders. However, analysis of the treatment effects of such studies shows an inconsistent pattern of relief, and in some studies, such as a study of stress-reduction techniques on hypertension, relief was usually found not to be clinically effective (Dafter, 1996).

While initially promising, psychologist Patrick Dafter (1996) argues that such findings would seem to indicate that "the variables for using psychological treatments to influence physiological systems are more complex than can be accommodated by a black

and white model of stress in which negative emotions...have pathogenic effects and positive emotions, beneficial ones" (p. 9). Dafter analyzes recent studies that point to a different understanding of emotion. Rather than polarizing emotion into two categories and suggesting that negative emotions cause health decline or poor immunological reactions to disease and positive emotions bolster the immune system and protect against certain illness, Dafter suggests a spectrum model of emotions.

The spectrum model argues that emotions are neither positive nor negative. Rather, they are innate, neutral psychobiological signals having distinct and corresponding physiological manifestations. These signals serve as a bridge for mind-body healing for the individual who, using the full range of emotions, can appropriately express and process such signals. Such a view leads Dafter (1996) to conclude that the "key to the 'negativity' of an emotion is not its content [as was previously thought], but whether or not it is acknowledged and expressed" (p. 13). Before extrapolating such a claim to morality, it is necessary to briefly present the evidence behind Dafter's conclusion.

As a first step, Dafter points to studies illustrating a correlation between stress and immune responses in cancer. Such studies show two general effects of stress on immunity: Stress down-regulates and relaxation up-regulates immune responses. The former effect has been implicated in immunosuppression and increased cancer risk. The evidence for the latter is mixed, but researchers have suggested that up-regulation from relaxation aids in healing cancer and in improving the ability of the immune system to ward off cancer. Despite these observed correlations, Dafter argues that there is not yet

enough research to substantiate the hypotheses fully. Furthermore, he points to several contradictory findings from stress research, suggesting that the relation between stress and emotions and stress and the immune system is more complex than the up- and down-regulation hypotheses can accommodate. Dafter advances several variables that illustrate the complexity involved, leading him to conclude that a broader theory is needed to account for all the evidence.

Emotional maturity is one such variable. Studies indicate that the up- and down-regulation effects of stress is more pronounced in younger subjects than in older subjects, suggesting that emotional habituation and life experience can moderate up- and down-regulation of immunity. Moreover, the amount and type of social support subjects receive in times of stress, especially during grieving after the loss of a loved one, buffers the presumed adverse effect of stress on health. Dafter (1996) hypothesizes that social support provides a safe place for the experience and expression of so-called negative emotions (anger, fear, frustration, and uncertainty). Time is also a factor in the strength and duration of stress effects on health. Thus, the fact that specific stress regulation studies either focused on one single measurement during chronic stress or evaluated short-term immunological effects after only a period of minutes or hours limits the scope of the conclusions such studies can draw. Measuring stress responses at different intervals and under variable conditions during chronic stress would provide more clinically relevant information, according to Dafter.

As a final, mortal blow to the up- and down-regulation of stress hypotheses and thus the positive-negative dichotomy of emotions, Dafter cites numerous studies that

show triggering either so-called positive *or* negative emotions produces positive immunological effects. In these studies, “the acknowledgment and expression of so-called negative feelings were associated with better physiological activity” (Dafter, 1996, p. 11). The findings from such studies are interesting examples of how the full spectrum of emotions, properly acknowledged and expressed, provide positive health benefits.

Two studies suggest that breast cancer patients who had higher anger scores on standard psychological tests and who were antagonistic and uncooperative with caregivers had higher survival rates than patients with lower anger scores and with pleasant, cooperative attitudes. In another series of studies with skin cancer patients, researchers correlated tumor thickness and immunological response with the expression of sadness or anger by patients. Patients who did not express so-called negative emotions had thicker tumors. The same observation was noted in those patients who denied their anger, fear, and sadness but whose emotions registered in their facial expressions and on instruments designed to measure their psychophysiological responses. On the other hand, those patients who displayed and expressed their sadness and anger exhibited two positive immunological responses—more white blood cells and macrophages, cells involved in immunological responses to cancers in the body, near and around their tumors.

On the basis of such studies, Dafter argues that while the up- and down-regulation studies show that alterations of immunology occur in response to stress and emotions, they cannot conclusively be considered the sole causal agents of such changes. The upshot of this discussion is twofold. First, the presumption that stress directly causes

illness is more complex than originally believed. Second, and more important, overall health turns on whether the individual is aware of the information transmitted by their emotions and whether they can make use of that information to initiate behaviors to improve their condition. Dafter cites additional studies on cancer support groups and a new hypothesized personality type C as evidence for the second claim. These studies clearly establish the need for a theory of emotion that does not polarize emotions into negative and positive categories.

The studies on cancer survival and expression of so-called negative emotions has led to the development of a theory correlating an observed behavior pattern, termed type C, with vulnerability to cancer. Type C personalities mask feelings like anger, fear, and sadness with pleasantness and put the needs of others before their own. In the cohort of skin cancer patients studied, 75 percent exhibited the characteristics associated with the Type C personality. This finding has prompted researchers to hypothesize that "the constant, repetitive repression of emotions creates immunosuppression and that deviating from Type C behaviors might help some people recover from cancer or prevent it from developing" (Dafter, 1996, p. 12).

Moreover, Dafter presents studies on cancer support groups that show a direct correlation between the expression of anger, fear, and depression and length of survival. Interestingly, researchers found no correlation between so-called positive feelings and length of survival or recurrence of cancer in these studies. Researchers have argued that the social support and feelings of connectedness engendered by groups enabled the exploration and expression of all emotions. They hypothesized that since "serious illness

often activates unfinished life issues, the 'toxic' emotions that naturally arise during…life reviews can actually provide energy and motivation for important inner and outer changes" (Dafter, 1996, p. 12).

On the basis of the evidence against the categorization of emotions as either positive or negative and the benefits of acknowledging and expressing so-called negative emotions, Dafter argues that a broader theory of the function of emotions is needed to account for the accumulated evidence. The research points to a spectrum theory of emotion: Emotions are distinct, innate, psychobiological responses manifesting in specific physiological states. Such a claim suggests a distinctive number of emotions, called primary emotions, which can be blended together like primary colors and from which we derive the entire "emotional color spectrum" of subtly different emotional experiences.

Psychologists have identified at least six and as many as nine primary emotions. Most agree that the following seven represent innate emotional responses: anger, interest, contempt, disgust, fear, joy, and shame. Research has confirmed the primacy of these emotions by correlating subjects' subjective experience of them with unique physiological states and characteristics. Ethnographic studies have established the stability and consistency of these primary emotions and their distinctive physiological manifestations across numerous cultures. Furthermore, child development research has shown that infants seem "prewired" to exhibit a range of primitive emotions and learn to shape these emotional building blocks into increasingly complex expressions of specific emotions via interpersonal contact with parents and relatives (Darwall, 1998). Thus, "the

stress and relaxation responses—the bad and the good emotions—do not exhaust the emotional domain. Instead, they…[are the] gross end points of a spectrum of emotions of many more subtle biobehavioral states" (Dafter, 1996, p. 13).

The spectrum model regards so-called negative emotions as a necessary and instructive source of information for the individual experiencing or expressing them, not as a sign of emotional weakness or a failure to remain optimistic. According to Dafter (1996), "emotions motivate us to act in self-adjusting ways, provided they are expressed in a regular fashion rather than held in, in which case they tend to build up to a violent expression" (p. 13). For example, anger can energize us to take action in response to an unfair or threatening situation. Sadness moves us to seek comfort and contact. Fear prompts us to challenge or flee danger. But more important, in certain healing relationships (such as between patient and physician or between intimates) recognition of the interpersonal cues and outward expression of another's emotions prompts what Dafter (1996) terms "empathetic attunement"—"the capacity to understand and value a[nother] person's subjective experience" (p. 16). Empathy, then, is a learned emotional response with the aim of helping the other to "access and utilize their full spectrum of emotions to enhance their own well-being" (Dafter, 1996, p. 16).

What relevance does this discussion of the interplay between emotion and health have for morality? It is relevant on two grounds. First, it is possible to make an analogy between ethics consultation and the health benefits of fostering so-called positive emotions and allowing the acknowledgment and expression of so-called negative emotions. As I will argue in Chapters Five and Six, one crucial first step in an ancillary

process to supplement ethics facilitation involves allowing all parties in an ethics consultation the opportunity to acknowledge and express their emotions. Just as the acknowledgment and expression of so-called negative emotions can improve immune responses, an analogous process in ethics consultation might help to establish improved communication responses (i.e., the collective empathy needed to reach consensus).

Second, the psychology literature on moral development and moral decision-making, presented in detail in the next section, parallels Dafter's spectrum model of emotions. Moreover, this literature places emotion on equal moral footing with reason, which has been extolled as the pinnacle of psychological moral development. However, rather than suggesting that emotion supplant reason in moral decision-making, this literature suggests that both should act in concert. Analysis of this literature, therefore, suggests a connection between the biological and psychological nature of emotion and its integrative role in morality.

Just as it is possible to analogize from Dafter's conclusion regarding the positive health benefits after acknowledging and expressing so-called negative emotions, an interesting analogy can be made regarding the necessary integration of emotion and reason in morality and ethics consultation. Decisions made without first balancing or integrating our emotional reaction with our reasoned evaluation of a moral situation will fail to acknowledge that emotion plays an integral role in morality. Such decisions may lead to the sort of moral distancing that characterizes purely cognitivistic or "ideal observer" theories of morality that emphasize rational objectivity. As bioethicist Erich Loewy has argued, morality requires integration. In his words, "Feeling…without theory

has no head and, therefore, no plan and no direction; theory eventuating in sterile rules…lacks humanity and heart. Neither one nor the other is complete in itself" (Loewy, 1995, p. 56).

Part II: The Integrative Nature of Morality: A Brief Review of the Psychology Literature and its Relevance to Bioethics

In her landmark book *In a Different Voice: Psychological Theory and Women's Development*, Carol Gilligan (1982) challenged the psychological findings of her professor, Lawrence Kohlberg. Kohlberg (1981) argued that the moral development of children, like their cognitive development, progresses until they become increasingly independent and autonomous. Gilligan noticed that Kohlberg's work depended on studies of boys and men. She repeated those studies using girls and women as subjects and observed that girls and women seem to conceptualize moral problems differently than boys and men. Girls and women characterized their moral experiences not by independence and abstract reasoning, but rather by concern for sustaining the quality of moral relationships. Rather than concluding that girls and women were somehow morally inferior for not reaching the level of moral development hypothesized in Kohlberg's work, Gilligan (1982) surmised that girls' and women's "awareness of the connection between people gives rise to a recognition of responsibility for another" (p. 30).

Gilligan's challenge to the received view that the pinnacle of moral development involves independence, autonomy, and rationality inaugurated a renewed interest in how relationships, emotions, and caring function in morality. As a result, scholars across the

disciplines have called for the type of integration of reason and emotion in moral decision-making for which Gilligan's work compellingly argues. Psychologist Sidney Callahan, who attempts to develop a comprehensive theory for moral decision-making, is such a scholar. Callahan's account of conscience—the self-conscious and active integration of reason, emotion, and will—relies on Gilligan's account of moral development.

Callahan argues that at first it seems Gilligan's research suggests morality is gender-specific and therefore unintegrated—men use reason and women use emotion to solve moral difficulties. This erroneous interpretation is often attributed to Gilligan's work, Callahan indicates. Gilligan (1987), however, argues in a subsequent paper entitled "Moral Orientation and Moral Development" that integration of both moral "voices" is possible and, in fact, necessary to resolve moral conflicts and encourage moral development. Gilligan's latter work provides the foundation for Callahan and a multitude of bioethicists to argue that moral decision-making must be integrative.

Although bioethicists have not attempted to develop a full-fledged theoretical framework for integrating emotion and reason like that of Callahan, many have been influenced by Gilligan's work. They, like Gilligan and Callahan, advocate for an integrative approach to ethics that incorporates reasoning as well as emotion, character, and life experience. For Priscilla Alderson (1991), "true respect for human beings involves respecting emotions, in oneself and others, and learning through them.... Patients need medical ethics which respects the whole thinking-feeling person, not just the rational person" (p. 16). Such a claim underscores the importance of the

complementary nature of emotion and reason. Rationality is important in ethical decision-making. However, to deny the place of emotion is to deny an essential element of the human condition. As Alderson (1991) suggests: "People are guided by moral (not just cognitive) reasoning, feeling and intuition, by the essential wisdom in themselves and others" (p. 18). For instance, minimizing the moral significance of the feelings Mrs. Jackson and Rev. Williams experience—shock, anger, and fear at the team's proposal to withdraw Jamie's food and water or the influence of their religious values—denies them standing as moral agents and human beings. According to Dafter's spectrum model of emotion, it is necessary to understand the roots of Rev. Williams' strong emotional reaction to withdrawing Jamie's feeding tube, allow him to express and acknowledge such emotions, and facilitate understanding of how his emotions impact the decision to be made.

Traditional bioethical principles concentrate on issues of power and authority in relationships.[13] For example, it could be argued that the conflict between the team and Mrs. Jackson and Rev. Williams could be resolved by introducing a conceptual distinction from the bioethics literature on decision-making. Rather than privileging the religiously-based choices of Mrs. Jackson as Jamie's mother and care-giver, since the medical team has Jamie's best interests at heart in recommending their course of treatment, it could be argued that their decision should prevail.

[13]The patient self-determination movement in the last three decades has seen respect for autonomy overthrow beneficence as the overriding principle governing health care provider and patient relations. Concern over the inclusion of women, children, and minorities has spurred justice-based changes in policies governing the inclusion of such subjects in research.

In a critique of this traditional, adversarial configuration of power in medical decision-making, Virginia Warren suggests that bioethical principles should emerge from life experience. Inherent in her statement "that life precedes theory" is the assertion that "we need to stop segregating nurturing from theory" (Warren, 1992, p. 24). Part of this goal entails integrating reason and emotion in ethics. Warren (1992) argues that "we need to get to the heart of matters of the heart" (p. 28). Our ethics have not accounted for the variety and multiplicity of considerations that influence moral decision-making. When the moral features of relationships—emotional attachments, feelings, and intuitions, such as those Mrs. Jackson has for her only living son—achieve their due status in ethics, Warren argues that both the process and substance of bioethical discussions will be transformed. No longer will ethics make the person behind the moral decision-making invisible or "omnicompetent," as Thomas Nagel's view from nowhere requires.

Jocelyn Downie and Susan Sherwin (1992) take Alderson's and Warren's arguments one step further and apply their mode of thinking and analysis to ethics consultation. They concur with Warren's insight regarding the transformative force that a feminist approach brings to bioethics. They base this conclusion on Gilligan's research and argue that consideration of Gilligan's findings will legitimate "patterns of moral decision-making commonly associated with women" (Downie & Sherwin, 1992, p. 168). Instead of merely replacing reason with emotion, a feminist approach to bioethics case consultation "attends to these two different patterns of ethical decision-making and, in contrast to traditional ethics, views both of them (and others) as being legitimate in certain contexts" (Downie & Sherwin, 1992, p. 169). In this way, both emotion and

reason can be incorporated into moral thinking. The challenge, however, remains how to procedurally operationalize this integration in ethics consultation.

Erich Loewy's analysis takes a first step towards operationalizing the integrative nature of morality. He suggests that morality without reason is no better than morality without emotion. Instead of the tendency to supplant reason with feeling, Loewy argues that an incorporation of the best features of both elements should yield a superior approach to moral problems. Emotion should be used "as a starting point or to help guide and modulate, but not to control thinking" (Loewy, 1995, p. 60). Moral deliberation must incorporate care- and justice-based approaches, characterized, respectively, by feelings, intuition, and emotion on the one hand and reason on the other. As Loewy (1995) argues: "[Regarding] the individual case, we may call into doubt the options derived by justice-based reasoning and, modulated by the way we feel about the case, we may correct…our justice-based reasoning just as our justice-based reasoning may correct our gut feelings" (p. 60).

Remarks from Alderson, Warren, Downie and Sherwin, and Loewy suggest a growing trend across multiple disciplines regarding the integrative nature of morality. By themselves such remarks cannot elucidate a full-fledged theory upon which to operationalize the integration of reason and emotion that Jamie's case in particular and ethics consultation in general requires. However, several authors working independently, at different times and in multiple disciplines, have attempted to construct such theories, and synthesis of their respective work may help provide elements of the process this dissertation seeks.

As alluded to in the brief survey of the bioethics literature and its genesis in the work of Carol Gilligan, psychologist Sidney Callahan has attempted such work. In-depth examination of Callahan's theory helps understand how emotion and reason should be integrated in order to achieve inner harmony between these complementary moral faculties. However, it will be necessary to extend Callahan's theory to the realm of interpersonal interactions, for ethics consultation involves numerous parties who must solve shared moral difficulties. As I will argue in Chapter Four, philosopher Arne Vetlesen's work on empathy extends Callahan's internal cycle between reason, emotion, and will to the interpersonal realm.

Part III: The Psychological Role of Emotions in Morality: Callahan's Cycle of Conscience

Callahan proposes an usual understanding of the term 'conscience' to describe the self-conscious and active integration of emotion and reason in moral decision-making. She argues that reason and emotion must be intricately linked in order to make decisions in conscience. Reason judges and tutors both itself and emotion, emotion tutors itself and enacts other emotions, and our ability to listen attentively to the inner flux of this dialogue generates the will to put into action the decision that results. In order to understand this process—what I term Callahan's cycle of conscience—it is necessary to explore first what Callahan means by the term 'conscience' then how the various parts fit together into a coherent theory.

Normally, conscience refers to a self-conscious feeling that one's actions are blameworthy, which sparks a self-assessment of the reasons, followed by the generation of a procedure to correct such an action or its consequences. However, Callahan's definition of conscience does not refer to this ordinary conception. For her, conscience is not some little voice inside our head that directs us towards the good and reprimands us when we are bad. Conscience is a more dynamic, holistic, and integrative faculty; it is "a personal, self-conscious activity, integrating reason, emotion, and will in self-committed decisions about right and wrong, good and evil" (Callahan, 1991, p. 14).

Callahan suggests that cultural understandings of conscience manifested in such adages as "let your conscience be your guide" and "follow your conscience" only bring confusion to the topic of conscience. Instead of thinking of conscience as a noun describing a property that individuals possess, conscience describes an invisible, intangible psychological activity of self-consciousness. Thus, conscience is not a material object, an "it" a person "has." Rather, Callahan equates the development and use of conscience with what Aristotle called a disposition to choose in accord with right reason. Hence, a person "has" a conscience because he or she has continuously performed actions in accordance with conscience, and these past actions predispose the person to perform present and future acts in accordance with conscience.[14] Callahan suggests that the term

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[14]Philosopher Nancy Sherman (1995) makes a similar argument regarding our ability to tutor emotion. Both action and emotion, Aristotle holds, "are subject to choice in that we choose to develop a state of character that stabilizes certain dispositions to action and emotion. In this sense, how we feel (and act) may be less a matter of choice at the moment than a product of choice over time. In the case of emotion, especially, there are few shortcuts. For unlike action, emotion does not seem to engage choice (or will) in each episode. At a given moment, we may simply not be able to will to feel a certain way even though we can will to act in a given way. Cultivation of appropriate ways of standing toward our emotions, that is, of dispositions or character states, is our best preparation for those moments" (p. 668).

'conscience' is merely shorthand to describe the inculcated potential to act in a characteristic, patterned way.

Although Aristotelian predispositions provide a rudimentary understanding of how to develop conscience, many elements need further explication based on Callahan's definition: self-awareness, self-integration, holism, self-avowal, and conscience's orientation to moral goodness. Exploration of these elements provides a segue to a central concern of this chapter—analyzing Callahan's framework for how the integration of emotion and reason can help pinpoint specific elements that integration in ethics consultation will require.

For Callahan, conscience and consciousness are as deeply connected conceptually as the two terms are etymologically. Since conscience is a self-conscious, inner activity, self-awareness is a prerequisite. Self-consciousness implies that we must be awake and not drugged or sleeping. It also means that we should act with conscious, inner awareness of our self and our external environment. Callahan (1991) terms this simultaneous awareness as conscience operating in "a complex double-directed way" (p. 41).

Self-consciousness, however, does not fully describe the uniqueness of conscience. Self-integration and holism are required as well. Both elements must be present in tandem. Callahan refers to the complexity and multidimensional structure of human consciousness, its multiple capabilities, and its semi-independent partial systems to show the often diffuse nature of consciousness. One's "personal stream of consciousness is often one-sided, not broadly engaged, or focused as a whole," Callahan (1991) asserts (p. 15). Callahan argues that our faculty of self-consciousness must be

wholly engaged and focused in order to make decisions in conscience. Thus, holistic self-integration coupled with self-awareness requires constant and intense monitoring of both our inner and outer environment and how we are interacting on three fronts—emotional, rational, and volitional—with both of these environments. Needless to say, acts of conscience require immense inner resources, energy, and concentration.

However, the simultaneous holistic, self-integrative activity of self-consciousness is not enough to completely describe conscience. Two problems arise. The first concerns the intensity of our inner experiences in reaction to our outward environment. Callahan (1991) argues that when "under intense shock or stress, a person may be out of touch with the real external environment, as well as unaware of her or his own distorted perceptions and functionings" (p. 41). For example, perhaps the shock and stress of receiving such devastating news explains the emotional outburst Rev. Williams displayed in Jamie's case. The second problem concerns the scope of self-integration. That is, many activities—Callahan suggests sex, work, or the fact that one will be executed in a few hours—require holistic, self-integrative self-awareness. However, these example activities are not instances of acts of conscience. Conscience requires two additional elements—self-avowal and an orientation towards moral goodness.[15]

Conscience's ability for self-avowal—to motivate our will into action—is akin to what existentialist Jean-Paul Sartre (1956) described as self-authorization, the upsurge of the "for-itself," an act of consciousness transcending its own being to achieve freedom.

[15]At first it seems strange for Callahan to say that all acts of conscience must aim towards the good. However, the phenomenological accounts of Haney and Vetlesen in the next chapter clearly argue that the aim of empathy is to regard others as subjects of respect and concern, and, of course, Aristotle's system of ethics aims at producing the good.

Interestingly, Callahan (1991) describes self-avowal in phenomenological terms close to Sartre's understanding: "Commitment occurs when the self acts as agent, and simultaneously mobilizes one's inner personal capacities to support and infuse the action with personal emotive force" (p. 16).

Self-consciousness plays a vital role in self-authorization. Callahan (1991) depicts self-consciousness in acts of conscience as self-consciousness "squared, or self-multiplied" because "we reflexively muster our selves and our inner resources as guarantee in self-authorization" (p. 16). Borrowing from philosopher Harry Frankfurt's terminology, self-conscious self-authorization results in a second-order state of willing: "Because we are self-conscious, we can be self-consciously self-directing, and produce inner mobilizations of self-binding, self-warranting, self-authorizing acts. We can knowingly will to will our actions" (Callahan, 1991, p. 16). When such personally authorized, self-conscious acts are directed towards producing right, good, and just outcomes, we have acted in complete conscience.

Callahan has presented a comprehensive conceptualization of what conscience is, but more is needed to understand how the various parts function together. She describes the nature of conscience as intrinsically unifying. Thus, decisions made in conscience involve "an integrated, recursive process in which we direct and focus attention back and forth, within and without, activating, mutually testing, and monitoring all our human capacities of thinking, feeling, and self-consciousness" (Callahan, 1991, p. 115). Reason and emotion have dual roles within this process. Not only can reason be consciously used to test reason, emotion, and intuition, but emotion can monitor reason and emotion to

achieve a balance between the two elements. Given the mutual, integrative interplay between emotion and reason, I term Callahan's theory the cycle of conscience, and a schematic in Figure 1 illustrates the inter-relationships between emotion and reason:

Reason Judges and Tutors Reasoning and Intuition. Callahan argues that two forms of thinking should be integrated into the decision-making process. Directed rational thinking involves the conscious and purposeful application of problem-solving techniques of the intellect whereas intuitive thinking consists of thoughts that arise in the mind without conscious control. For Callahan, intuitive thinking, while not completely infallible, represents a complementary and important method for reasoning through moral problems of conscience.

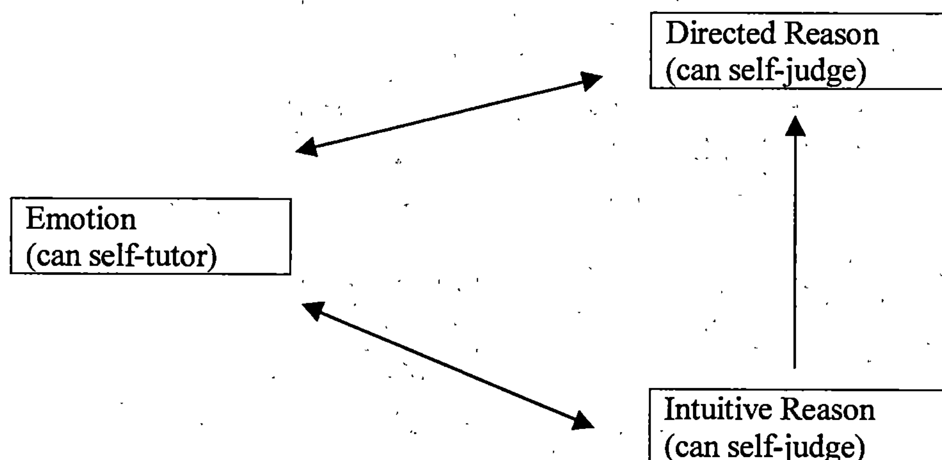

Figure 1: The Cyclical Relationship between Reason and Emotion

Callahan likens the scientific method to the process by which reason judges reasoning and intuition. She suggests the criteria by which reason should be judged and accorded assent. In addition to "consistency, logic, rules of evidence, appropriateness, coherence, clarity, completeness, and congruence with received reality and meaning," the

"assessment of a reasoning process and its outcome is made by seeing how the specific arguments and evidence presented cohere with everything else that the problem solver knows" (Callahan, 1991, p. 126).

Although its manner of presentation to consciousness is different from self-directed rational thinking, intuition actively and "reflexively assesses its own productions and operations in recursive strategies of skeptical double-checking" (Callahan, 1991, p. 127). Not only does reason operate reflexively on reason and intuition, but reason also activates and tests particular nonconscious emotional states.

Reason Judges and Tutors Emotion. Callahan argues that within the process of directed problem-solving, emotions filter through the nonconscious and enter into conscious awareness. Emotions, according to Callahan, act as "vital signs" from one's self to one's self. Not only can we be consciously aware of the influence of emotions on our rational deliberations, but our rational faculties can test, judge, and mold emotions. The relationship between reason and emotion is bivalent—that is, reason can spark and monitor emotion, but the reverse also occurs.

Emotion Tests and Tutors Reason. Callahan suggests that emotions especially influence our rational intuitions, which then provide a test for our more directed, rational processes. Feelings "are reflexive, personal signals or 'vital signs' of our inner processing of the present and the past. These signals, often blending with our spontaneous intuitions, can be morally helpful and even tutorial" (Callahan, 1991, p. 130). The challenge is to understand, at a conscious level, the influence that our emotions play in decisions of conscience. Callahan (1991) argues that, fortunately, emotions themselves can produce

certain emotions and emotional states that are conducive to moral decision-making or supply early detection systems for poor judgments (p. 133).

Emotion Tutors Emotion. The ability of emotion to monitor other emotions completes the cycle of conscience. Callahan suggests two monitoring functions for emotion. First, emotion plays a positive role in helping to gain "rational control" of emotion (Callahan, 1991, p. 133). Our ability to enact emotions when we feel a certain way helps to cognitively process and understand why we feel that way and help change the way we feel if we judge we should feel differently. Second, emotion can assist reason to ensure the integrity of our decision-making process: "Reactions to our own emotional reactions can be sought, other emotions enacted, and a numbed, shallow, or qualitatively fevered emotional response be felt as suspect" (Callahan, 1991, p. 134-135).

Ensuring the integrity of our decision-making process, however, need not only yield suspicion. Callahan (1991) also argues that emotion serves as a source of our most genuine selves: "As we deploy our attention, we will be most emotionally drawn to the past, present, and future emotions that we appropriate as most completely ours. We can enact those emotions that express the whole 'me,' the fruit of our own life stories" (p. 135). For Callahan, emotion, if properly tutored and tested with the aid of reason, can be a wellspring of our most essential and genuine moral values.

In philosophical terms, acting in conscience seems related to authenticity. The goal of conscience is to embrace those emotions that are genuinely ours and attempt to align them with our more rational decision-making processes. Achieving intrapersonal authenticity helps individuals to integrate emotion and reason within themselves. Moving

from personal authenticity to interpersonal authenticity represents one challenge for the parties in Jamie's case. After personally integrating emotion and reason, can the ethics consultants help the parties to integrate the larger, interpersonal epistemological split between emotion and reason—the largely factual basis the medical team and the emotional and religious basis Mrs. Jackson and Rev. Williams are operating from? Unfortunately, Callahan's concept of conscience exclusively concerns personal decisions. Thus, it requires adaptation to the realm of the interpersonal to meet this challenge. In the next chapter I suggest that a phenomenological concept of empathy—one which presumes the very nature and integrative role of emotion presented in this chapter—allows intrapersonal and interpersonal authenticity to emerge.

The sketch of the argument from Chapter Two alluded to the connection between emotion, empathy, and authenticity. It is necessary to discuss empathy in detail first, however, for interpersonal authenticity presupposes a phenomenological conception of empathy and its ability to foster interpersonal dialogue. Moreover, it is necessary to complete the philosophical and bioethical analysis of emotion and its role in morality.

Fortunately, completing this analysis helps make the transition between emotion and empathy. Recent philosophical and bioethical conceptions of emotion suggest not only that emotion must be integrated with reason, but that emotion, when properly acknowledged and expressed, facilitates the resolution of interpersonal moral difficulties via empathy. Thus, collapsing the distinction between so-called positive and negative emotions, focusing on their respective acknowledgment and expression, and suggesting

emotion and reason must be integrated in morality provides a basis for the philosophical argument that emotions play an important role in morality and empathy.

Part IV: The Role of Emotions in Morality: Exploring the Connection between Psychology, Philosophy, and Bioethics

Interestingly, a passage from Callahan herself shows the connection between the psychological and philosophical concern with the role of emotion in moral decision-making. Callahan argues that her treatise on conscience represents an attempt to bridge the disciplinary gap between psychology and philosophy. Separation of these two disciplines has only hindered our understanding of moral decision-making and the role of emotion in it, she argues. Specifically, she charges psychology with "misreading human experience" when it has "ignored the real power of free, rational moral agency and the force of reasoning and philosophical justifications in decision making" (Callahan, 1991, p. 6).

Likewise, Callahan feels that an exclusive philosophical focus on the rational is wrong-headed because it "wrongly ignores the self who is inevitably informed and shaped by emotions, tacit personal knowledge, intuition, imagery, developmental history, and group experience" (Callahan, 1991, p. 6). Her account of the role of emotion in moral decision-making represents a synthesis of psychological understandings of the self and philosophical arguments regarding the complementary roles of reason and emotion. Since the self and the self as moral agent are both subjects of broad philosophical and

psychological interest and inquiry, it only makes sense that Callahan's account represents an interdisciplinary blending of these two disciplines.[16]

As a specific example of the close connection between psychology and philosophy, Callahan alludes to philosopher Mary Midgley's notion of the unity of the moral enterprise to provide philosophical justification for the integrative role of conscience in moral decision-making. Conscience is the active fusion of emotion, reason, and will in a self-assessment of whether to perform certain actions. Like Callahan, Midgley argues that moral decisions follow a particular sequence of feeling, thinking, and acting. Avoiding "snap" decisions requires two inseparable elements designed to achieve a change in the action originally considered: a change in feeling and a changing sense of "the facts" (Midgley, 1987, p. 278; Callahan, 1991, p. 134). That these elements must be present in concert denotes Midgley's concern with the *unity* of the moral enterprise.

In terms of Callahan's cycle of conscience (see Figure 1 in this chapter), it is possible to posit a similar configuration for moral decision-making on the basis of Midgley's unity of the moral enterprise:

[16]A historical precedent exists for adapting psychological research to philosophy and bioethics. The psychological debate on behaviorism influenced philosophical thought on free will and determinism. Moreover, the next chapter will rely on a correlation between psychology and philosophy to show an emerging similarity in conception of the dialogical nature of empathy. More recently, as discussed earlier in this chapter, the psychological debate on gender and moral development has influenced bioethical discussions regarding the integration of justice and care perspectives in ethical decision-making. The latter two instances most forcefully exemplify the close connection between psychology, philosophy, and bioethics.

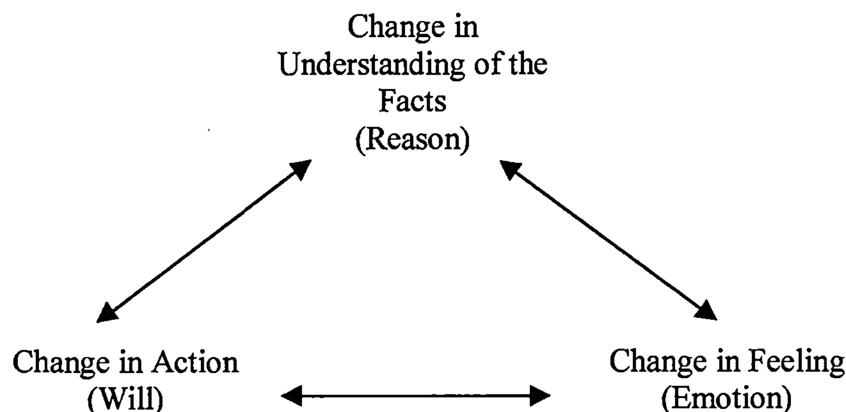

Figure 2: A Cyclical Model of Midgley's and Callahan's Work

The change in action we seek by integrating our capacities of thinking and feeling corresponds to what Callahan (1991) terms 'will'—the self-conscious authorization of decisions representing us most authentically. Achieving a change in feeling and encouraging re-interpretation of the facts in light of our changed feelings corresponds to our ability to tutor and assess our internal emotional reactions with directed rational and intuitive processes.

Although Midgley's notion of the unity of the moral enterprise clearly links Callahan's cycle of conscience to philosophy, the role emotion plays in the moral enterprise is not immediately evident (as evinced by the bi-directional arrows between the elements in Figure 2). How does the sequence begin—with a change in feeling or a change in our view of the facts?[17]

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[17]The fact that Callahan does not specify an order for integrating emotion and reason is significant. For Callahan, as long as integration occurs before implementing an action, it does not matter whether emotion tutors reason, or vice versa. In fact, since conscience is best described as predispositions to act in a particular manner, the particular sequence of integration may differ from person to person or from situation to situation. Some persons may be more cognitively focused whereas others are more sensitively attuned to their inner "vital signs."

A passage from Midgley's article may provide an answer to this question. Midgley appears to ground the unity of morality in a phenomenologically-influenced conception of moral perception and judgment similar to Vetlesen's account of empathy. She argues that "Facts are data.... They are...never completely 'raw data'—'brute facts,' because anything we can think about...has been...shaped by...concepts in the process of perception. And the data of any serious moral problem always incorporate quite complex conceptual schemes" (Midgley, 1987, p. 277). Given this view of perception, one answer to the question regarding the sequence of elements in Figure 2 becomes possible.

Midgley claims that our perceptions defy distillation into more elementary elements—separating a felt emotion from a cogitated thought is impossible during the sequence of perception. Moreover, it is not possible to determine which—feeling or thought—comes first during perception. Both are combined in a single gestalt, suggesting tight integration of both elements are necessary for proper moral perception. However, perceptions do not arise *ex nihilo*—something must catch our attention and direct our perceptual faculties. Animals not capable of cognition have this primitive perceptual ability. Such a primordial faculty must involve our ability to sense, to perceive, to feel. However, such animals merely react to stimuli. Cogitation, evaluation, and feedback between thought and feeling allow humans and other neurologically advanced forms of life to develop complex responses to stimuli. Regarding moral decisions, it might seem easy to suggest that our ability to feel, our emotive nature, plays the role of progenitor in the sequence of moral perception. However, suggesting such a sequence for the interplay between thought and feeling denies the fact that some people consciously develop in

themselves particular ways of seeing. Some persons perceive better through their emotionally sensitive faculties, whereas others structure perception according to logic, deduction, and what matches their reality. In terms of Midgley's elements of the unity of the moral enterprise, our ability to perceive directs our attention to moral situations and provides force for an assessment of our view of the facts, our interpretation of what we have perceived. Thus, a change in our view of the facts requires a prior moral perception of events, an understanding of how we feel about a situation, followed by a change in our feelings, a reinterpretation of our moral perception.

The role of perception in Midgley's unity of the moral enterprise is conjecture at this point. The next chapter will provide foundational support for a phenomenological view of moral perception and judgment that seems to underlie Midgley's conception of the unity of the moral enterprise.[18] Moreover, other philosophical sources of support can be mobilized for the dual role of emotion in perception posited by Midgley's theory, thus illustrating further the connection between Callahan's cycle of conscience and philosophical discourse on the role of emotion in morality. Fortunately, both of the roles can be extracted from philosopher Nancy Sherman's (1995) understanding of emotion and its importance in moral decision-making processes.

Sherman argues that emotion serves as both a mode of perception that allows us to grasp the morally salient features of particular situations and an intrapersonal and interpersonal means by which to communicate these features to ourselves and others. As

[18]Moreover, future chapters will rely on additional moral frameworks, each of which attempts to integrate emotion and reason (Aiken, 1962; Churchill & Cross, 1986; Hayes, 1986; Vetlesen, 1994). All of these frameworks argue that emotion and cognition must be tightly interwoven in the process of moral judgment.

a mode of perception, emotion functions in concert with cognition as the genesis of moral occasions. According to Sherman (1995), "the report of the emotions may not be final or decisive. But it is an important way to begin to mark a moral occasion" (p. 665). As a means of communication to ourselves, emotion provides a test for our initial evaluation of our perceptions. The fact that we "*feel* discomfort, anxiety, anger, or some other disturbing emotion" when encountering a moral problem suggests that emotion can function as an early warning system for moral difficulties (Purtilo, 1999, p. 25).

Sources from the nursing literature on the evolution of moral difficulties into ethical conflicts support this early warning role for emotion and connect the philosophical literature to the more applied bioethics literature. Nurse Lucia Wocial (1996) argues "uncomfortable emotions often serve as the first warning that a moral dilemma exists" (p. 152). Philosopher Andrew Jameton (1993), writing about the responses of nurses to difficult moral situations, argues that when barriers prevent us from either doing what we believe is morally right or from being the kinds of persons we morally wish to be, we feel intense moral or ethical distress. According to Purtilo (1999), "the psychological response of ethical distress is the first sign...that something has gone—or is about to go—wrong, something that will threaten you or your...integrity" (p. 71).

Besides providing early detection of moral difficulties, emotions, when integrated with cognition, help us to focus where moral action should be directed—whom we should help and by what means. In this second role, emotions like concern and interest provide moral motivation. To borrow from bioethicist John Fletcher's assessment of the moral theory of Henry David Aiken (1962), emotions help keep our hearts in the struggle to be

moral when the head grows weary (personal communication). However, as bioethicist Erich Loewy has argued, emotion without direction and without forethought or proper expression can sometimes result in unintended and harmful effects. Thus, in order to provide moral motivation, our emotional impetus to help others requires careful consideration and deliberation, lest we act on impulse. Emotion most certainly can play a positive role in such assessments, along with our more cognitive abilities at moral deliberation and evaluation. Fortunately, accounts from the bioethics literature comport with this dual understanding of the role of emotion in moral decision-making. One such account in particular combines the early warning function of emotion, the experience of ethical distress or ambiguity, and a rational means to resolve the strong emotional tug of ethical distress.

Fletcher and his colleagues, Franklin Miller and Edward Spencer, (1998) suggest feeling is often the starting place for morality: Without ethical distress, the ability "to feel conflicting emotions and obligations, we fail to recognize that moral dilemmas exist at all" (p. 11).[19] The moral ambiguity associated with conflicting emotions and obligations represents a normal response to an ethical problem. However, reacting emotionally without forethought—what Fletcher and colleagues (1998) call "shooting from the hip"—

[19]Fletcher, et al. suggest that empathy plays an important role in helping individuals discover how best to resolve the inner conflict of moral ambiguity and facilitate the outward expression of moral concern. Such a conception provides a direct correlation between emotion and empathy. Since the "capacity to empathize with another person, or to put oneself in the other's place, is needed to be moral," empathy represents a prerequisite to appropriate moral action—intervention that may help to avoid "shooting from the hip" (Fletcher, et al., 1998, p. 11). However, in order to account for how empathy can prevent "shooting from the hip," we require a more sophisticated understanding of empathy as both an emotively and cognitively balanced faculty than this common usage by Fletcher and colleagues suggests. The dual role of emotion as early detection system and motivation for moral action are reflected in philosopher Arne Vetlesen's account of empathy. I will explore the connection between empathy and its integrative role in morality in more detail in the next chapter.

can sever the process of ethical deliberation and interfere with our ability or willingness to solve moral difficulties (p. 11). In other words, experiencing ethical distress when emotions conflict with our perceived moral obligations is an important part of responding to a moral difficulty. Without thought as to how to proceed, responding on the basis of ethical distress might result in unintended and unforeseen moral consequences. Emotion as an early warning system, combined with rational reflection as a means of ethical deliberation, illustrates Sherman's philosophical concern with the importance of emotion in the moral sequence—feeling combined with thinking, including thinking about feeling, to arrive at actions which are morally appropriate.

The diverse sources surveyed thus far clearly suggest that emotion plays several important roles in morality: early detection system, facilitator of our morally perceptive abilities, and moral motivation and perseverance during the sequence of moral perception and judgment. Nevertheless, the literatures also clearly show that emotion must be balanced with rational tools of moral evaluation. As Jamie's case reinforces, strong emotional reactions can signal the beginnings of moral difficulties. If unexplored, unexpressed, and unacknowledged, Rev. Williams' emotional outburst could sidetrack the consultation. However, if explored, expressed, and acknowledged, his emotional reaction could provide the basis for continued moral dialogue and alignment of the moral interests of the parties.

Analysis of the features of Jamie's case in light of the understanding of the nature and role of emotion presented in this chapter clearly points to the need for a process to supplement ethics facilitation. It would be a disservice to Rev. Williams and the other

parties to attempt to identify and analyze the underlying value conflict behind the option to withdraw Jamie's food and water without first understanding what role Rev. Williams' emotional outburst and the emotions of the other parties is playing.

Part V: Jamie's Case and the Genesis of Transformative Ethics Consultation

The upshot of the discussion regarding the role and nature of emotion finds its most eloquent expression in analyzing Jamie's case. The last chapter concluded the case presentation after Rev. Williams' emotional outburst. In the argument presented in this chapter, I suggest that, rather than moving on to discuss the factual and value-laden ramifications of his statement—Jamie will not starve to death if his feeding tube is removed— the ethics consultants should explore the emotional roots of Rev. Williams' remark. All of the parties seem to be experiencing moral distress, and Rev. Williams' outburst represents its most clear indication.

Unfortunately, the ethics consultants in this case did not explore the emotions underlying Rev. Williams' outburst. Rather, following the ethics facilitation approach, they attempted to explain, as unequivocally as possible, that removing Jamie's feeding tube would not cause him to starve to death, and, thus, it was an ethically acceptable option in the case. I argue that Rev. Williams was not in an appropriate emotional framework to hear, understand, and process that highly cognitive explanation. In the next chapter, I will "reconstruct" Jamie's case to show what the ethics consultants should have done—acknowledge and explore his emotional reaction—had a process been available to supplement ethics facilitation.

As Callahan has suggested, stressful situations can cause distortions in a person's ability to integrate their emotional and rational faculties. If not balanced, emotion can overwhelm rationality or vice versa. The former phenomenon is most clearly observed in Jamie's case with Rev. Williams' outburst, but the latter—over-intellectualization, rational denial, and rationalization of emotions—also occurs. In fact, without first acknowledging what Rev. Williams is feeling, the ethics consultants risk alienating him from the process and thus undermining his autonomy. After exploding in anger and disgust, he might emotionally shut down and refuse to participate or non-verbally communicate to Mrs. Jackson that she should not participate. By exploring the emotional dimensions of his comment and acknowledging the emotions he feels without validating the moral position underlying the comment,[20] the ethics consultants can help Rev. Williams determine how his emotional position is connected with his concern for Jamie and with the option presented by the medical team.

Rev. Williams' outburst should signal to the ethics consultants that there is an underlying emotional tension. While Rev. Williams' remark may appear to be a pure expression of his anger or mistrust, it also reflects his perception of and moral distress associated with the power dynamic present. Recall that all the clinicians were wearing white coats and were clustered around the consultants at one end of a conference table in a small room. There were also unspoken racial tensions. The medical and bioethics

[20]Blank statements, reflecting the emotional content and providing an emotional label to his reaction ("You seem angry, Reverend."), might help Rev. Williams explore more deeply the feelings underlying his outburst and how they are connected to his values regarding Jamie's care. Such statements, a technique called active listening, and their effectiveness in acknowledging emotion and encouraging rational reflection and connection with positions or interests will be explored in more detail in Chapters Six, Seven, and Eight.

literature documents that a pervasive sense of distrust in the health care delivery system exists among some African-American community members (Caralis, Davis, Wright, & Marcial, 1993; Dula, 1994).[21]

One manifestation of this medical distrust arises in some African-Americans requesting what seems futile or aggressive treatment for their loved ones despite the disclosure of poor prognoses (Caralis, et al., 1993). Studies exploring this phenomenon have traced such over-treatment preferences to deeply rooted fears that care will be prematurely withdrawn from African-American patients (Caralis, et al., 1993; Dula, 1994). Perhaps this fear, coupled with strong religious convictions, explains the ferocity of Mrs. Jackson in protecting her son and her refusal to make him a DNR. If real, such a fear might also explain Rev. Williams' belief that the team only wants to starve Jamie to death.

It is also important to remember what sparked the consultation in the first place—the moral frustration of the team, especially Dr. Cassidy and Nurse Evans. Although not explicitly identified during the consultation, their feelings of moral distress–frustration with the past failures to address end-of-life issues–could be used to galvanize the solidarity of all parties. The first stage of the consultation should acknowledge Rev. Williams' anger and Mrs. Jackson's mistrust and explain the team's sense of moral frustration without laying blame on other members of the health care system. Such an

[21]Perhaps such mistrust is not unwarranted. A recent study of treatment options discussed and provided to black versus white lung cancer patients reports that blacks receive far fewer surgical resections (the standard of care) than their white counterparts, thus creating a disparity in outcomes and survival rates (Bach, Cramer, Warren, & Begg, 1999). Thus, perhaps Rev. Williams and Mrs. Jackson are experiencing subconscious distrust—the neurologists did, after all, somewhat prematurely conclude that Jamie was in a PVS.

effort should provide the parties with a sense that they now share a common difficulty and must work constructively together to find options that will best approximate their individual understandings of the situation. For such a shift to occur, the consultants will need to expand empathy beyond the sort *Core Competencies* endorses.

In Chapter Two I argued that although ethics facilitation provides skills and procedures for showing empathy, they are designed for one specific goal—empathy directed from the consultant to one or more of the other parties in order to establish trust and rapport. Analysis of Jamie's case reveals a level of emotional tension for which this construal of empathy will be inadequate. My analysis in this and subsequent chapters suggests that empathy should be expanded into two separate phases to supplement the inadequacy of the form endorsed by ethics facilitation. The first phase concentrates on the appropriate exploration, expression, and acknowledgment of emotional tensions to prevent them from erupting into impasses that could derail the consultation, and the second on developing the sort of collective empathy that a durable and appropriately reached consensus will require.

Emotional tensions are experienced both within the person (intrapersonal) and between persons (interpersonal). In fact, as Jamie's case illustrates, both forms of tension are sometimes linked and follow a specific sequence. First, a person emotionally perceives or reacts to particular value statements of others, producing an intrapersonal emotional tension with the deeply held values of that person—Rev. Williams' emotional reaction to the team's suggestion to withdraw Jamie's feeding tube, for example. Attempts to communicate fail for several reasons. Power differentials prevent others from

respectfully hearing the person experiencing the intrapersonal emotional tension; educational differentials or using highly technical medical jargon prevent effective communication; simple misinterpretation or misunderstanding prevents true understanding; or, as Callahan suggests, an intrapersonal emotional reaction causes lack of integration with intrapersonal cognitive processing.

The result of such a lack of intrapersonal integration is an interpersonal emotional tension—often characterized by feelings of moral distress, which manifest themselves in strong emotional outbursts such as anger, frustration, envy, crying, or burying emotions and emotionally shutting down. If not addressed early in ethics consultation, emotional tensions caused by moral distress can evolve into emotional impasses and derail attempts to engage in moral dialogue. As I have shown in this chapter, it is not the emotion or its experience that has negative consequences for moral dialogue, but rather how the emotion is expressed and received by others. If appropriately expressed, then acknowledged by others participating in moral dialogue, emotion can provide either a source for exploring particular options or motivation for continued dialogue.

Consultant-directed empathy can help overcome emotional tensions patients, surrogates, or clinicians feel towards the consultants. However, an expanded, collective conceptualization of empathy will be required to overcome emotional tensions that patients or surrogates feel towards clinicians, that clinicians feel towards patients or surrogates, or that patients feel towards surrogates and vice versa. Achieving this form of empathy comprises the second phase of the process to supplement ethics facilitation.

In Chapter Two I introduced a phenomenologically-inspired concept of empathy that may help in generating collective empathy, for it combines the very elements that are lacking or disjointed when an intrapersonal emotional tension erupts into an interpersonal emotional impasse. Empathy, as articulated by philosopher Arne Vetlesen, combines intrapersonal and interpersonal elements by suggesting both emotion and cognition need to be combined in moral decision-making. The challenge, which I take up in the next chapter, concerns exactly how to achieve this form of empathy—intrapersonal acknowledgment and expression of emotion and rational integration with emotion, followed by interpersonal moral dialogue with our fellow moral agents. Precisely how this form of empathy can be operationalized in ethics consultation as an adjunct to ethics facilitation remains an additional challenge that I will tackle in later chapters.

Chapter Four

The Role of Empathy in the Interpersonal Integration of Emotion and Reason and its Implications for Ethics Consultation

"Empathy is a mode of caring…. [Hence, it] is not…a psychic leap into the mind of another person, but an openness to, and respect for, the personhood of another"
—Jeanne Levasseur & David Vance, 1993, pp. 82-83

Introduction

Jamie's case provides an opportunity to see the interplay between cognitive and emotive dimensions in ethics consultation. In Chapter Three I argued that morality must integrate these two dimensions, and, as a specific type of process for resolving ethical conflicts or uncertainties in health care delivery, ethics consultation must fuse these two complementary elements as well. Moreover, Jamie's case illustrates the necessity for integration on two separate levels—the level of the individual (intrapersonal) and the level of the group (interpersonal). For instance, the ethics consultants must address Rev. Williams' emotional outburst, the most obvious sign of emotional tension, and the team's sense of moral frustration in order to prevent these emotional tensions from erupting into interpersonal impasses to the consultation.

As I argued in Chapter Three, methods, such as Callahan's, facilitate intrapersonal integration of emotion and reason. But achieving interpersonal integration involves moving beyond the intrapersonal level of conscience. In Chapters Two and Three I suggested that development of collective empathy might facilitate this transition. If achieved, collective empathy, which includes interpersonal dialogue regarding different interpretations of individual intrapersonal assessments of thoughts and feelings, can help

prevent intrapersonal emotional tensions from evolving into interpersonal impasses. This chapter expands the discussion of the integrative nature of morality to the concept of empathy as a means to ensure integration on both of the levels required for ethics consultation. Discussion of theories of empathy will help provide elements and point to processes that ethics consultants must utilize in order to achieve integration. Further presentation and analysis of Jamie's case in tandem with discussion of such theories lends support for how to achieve integration.

Part I: Empathy and its Connection to Interpersonal Integration of Emotion and Reason

In Chapter Three I made several allusions to the intimate link between empathy and emotion. Dafter's spectrum view connects emotion with what he terms empathetic attunement—to appreciate the subjective experience of another. Fletcher and colleagues argue that empathy—the ability to put oneself in the shoes of another—can help in resolving the moral distress we normally feel from conflicting obligations and emotions. Both of these examples, however, do not adequately take into account the highly nuanced nature of empathy found throughout the philosophical, psychological, and medical humanities literature. In fact, the view regarding the nature of empathy and its role in morality that is suggested by examining these diverse sources helps to overcome several remaining problems or difficulties in the attempt to achieve a supplemental process for ethics facilitation.

One such problem concerns extending the integrative nature of morality beyond the intrapersonal level. In Chapter Three I presented Sidney Callahan's theory of conscience as one method to achieve intrapersonal integration of emotion and reason. However, conscience retains a vestigial shortcoming despite Callahan's attempt to liberate the concept from its ordinary usage. Conscience refers to an inner faculty, and even though self-awareness and self-consciousness require monitoring of the external environment, conscience cannot extend beyond personal decisions.

Conscience refers to an active faculty of my own consciousness that integrates my feelings with rational processes regarding a decision I must make. Although it can ensure my own personal integration of emotion and reason, in those situations in which I must jointly reach a decision with a fellow moral agent, conscience cannot extend beyond intrapersonal integration. Such situations, such as surrogate decisions to withdraw life-sustaining treatment, typify the gold standard of joint medical decision-making between health care providers and patients or their proxies.

According to existentialist thought, mediation between two persons who must make a shared decision in conscience seems an impossibility. If conscience cannot reach beyond my own personal decisions, no means exists to ensure that the other with whom I must jointly reach a decision is acting in good conscience. The same difficulty holds for the other—he or she cannot be sure I am acting in good conscience. Such lack of intersubjective, mutual assurance seems to doom Callahan's concept of conscience from playing the interpersonal role ethics consultation requires. Ethics consultation in general, and resolution of Jamie's case in particular, must be interpersonal. Despite its ability to

integrate feeling, thought, and will by monitoring our inner mental world and attending to the influence of our perceived external world, conscience extends only to our own personal decisions.

Fortunately, several philosophical investigations focusing on the role of empathy and dialogue help extend the essential features of Callahan's cycle of conscience to the interpersonal realm of joint decision-making. This chapter presents one such account, based on work in phenomenology and supported by sources in psychology, feminist thought, and the medical humanities literature on empathy. All of these sources aver the integrative nature of emotion and reason that distinguished Callahan's theory. However, beginning with the phenomenon of perception, which involves an inward turn of self-reflection followed by an outward turn to other minds, it is possible to extend the integration of emotion and reason in our perceptions and judgments from within to the decisions we make with others.

As I illustrated in Chapter Three, scholars across the disciplines have called for the integration of reason and emotion in moral decision-making. Several, most notably Sidney Callahan, trace the call for the complementary role for emotion in morality to Carol Gilligan's pioneering work in care theory (Callahan, 1991; Surrey & Bergman, 1994; Connelly, 1998). Interestingly, many of the bioethicists who echo the call for integration also cite Gilligan's work as the genesis for integrating caring—characterized by feeling, consideration of relationships, and empathy—with morality's traditional focus on justice and reasoning (Alderson, 1991; Downie & Sherwin, 1992; Warren, 1992; Loewy, 1995; Tong, 1997).

Care theory has brought the importance of emotion and its integrative role in morality to the forefront. An analogous movement in phenomenological circles has advocated hermeneutics, which emphasizes the role of emotion in conjunction with reason in interpreting moral narratives, as one method for achieving integration in morality (Árnason, 1994; Haney, 1994; Vetlesen, 1994; More, 1996).[22] Central to such views is the faculty of empathy, which has an interesting philosophical and psychological history—one that shows an evolution from equation with sympathy into a highly nuanced faculty of consciousness integrating current psychological models of emotion with phenomenological understandings of human perception and judgment.

The word 'empathy' entered the English language in 1909 when Edward Titchener translated the word '*Einfühlung*' from German aesthetics. '*Einfühlung*' derives its meaning from the German verb "to feel one's way into" (Darwall, 1998, p. 262). The concept and definition of empathy has shared an interesting philosophical history with its emotive cousin, sympathy. David Hume and Adam Smith both used the word 'sympathy' to describe what many psychologists, psychiatrists, and philosophers now describe as empathy. For instance, Hume (1978) used the word 'sympathy' to refer to the "propensity we have...to receive by communication [others'] inclinations and sentiments" (p. 316). And, quoting Horace, Hume (1975) further suggested that "the human countenance...borrows smiles or tears from the human countenance" (p. 220). However,

[22]Bioethics and medicine have recognized the importance of this method, as articles on the narrative nature of informed consent (Rosenberg & Towers, 1986; Árnason, 1994), the physician-patient relationship (Brody, 1987; Árnason, 1994; More, 1996; Tong, 1997), and ethics consultation (Walker, 1993; Casarett, et al., 1998) have been published.

as I will argue in Part III of this chapter, this so-called form of sympathy is more properly linked with a subtype of empathy termed emotional contagion (Darwall, 1998).

Although Smith's definition of sympathy is also more properly understood in terms of empathy, it differs fundamentally from Hume's. Hume argues that sympathy is felt from the standpoint of an observer who infers the cause of the behavior he or she perceives in the expression of another. In contrast, Smith (1976) suggests that through "imagination we place ourselves in [the other's] situation," and imaginatively project "what we ourselves should feel in the like situation" (p. 9). While somewhat closer to sympathy, Smith's conception matches what Darwall terms projective empathy and simulation.

Confusion has often plagued these two related concepts, on the level of ordinary language use as well as scientific and philosophical conceptualization. To further compound this confusion, there is philosophical and psychological debate as to whether empathy involves an a way of knowing what another is feeling or a way of feeling and projecting what another seems to be feeling. The goal of the next three sections is to discuss several conceptions of empathy. Examination and analysis of several sources from this diverse literature allows a core view to be constructed regarding the role of empathy in moral decision-making. This core view involves elements of each approach—knowing, thinking, and feeling from a variety of perspectives. I begin the discussion with a phenomenological account of empathy.

Part II: Empathy and Phenomenology

Phenomenology acknowledges the fact of human communication and the possibility of relating ethically to our fellow human beings. This fact presupposes that recognition and understanding of others is possible. But then what links our inner world with the inner worlds of others? Edmund Husserl, the father of phenomenology, suggested empathy is the faculty that allows communication with other minds. Empathy bridges the world of our inner experience and our external world of perceived numerous others, all of whom have their own inner experiences, supposedly inaccessible to us. The process Husserl used to reach this conclusion demonstrates the phenomenological method—suspending existential claims, focusing on the perceptions present to our immediate grasping, and subjecting them to rigorous analysis.

Our perceptual field is an ever-shifting temporal horizon of possibilities. Objects appear, change configuration, shape, and constitution as our perceptual field shifts (i.e., we move our heads). Some objects seem inanimate, incapable of movement by their own will, whereas others appear to have this power. Moreover, our ability to focus perception allows us to bring certain objects more clearly into our perceptual field for examination. Other objects in our perceptual field become fuzzy and indistinct when we focus intently on a particular object. Phenomenologists refer to this perceptual ability to focus on objects in terms of foreground and background. Objects in our foreground are more perceptually distinct to us, whereas objects in the background are less so.[23] Since I can

[23] A two-dimensional rendering of a three-dimensional landscape in a painting captures the intent behind the distinction. The house and stream, the main subjects in the painting, are clearly discernible—the house's window dressings, the texture of the stones in the stream, and so on—but the mountains and forest in the background are fuzzy, indistinct, and blend together.

manipulate many objects and will my perception to focus on particular objects, a phenomenological view of perception suggests that my acts of consciousness and perception are responsible (in the epistemological, not the moral sense) for the interaction of the objects within my perceptual field.

Yet one type of object in particular, the human being, seems to violate this dictum. Like me, other human beings appear to perceive a field of possibilities (phenomenological shorthand for "potentially knowable or graspable objects of one's perceptual faculties"), one in which I am a possibility to them, just as they are a possibility to me. To avoid the obvious problem of solipsism, phenomenology requires that human beings be accorded special status as other minds, as subjects, not objects. According to commentator Kathleen Haney (1994), the acknowledgment of other minds is necessary in Husserlian phenomenology, lest we be unable to explain the fact that we communicate with these other human beings through words, gestures, and interpretations of these words and gestures. Although Husserl's phenomenology concentrates on the ontological and epistemological connections between individuals, our ability to communicate with others via the faculty of empathy brings a certain ethical element to human relationships. For instance, Haney, paraphrasing phenomenologist Emmanuel Levinas, asserts that "the face of the other…confronts us with immediate ethical responsibility…. Through empathy, the other can be present to me in his life which I 'read' of[f] [*sic*] his physical expressions (including words and gestures) and situate within his context" (Haney, 1994, p. 61).

Through communication with others, we make our distinctive perception of our inner world and our experience of the external world known (albeit incompletely) to others and they to us. To accomplish this combined feat of perceptual intuition, cognitive interpretation, and expressive communication, we need to make the other the subject of our perception. Husserl wondered what faculty allowed this insight into the inner world of others that defies our direct phenomenological grasping. We seem to intuit meanings and interpret the verbal and non-verbal gestures the other makes, and these seem intelligible to us.

This intelligibility must be accounted for by an act of my consciousness, but how is it possible when I lack direct access to the inner mental world of others? That is, the other and I are separate minds, yet mediation of the separateness is possible—the inner world of the other with whom I communicate becomes potentially knowable. Husserl argues that empathy must provide mediation between separate minds.

As Haney (1994) argues, Husserl's conception of empathy "does not reveal the brute otherness of the other; rather, it overcomes the separation between subjects" (p. 58). Thus, for Husserl, the realization that I exist as an other among others provides the context for the possibility of empathy to mediate the epistemological gulf between subjects. Such a realization brings the discussion of empathy to the realm of the ethical. According to Levinas, the face of the other presents itself to me with immediate ethical responsibility. Why? Because my perception of the other involves seeing that the other is an other like me—with hopes, dreams, thoughts, and feelings. Thus, I must relate to this other in a way similar to the way I relate to myself—as an agent of value and

responsibility with choices and decisions. A passage from phenomenologist Paul Ricoeur's (1967) book on Husserl clearly illustrates this sentiment:

> If it is true that only one is I, and that Others are others, this objectifying equalization by which I become an Other for those Others, an Other among these Others, must be accounted for. It is an equalization in the sense that reciprocity abolishes the privilege of a single ego, and it is an objectification in the sense that this reciprocity brings it about that there are only Others. I am an Other among Others. Thus, a community of real men is possible (p. 136).

The implied premise left out of Ricoeur's analysis is that the reciprocal responsiveness that characterizes mutual empathy makes such a community possible. Such reciprocity turns empathy into not merely a faculty of consciousness by which human communication is possible, but also a way of relating to the others with whom we share the world and with whom we might disagree regarding our perception and interpretation of events. However, before describing how mutual empathy is possible and how it describes the moral relationship that holds between individuals, it is necessary to understand how phenomenology can account for differences in moral interpretation of events.

Husserl's phenomenology does not concern morality in the sense I intend to use it. Phenomenology is a way of perceiving the world and one's own experience in that world. It is purely concerned with describing the existential, epistemological, and ontological features of the world in relation to what we think we know or perceive. In order to make the connection between phenomenology, empathy, and morality, a more basic question must be asked and answered. What does morality concern? What is its subject matter? Morality seems to concern two distinct but related ideas. The first

concerns what customs and habits govern the general conduct between persons. Or, stated in phenomenologically-inspired terms, what ontological and epistemological stance must I take to others in order to interact and communicate with them? Our ability to empathetically grasp the meanings of others helps to delineate an appropriate epistemological stance, one that underlies our ability to engage the other in dialogue on moral matters. When I reach out to the other in empathy, what fundamental ontological stance governs my ability to establish an empathetic connection?

Robert Sokolowski (1985) answers this question in his book *Moral Action.* He argues that the development of a moral connection between individuals requires each imbuing the other with the meaning "other I."[24] Such a proposition extends Husserl's argument that we must regard other human subjects as other minds to the realm of morality. By imbuing other subjects with the same ontological-moral status that I take for myself, empathy requires that I treat other minds with the same respect and concern that Kant considered the most fundamental moral duty. As Haney (1994) reiterates, when I recognize "my self as one-among-others," "empathetically, I live respecting others' uniqueness and the universal claim which each makes upon the other" (p. 63).

Empathy, then, is more than mere respect and concern for others and their inner mental life. It also includes a value dimension–that one ought to respect the choices and decisions of others as one would wish others to reciprocate regarding their own choices

[24]Although at first it might seem that such a statement can have implications for whom we include in our moral community of "other I's," it is important to remember that an existentialist interpretation of others depends not on social consensus (such as according some special sense of personhood to infants, persons in persistent vegetative states, etc.). Rather, the act of positing an other as an other "I" represents a personal choice to value the other in all of their human dimensions. To do otherwise, as I will detail in the next chapter, is to act in bad faith.

and decisions. Perceptions may differ between persons, and conflicts may result regarding how to reconcile these differences in moral matters. Empathy's moral orientation of respect and concern may help to resolve conflicts between differently perceived and valued states of affairs. This ability constitutes the second function of morality and brings us to how phenomenology can account for differences in interpretations of the same event.

For Husserl, our perception of the external world is always incomplete. Although we may intuit that a desk has many different sides, we can only perceive at most three of its sides in one sweep of our perceptual faculties. Walking around the desk reveals many different angles from which to view the object. Our minds compute these different perspectives—what Husserl termed adumbrations—and we conclude that the desk has several sides, and that it is one, distinct object. Thus, our perception of objects in the external world is always missing at least one perspective. This incompleteness can potentially account for why different persons seem to see things differently—objects, certainly, but also our interpretation of various moral events as well.

Communication and dialogue with others can overcome potential conflicts when two persons differ regarding their interpretation of particular moral events. As Haney (1994) argues, our ability to resolve different interpretations depends on empathy: "If, through empathy, I have understood myself and the other person as each one among many others, I see that each perspective has its place" (p. 62). Thus, just as empathy operates as an epistemological mediator between separate minds, achieving an empathetic stance toward another can help mediate differences in moral perceptions. The

willingness to communicate with others with whom we disagree forms the basis for forging consensus, at best, or understanding, at minimum.

In order for such mediation to occur, however, the problem of language must be overcome. As Edith Stein, one of Husserl's students, argued in her doctoral dissertation, empathy requires dialogue. In addition, dialogue requires the translation of our inner experience into a linguistic form that represents our perceptions and meanings to others. Our listener must then reverse this process and translate the language into meanings and interpretations of his or her own. As with any translation process, there is a chance of error during any part of the process, but especially in trying to translate the precise sense conveyed from one person to the other. Failure to overcome the problem of language—by misinterpreting or misunderstanding the original sense intended by our speaker—can account for differences which require additional communicative efforts, double-checking, and dialogue in order to be resolved.

According to Stein, to properly understand the sense intended by the original speaker requires empathetic give-and-take. For Stein, empathy is a unique faculty of perceptual intuition, "a *sui generis* conscious process through which we make sense of others in their self-experience" (Haney, 1994, p. 59). Like our other senses, empathy imparts intuitions to us about others based on their expressions, gestures, and our interpretation of their words. If we are confronted with a moral decision, empathy then becomes necessary for moral dialogue and the relationship that holds between two moral agents, for how can we judge the intentions of others if we cannot first grasp their meanings?

Empathy is a precondition for moral dialogue. Communication, understanding, and mutual empathy can help resolve different moral interpretations. While Stein describes empathy as *sui generis*, it does not occur *ex nihilo*. The persons engaging in communicative efforts must be willing and must consciously choose to discuss differences in their interpretations. Thus, empathy seems to require reciprocity, but, as Stein argues, reciprocity is not always assured in the empathetic turn to the other in expressive communication. When not reciprocated in a moral relationship between persons, empathy's power to effect communication, understanding, and dialogue diminishes. However, it can still help the person empathizing to uncover and process his or her own emotional reaction to the other's moral situation.[25]

Without empathy, the possibility for sympathy also becomes nullified. As Haney (1994) argues, "sympathy must be founded on empathy since it is impossible for me to feel genuine compassion unless I am aware of whatever acts upon you and the way you experience such forces" (p. 63). Ultimately, the absence of empathy points to one of two moral deficiencies—(1) the *inability* to perceive others as worthy of the same respect and concern the one-empathizing posits for the one-empathized-with or (2) an *unwillingness* to do the same. Phenomenologist Arne Vetlesen argues persuasively in his book that the latter allowed the Nazis to exterminate millions of Jews, Roma (gypsies), homosexuals, and other groups during the Holocaust.

[25]This latter use for empathy supplies the rationale behind the discussion of ways to alleviate moral distress outside of ethics consultation in Chapter Eight.

In short, a phenomenological understanding suggests that empathy involves the very conception of emotions that Nancy Sherman asserts. Empathy is a mode of sensitivity that focuses our perception on what is morally salient in our observation of the experience of others and facilitates communication between self and others. Empathy requires intrapersonal assessment of our perception of others, intrapersonal generation of a moral judgment about the other based on our own experience and repertoire, and, finally, dialogue with the other to determine if our moral judgment is accurate and appropriate. Empathy requires that we adopt a moral attitude of concern for others—that we consider the other as an "I," with moral standing as a person whose uniqueness as an agent of value and choice must be accorded respect. In this way, empathy is a precondition for moral dialogue and resolution for times when persons differ regarding the interpretation of particular valued states of affairs or choices.

Part III: The Integrative Nature of Empathy and Personhood

Jeanne Levasseur and David Vance link empathy to personhood in suggesting empathy is a mode of caring that requires respect and concern for the unique personhood of others. It is easy to extend the discussion of empathy as respect for the personhood of another to a wider epistemological and ontological discussion of empathy and personhood. The reason why concerns the fact that the respect and concern associated with empathy represents more than merely acknowledging the inner mental life of others. This minimal sense of respect and concern—mere acknowledgment—treats persons as

objects, not subjects. This type of objectification characterizes what I will term a third-person perspective to empathy.

Moreover, since empathy does not allow immediate access to the inner life of others, it is epistemologically not possible to identify completely with the other. In fact, to suggest so is a form of bad faith, according to existential thought. Thus, completely identifying with a person and thinking their experience is exactly like mine substitutes my own personhood for the other's—a situation I will term a first-person perspective to empathy. As the following discussion will show, empathy requires treating persons as second persons. Rather than treating persons as pure objects or pure identifications of my self, second personhood acknowledges the other as a separate agent of worth whose experience and personhood has its own place and value. Through dialogue, I can attempt to interpret what the experience of the other means. But to either substitute my own experience for the other's or merely acknowledge the other's experience without trying to comprehend it in terms of the other's understanding oversteps the epistemological and ontological boundaries of empathy on the one hand and minimizes those boundaries on the other.

Sources from the philosophical, medical humanities, and feminist ethics literature specifically address the topic of personhood as it relates to empathy. These sources, however, respond to these two topics with differing answers and use different terminology. For example, philosopher Stephen Darwall (1998) contrasts empathy, which he defines as sharing the other's mental states from the other's standpoint, with sympathy, which involves feeling the plight of the other "from the third-person

perspective of one-caring" (p. 263). Most other authors I will survey would disagree with Darwall's basic distinction between empathy and sympathy for several reasons. First, they would argue against empathy as a sharing of the mental states of another. Second, they would argue that the third-person perspective objectifies the other and makes empathy (or sympathy) either impossible to establish or inauthentic. For example, Ellen More (1996) argues that empathy involves an internal and external interplay between self (a first person orientation) and other (a third person orientation). In between these endpoints of personhood lies second personhood.

The accounts share some basic foundations, however. Empathy (or sympathy) is a relationship between two individuals (even if the other does not share actively in such a relationship). Thus, it is important to distinguish between two different aspects of an empathetic relationship—(1) the relationship that the one-empathizing has with respect to the one-empathized-with and (2) the relationship the one-empathizing has with respect to his or her own thoughts, feelings, interpretations, and judgments. After this level of commonality, the accounts of empathy depart in terms of substance and terminology.

To simplify differences in terminology, I term the second empathetic relationship above one of *orientation*. A first-person orientation to my own feelings means that I consciously reflect on my feelings to determine how to feel towards another. Words like 'self' in Ellen More's account of empathy characterize this sort of orientation. A third-person orientation to my own feelings (I think it may be nonsensical to speak of a second-person orientation to my own feelings) is to numb myself to what I am feeling or to ignore either consciously or unconsciously what Callahan called the inner flux of the

faculties of conscience. Thus, I term the first type of empathetic relationship one of *perspective*. To take a first-person perspective to the feelings of another verges on substituting my own feelings for the experience of the other. To take a third-person perspective to another is to objectify them and attribute less significance to their feelings or experience. Both are not appropriate perspectives for true empathy.

The terminology is taken from Darwall's definitions and related to the work of other authors who would disagree with how he posits the relationship between the one-empathizing and the one-empathized-with. Thus, it will be possible to show that, contrary to Darwall's excellent taxonomy of empathy and sympathy, true empathy requires a middle ground between the two perspectives he identifies—a second person perspective. First, I examine Darwall's discussion and taxonomy of empathy and sympathy, for it provides the basis for analyzing other sources on empathy from the medical humanities and feminist ethics literature in Part IV.

For philosopher Stephen Darwall, determining the orientation persons take towards themselves and others when they notice the plight of another allows him to distinguish between empathy and sympathy. His account is important on several levels. First, it incorporates much of the philosophical treatment of empathy and sympathy in ethical theory while combining it with features from current findings, like those of Dafter, in psychology. Second, it separates out the rich philosophical history on the subject into a progressive taxonomy of empathy and sympathy. According to Darwall, empathy has elements of emotional contagiousness, projection and simulation, and finally a type of proto-sympathy.

Darwall differentiates sympathy and empathy based on the standpoint of the person experiencing the feeling. Sympathy, he argues, is felt from a third-person perspective. He borrows care theorists' concept of "one-caring" to refer to this perspective. Sympathy refers to the emotion or feeling evoked when the good or well-being of another is impeded or threatened. However, it is more than merely emotional identification with the lived experience of another; rather, it involves concern for that person as that person would experience the feeling of loss, betrayal, anger, or whatever.

Empathy, on the other hand, involves a first-person perspective according to Darwall—sharing the mental states and experienced emotions of another from a number of standpoints. These standpoints include: without conscious thought about how the other experiences such emotions, as a neutral observer, or from the other person's standpoint. For Darwall, each of these different perspectives delineates a unique form of empathy, with the final perspective coming close enough to sympathy to be termed proto-sympathetic empathy. A more detailed discussion of empathy in terms of these perspectives helps to illustrate the epistemological and ontological connection between emotion, empathy, and personhood.

Some emotions are contagious. The sight of a smile or the sound of laughter often produces a smile or a chuckle from us. Darwall terms this phenomenon emotional contagion. Emotional contagion involves directly "catching" and mimicking a feeling or an emotional state from another. This rudimentary form of empathy involves two orientations to persons. We observe the behavioral indicators of the emotional state of another, what seems a third person orientation, and reflect this state in our own

expressions. However, Darwall argues, since emotional contagion does not use imaginative projection (à la Smith) to determine what the other whom we observe is feeling, but merely mimic whatever emotional state they seem to be projecting, we do not take the other as a subject, but merely an object. Thus, the other need not participate in the relationship directly or actively in this form of empathy. Nevertheless, personhood *is* involved in emotional contagion—a first person orientation to our self. Even in its most rudimentary form, Darwall acknowledges that empathy involves a perception of an object, interpretation of what that object emotionally projects, and a cognitive self-assessment to determine what we ought to project.

A somewhat more cognitively sophisticated form of projection and simulation comprises Darwall's second level of empathy. This form involves a two-fold sequence and thus two distinct orientations to persons. We place ourselves in the situation of the subject we observe and cognitively determine what to feel as though we were the subject. Infants exhibit this form of empathy in social referencing, Darwall explains. When faced with a new situation, an infant will reference its mother's reaction to the same perception to determine what reaction to display. In a sense, the particulars of the situation suggest the type of reaction that is warranted.

In projection and simulation, feelings present themselves from a first person orientation, but only after we have judged, from a third person orientation, what the other seems to be projecting. Darwall terms this level of empathy projective empathy and simulation to mark the two-fold sequence involved. The sequence involves two distinct standpoints towards persons. However, unlike the sequence itself, it is not possible to

separate the orientations to persons this type of empathy requires. Projective empathy and simulation combines first and third orientations to persons. It is a third person attempt to determine what to feel by analyzing what others, in their first person, seem to be feeling. Thus, projective empathy and simulation involves somewhat more cognitively complex operations than the mere emotive phenomenalism of emotional contagion.

In projective empathy and simulation, the projection is onto the other's standpoint as that person experiences it. Attention is focused, not on the other as an other, but on the other's situation as we imagine the other sees it. By shifting attention somewhat, to the other and the relevance of the situation for the other (not for us), Darwall argues that empathy approaches sympathetic concern. Whereas projective empathy and simulation attempts to determine what our reaction should be, based on what we think the other is experiencing, in proto-sympathetic empathy the concern is more narrowly focused on the implications of the experience for the subject, not for us.

The standpoint to personhood presumed by this third form of empathy seems a combination of first, second, and third persons. The first and third perspectives are required in order to perceive the other as the other experiences the situation. But to achieve concern for the other as the other experiences the situation requires a radical shift in perspective. The other is not an other for us, but rather a fellow human being who deserves comfort, respect, and sympathy—that is, a second-person.

Darwall, however, defines sympathy in terms of a third person perspective, as "one-caring," to borrow from care theory.[26] It "is a feeling or emotion that responds to some apparent threat or obstacle to an individual's good and involves concern for him, and thus for his well-being, for his sake" (Darwall, 1998, p. 273). The thrust of Darwall's taxonomy of empathy and sympathy is that sympathy presumes a simultaneous first-person and third-person orientation towards the feelings of another. Not only must I observe how the other is feeling, but any determination of how the other feels must be from his or her own perspective.

According to the phenomenological account of empathy, however, when I observe the feelings of another and interpret them from his or her perspective, the other ceases to be a third-person for me, but rather a potentially knowable "you" (the word associated with the second person), with whom mutuality becomes a possibility.[27] Thus, Darwall's discussion of sympathy and empathy seems at odds with the phenomenological understanding of empathy as requiring a second-person perspective. Is it possible to have sympathy for another and not constitute that other as a second person? As a response to Darwall's emphasis on abstracting sympathy away from a second-person orientation, the next section answers this question and shows that maintaining a third-person stance to others has several moral dangers associated with it.

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[26]Interestingly, sources from care theory, on which Darwall bases his notion of sympathy, suggest that caring is essentially a second-person stance, not a third-person stance.

[27]In fact, the next chapter suggests that the failure to cease the interpretation of a person from a third-person orientation is a form of inauthenticity, bad faith.

Part IV: Empathy as Second Personhood: A Feminist Response

While empathy plays an important role in helping to establish a dialogical connection between individuals, empathy also has dangers associated with it when not properly cultivated. Empathy can become domination or the bad faith of bureaucratization when it remains objectively at a distance. Or it can become identification and possessiveness when it remains focused on the self. On the basis of the work of two feminists, Lorraine Code on empathy and Joan Tronto on caring, I argue such dangers can be overcome via a second person orientation for empathy *and* sympathy. Hence, empathy/sympathy is best represented as one seamless process involving an internal and external dialectical interplay between self and other, culminating in the respect and concern for the other as a second person.

Lorraine Code: Empathy and Distance. In criticizing traditional moral epistemologies that extol distance, disinterestedness, and rationality, Lorraine Code shows the inadequacy of the epistemology that treats persons as third-person objects about whom we can make objective judgments. Her account stresses the importance of acknowledging moral relationships and the fact that feeling, more than reason, characterizes such relationships. Code argues that the prevailing scientific paradigm emphasizes persons as data—to be observed, abstracted, analyzed, categorized, and generalized—and the production of knowledge as facilitating prediction, control, and generalization. Bureaucracies, with their emphasis on precision, organization, hierarchy, and efficiency, embody an instructive example of this paradigm. Such paradigms are destructive, if not antithetical, to empathy, either relegating it to the fringes of social

structures and institutions that remain reserved for women's traditional activities or arguing that it is a gender-specific, natural trait of women.

The goal of Code's (1994) analysis is to argue that "a society, and any practice within it, that devalues empathy is poorer, in human terms, for so doing" (p. 77). However, it is Code's presentation of empathy as an essential ingredient in how we relate to others that helps to focus on the relationship between empathy and personhood. Fundamental to her position is the fact that bureaucracy is a social structure that substitutes formal associations, hierarchy, and distance for the more affective, subjective, experiential interfaces that mark truly human, face-to-face interaction. Science treats persons like data, as objects of scrutiny, observation, prediction, and control. Such epistemologies, Code (1994) argues, "can accord no epistemic worth to the attunement, the sensitivity, that certain kinds of knowing demand; in their separation of reason and emotion, they foreclose possibilities for adequate analyses of emotional knowing..." (p. 78).

For Code, the culmination of the moral tensions between emotion and reason, empathy and distance find their expression in the justice and care debate. She cites Owen Flanagan and Kathryn Jackson's comparison of these two viewpoints as case in point for a radical shift away from traditional, positivist moral epistemologies that view justice as the pinnacle of moral development and relationship. Flanagan and Jackson (1987) describe "justice as fairness...[as] seeing others thinly, as worthy of respect purely by virtue of common humanity" (p. 623). Such reasoning seems to underlie Darwall's characterization of sympathy as requiring person-neutral concern. Abstracting sympathy

to the level of universalization where anyone should have reason to show concern for another comports with Flanagan and Jackson's understanding of the justice perspective. Opposed to this universalization, Flanagan and Jackson (1987) argue "morally good caring requires seeing others thickly, as constituted by their particular human face, their particular psychological and social self. It also involves taking seriously, or at least being moved by, one's particular connection to the other" (p. 623). Inherent in seeing others thickly, Code argues, is a radical epistemological shift from viewing persons as objects to viewing them, following Annette Baier (1985), as second persons.

The epistemological difference between third-person talk *of* or *regarding* persons and second-person consideration *for* persons concerns the level of engagement and care between persons. Baier (1985) describes a person "as one who was long enough dependent upon other persons to acquire the essential arts of personhood. Persons are essentially second persons" (p. 84). What matters for personhood is not some abstract notion of respect as codified in Kant's categorical imperative—that all persons deserve respect because they possess certain essential attributes, such as reason, which distinguish them as members of a certain class. As argued elsewhere, children, fetuses, the permanently unconscious, and many others, then, may not qualify for personhood (Engelhardt, 1996; Heller, n.d.).

By Kant's own definition, then, it might be ethically permissible to use such non-personal entities as means to an end—as potential experimental subjects, surrogate mothers, or even organ donors. Yet such propositions seem ethically repugnant. To minimize the consequences of defining personhood as requiring reason, at least one

author has argued that we should attribute a social sense of personhood to such non-personal entities (Engelhardt, 1996). So perhaps it is not so much an essential attribute that makes an ethical difference for personhood; it is the existence and quality of the relationships that hold and govern human interaction. Feminist ethicist Susan Sherwin (1993) makes this very argument regarding pregnancy and abortion in her book *No Longer Patient*. She, like Baier, and to some extent Engelhardt, argue that personhood is distinctly relational.

That personhood is relational is precisely Code's argument. "'Second persons' engage with one another and care about the quality of that engagement—whether in fondness or fury" (Code, 1994, p. 80). She cites Sartre's stark constitution of the other, as *en soi*, as an example of the need for an epistemological shift away from an objectifying morality of the other: "Imposing meaning on someone else's existence from a position removed from it, or ignorant of and indifferent to its specificities, is at the furthest remove from second person knowing" (pp. 80-81).[28] By contrast, Code (1994) cites empathy as embracing the epistemology that second person thinking requires. Her analysis of empathy parallels several features already discussed—its integrative nature, its basis in and implications for phenomenology, and its distinctly interpersonal nature.

Code (1994) argues that empathy, unlike scientific forms of knowing which emphasize objectivity, "resists closure, invites conversation, [and] fosters and requires

[28]It is telling that Sartre characterizes the other in terms unknowable to us and suggests the attempt to do so is a type of bad faith. Such a view becomes important not only in terms of the phenomenological conception of empathy presented in this chapter, but also the next, where the argument is entertained that moral dialogue—where the self encounters the other and the tension posed by interpreting such intersubjectivity—represents an authentic, interpersonal, and empathetic epistemological stance towards shared morality.

'second-person' relations" (p. 81). Much like Callahan's assessment of emotion, Code cites the ability of empathy, when properly cultivated, to judge its own aptness for particular situations. In order to accomplish this self-reflexivity, empathy requires sensitive attunement in two "moments"—its cognitive moment, where empathy works out how much one can or should know about another, and its affective moment, where empathy's "finely tuned sensitivity" to contexts helps determine the appropriate level or inadequacy of attunement (Code, 1994, p. 81).

As a response to the distancing objectivity of the scientific paradigm and its translation in social structures in terms of bureaucracies, feminist critiques like Code's call for empathetic engagement. According to Code (1994), this engagement "fosters the mutuality on which 'true' or 'authentic' community...must depend" (p. 81). The reason for this conclusion is that empathy requires direct engagement with the other who otherwise would be viewed distantly and judgments imposed on them from afar, without first understanding the other's context and situation as that other articulates it.

Empathy, as a means of achieving second personhood, requires negotiation, interpretation, and dialogue. Code's analysis of the dialogical and interpretative nature of empathy crystallizes the argument made in Chapter Two regarding the mutual responsibility of empathetic partners. As Haney argued, summarizing the argument of Stein, joint responsibility exists because of the interpretative nature of relating to others as second persons. Code acknowledges that empathetic interpretation involves issues of power, and without joint responsibility, empathy can be (or can change into) a dangerous tool of manipulation and coercion: "interpretation can...be monologically construed,

practiced in an authoritarian—coercive—manner. Interpretation [thus] invokes responsibility requirements, both *to* the 'datum' and *with* the subject whose experience is interpreted" (p. 87).

In a recent presentation, Kelly Edwards (1999) provided several critiques of empathy. Echoing Code, Edwards gave a critique that concerned empathy and power differentials. She argued that empathy, if used merely as a skill among health professionals, as a means to *an* end of learning more about a patient's condition or symptoms, risks the professionals identifying with and overpowering the subjective experience of patients. Patients are often in vulnerable positions, not only as sick individuals who need help, but also because health care professionals have knowledge of how to help and what resources to muster for help and act as gatekeepers for such resources. Thus, according to Edwards, to characterize an interaction with a patient by the statement, "I know just how you feel," and not truly understand how a patient feels or allow the patient to fully express how they feel, risks confusing true empathy with identification and domination. Those with greater power or knowledge can turn this so-called form of "empathy" into the very objective, distancing, scientific treatment empathy is supposed to avoid.

As a check against the coercive, authoritarian, and imperialist implications of identification, Code suggests that persons shoulder a significant moral responsibility to each other. Like Pellegrino, Code argues that this moral responsibility has an intrapersonal component. She terms this component "recognition"—"recognition of the possibility of putting oneself in another person's place, which in turn requires a

recognition of others as persons like oneself" (p. 89). The "otherness" that marks occasions of empathetic identification and its imperialist implications becomes transparent, in a phenomenological sense, as we each recognize that we exist as others among others, to borrow from Ricoeur, Haney, and Husserl, that we share the same human frailties and vulnerabilities. Such analysis clearly shows that Code's conception of empathy requires both an inner turn to our own motivations in empathizing and an outer turn to the other as a second person worthy of respect and concern. Both "turns" are required, not because I view the other as the same as me, but because I *could* be the same as the other, in his or her unique situation. This recognition sparks the feeling of mutuality that sustains the impulse to care.

Code cites philosopher Simone de Beauvoir and her emphasis on responsibility for and with others as an example of the sort of mutual recognition empathy requires. According to de Beauvoir (1962), true empathy involves acknowledging the ambiguity between recognizing the otherness of the other, while avoiding the desire to subsume the subjectivity of the other under one's own perspective. Thus, maintaining a second person empathetic perspective requires that we not view persons merely as others (a third person orientation) or the same as us (a first person orientation). Code quotes a passage from de Beauvoir (1962) on love to illustrate this tension: "It is only as something strange, forbidden, as something free, that the other is revealed as an other. And to love him genuinely is to love him in his otherness and in that freedom by which he escapes" (p. 67).

According to Code (1994), empathy simultaneously preserves the ambiguity in acknowledging one's own likeness to the other and his or her "irreducible strangeness, otherness" (p. 92). Inherent in taking a second person view of persons, then, empathy involves a simultaneous tension between one's own first person and the third person of the other. The moral challenge of empathy, then, is to resist allowing the second person orientation to collapse into either of these two competing forms of personhood—identification with, in the first-person, and objectification of, in the third-person. Such collapse would represent bad faith, inauthenticity.

Essentially, Code's presentation of empathy has much in common with several features of what has come to be called an ethic of care. Such an ethic views personhood as distinctly relational, and empathy, with its emphasis on feeling and appreciation of the subjective experience of the other, figures prominently in how persons who care for one another relate to each other. Although she does not address the concept of empathy directly, Joan Tronto's work on elucidating an ethic of care illustrates the complex, nuanced view of personhood operative in forming empathetic relationships. Her account addresses caring and what ethical responsibilities such an approach demands of persons engaging in caring. Since the work of Code clearly connects care theory to empathy, the analogy I will draw between Tronto's principles of caring and the stance towards persons empathy requires is not without basis. Moreover, since Tronto's work builds from such care theorists as Nel Noddings, who emphasize the relationship between the one-caring and one-cared-for that Darwall equates with sympathy, analysis of Tronto's work further establishes an implicit connection to the topic of empathy.

Joan Tronto: Caring's Connection to Personhood. Tronto's book *Moral Boundaries: A Political Argument for an Ethic of Care* examines the effects of three boundaries on morality and politics: (1) the boundary between morality and politics; (2) the "moral point of view" boundary, which extols dispassionate and impartial moral judgments; and (3) the boundary between the public and private life. Analysis of these so-called boundaries resonates with the critique Code makes against bureaucratic structures that alienate persons from empathy with each other. In fact, one could almost substitute the word 'empathy' for Tronto's 'caring' to illustrate the necessity to rethink the artificiality of these boundaries, for the kind of caring Tronto posits to overcome the three boundaries has much in common with empathy. What is needed is a caring attitude to others, Tronto argues, manifested in several ethical elements of caring, care-giving, and care-receiving. According to Tronto, caring requires proximity, attentiveness, responsiveness, competence, and responsibility. Tronto's explication of these elements reveals a clear connection to many elements associated with empathy.

Like Code, Tronto begins her analysis by arguing against the traditionally received view of morality as requiring dispassionate and impartial moral judgments, characteristics of cognitivistic-influenced moral systems like Kant's. According to Tronto, when we morally think about others as being distant from us, two consequences result. First, "the morally pure, rational actor may be less likely to be moved to moral action when others are so distant" (Tronto, 1993, p. 13). Thus, according to Tronto, caring not only calls for closeness—what Tronto terms proximity—but also perception of others in their unique particularity.

If we think of others as interchangeable units of moral calculation, the second consequence results: "the assumption that others are like us may well be wrong, and it may prevent us from being attentive to how we cannot simply apply our conclusions about morality to others' situations" (Tronto, 1993, p. 13). Proximity implies a particular kind of moral competence—one that refers to our ability to perceive the situation of another and our willingness to overcome personal and professional barriers to provide care. Just as empathy can bridge the gap between persons who are morally distant, Tronto suggests caring accomplishes the same moral feat.

Tronto views caring as a solution to the received view of morality and its emphasis on rationality, impartiality, and universalization. For her, caring is both a process and a disposition.[29] The process of caring comprises four phases: (1) *caring about*, recognizing the need for care and caring work; (2) *taking care of*, formulating a plan for responding to the other's need for caring; (3) *care-giving*, directly meeting others' needs for care with specific interventions; and (4) *care-receiving*, in which the one-cared-for responds to the care given.

It is remarkable how similar this sequence of caring is to the sequence of empathetic understanding outlined in Chapter Two. First, we recognize the needs of another by focusing our perception on another's experience of a particular situation (caring about). By combining our emotional and rational faculties ("I feel like I should respond with caring, but how?"), we respond to the needs of the other by formulating a

[29]In this regard, caring requires the same fusion of heart and mind as empathy: "caring is not simply a cerebral concern, or a character trait, but the concern of living, active humans engaged in the processes of everyday living" (Tronto, 1993, pp. 103-104).

moral judgment to guide intervention (taking care of). Next we attempt to meet the needs of the other by providing specific caring interventions (care-giving), and the other responds to our assistance (care-receiving). The elements of the caring process, just like empathy, can easily act as a feedback loop. Just as we can modulate our perceptions or judgments by conversing with the other whom we intend to help, we should change our caring efforts by ensuring they are received by, appreciated by, and appropriate to the one-cared-for.

Tronto argues that the process of caring presupposes several ethical principles. Caring about corresponds to what Tronto terms attentiveness, our ability to be attentive to the needs of another. Like empathy, attentiveness requires emotional attunement; Tronto (1993) even describes it in phenomenological terms—as "a reaching out to something other than the self" (p. 102). Also like empathy, if we lack the faculty of moral perception—if we are inattentive to the caring needs of others—then we are guilty of a moral failure, our failure to adequately address the other as a subject of moral concern.

It is not enough to recognize the need for care and do nothing. Taking care of corresponds to our moral responsibility to care for others. As Haney suggested, echoing phenomenologist Emanuel Levinas, the face of the other confronts us with an immediate ethical responsibility. Empathy becomes an ethical link with others who deserve our immediate respect and concern. Responding merely with empathy, however, does not do justice to the caring impulse. In addition to feeling, caring requires thoughtful consideration of the circumstances and situation of the other we intend to help. We must devise appropriate caring responses and interventions, which requires conscious

reflection, cognitive processing of the needs of others from their perspective, and the moral strength of will to provide such care.

Care-giving depends on our competence to provide care. In terms of empathy, competence implies emotional competence as well as technical competence. If we fail to recognize the needs of others (moral numbness or incompetence), we lack the emotional competence to care. Moreover, if we fail to intervene out of fear, lack of resources, or ability to effect the desired change, we lack the technical competency to deliver caring in an empathetic manner. *Both* elements of competence—the ability *and* the willingness to care—are required.

We may be willing to provide care to others, but if we lack the skills to deliver care ourselves, Tronto argues, it is incumbent on us not to abandon the other but to find another to deliver care. Tronto's strong emphasis on this responsibility almost approaches the level of a moral duty. As she phrases it, responsibility and competence require genuine caring, not the sort of "taking care of" a problem that characterizes many social, medical, and governmental bureaucratic structures. As an example, Tronto argues it is not enough for a central educational bureaucrat to redistribute teaching duties to another teacher not trained in mathematics in an underfunded school district that has lost its math teacher. Rather, true caring would involve hiring a new mathematics teacher, not "taking care of" the problem by redistributing the teaching duties. It is no wonder why Tronto (1993) suggests attentiveness is "a difficult task, and indeed, a moral achievement," for, like empathy, the entire sequence of caring depends on attentiveness and proximity to others in need (p. 127).

The final element, care-receiving, corresponds to responsiveness, the ability of the one-cared-for to enter into authentic dialogue with the one-caring to jointly discuss the appropriateness of our caring and whether changes need to be made in our efforts. Tronto, however, is quick to distinguish responsiveness from mere reciprocity. Thus, responsiveness, like empathy, is not merely "the ability of reasoners to put themselves into the place of the other person" (Tronto, 1993, p. 67). Rather, responsiveness must recognize inherent power differences in relationships. Responsiveness is "concerned with conditions of vulnerability and inequality.... To be in a situation where one needs care is to be in a position of some vulnerability" (Tronto, 1993, p. 134). Likewise, the ability to give care in a competent, empathetic manner opens the care-giver up to similar vulnerabilities—that care will not be appreciated, for instance.

The Sequence of Empathy: A Concurrence from the Literature. Responsiveness links the discussion of empathy, sympathy, personhood, and phenomenology. Darwall purports to use the stance the one-cared-for takes towards the one-caring as descriptive of sympathy. He argues it involves a third-person perspective, whereas empathy involves a first-person perspective. However, Tronto's analysis of care-receiving, combined with Code's analysis of distance, presents another possibility for empathy and personhood. The third-person *perspective* on which Darwall's sympathy relies requires a prior first-person, empathetic *orientation* towards another. Rather than separating empathy from sympathy, incorporating them into one seamless process involving multiple orientations

and perspectives towards persons at different times accounts for the integrative nature of empathy presented in this chapter.[30]

Since empathy and sympathy require a combination of reference to self and other, it involves both a first-person *orientation* to my self and a third-person *perspective* towards the other whom I intend to help. Achieving a mutual second-person stance towards others and others towards us requires respect, concern, and dialogue. Recognition that we exist as others among others requires the sort of mediation characterized by second-person thinking. In this way, all stances towards persons are involved in processes of empathy, sympathy, and caring.

Taken together, the work of Code, Tronto, and to some extent Darwall suggests a view of empathy compatible with the sequence introduced in Chapter Two by phenomenologist Arne Vetlesen. First, we recognize the plight of another by focusing attention on our perception of their feelings (attentiveness from the third person perspective of the other). Our initial response to this perception, if our moral faculties are intact and engaged, involves consulting our own experience to generate an initial caring impulse and hypothesis regarding the needs of the other (shifting from the third person, the other, to the first person, ourselves). If we identify with the other's plight (seeing that we could be like the other or in the other's situation), we mentally devise ways of helping

[30]It may seem that I have equivocated the terms empathy and sympathy by suggesting they can be integrated. However, the sequence for empathy/sympathy involves a crucial difference. First, I must have a first person *orientation* to my own thoughts, feelings, and judgments so I can properly determine how to care for another. This *orientation* must be combined with a third person *perspective* towards the other as a agent of value whose unique circumstances I must take into account when providing care. It would be an equivocation if both parts of the sequence involved a first person orientation combined with a third person orientation or a first person perspective combined with a third person perspective. The definitional difference between the use of *orientation* versus *perspective* avoids the equivocation.

by reflecting on what we can do to remove the other's pain, frustration, anger, or other feelings (responsibility). If we judge that we have the ability to help (competence), we may attempt to help the other (care-giving). Engaging the other in dialogue helps to determine if our caring efforts have met the needs of the other. If we correctly interpret the feelings of the other, they should respond to our care favorably (care-receiving), perhaps with appreciation (that another views them as a second person with inherent worth). If not, then we must shift our caring efforts to match what the other truly needs (competency with respect and concern for the being or authenticity of the other) through communication.

Part V: Interpersonal Integration of Emotion and Reason

Empathy requires dialogue, according to the sources surveyed thus far. Despite disparity in what stance towards persons characterizes empathy, these sources suggest that empathy is more than a personal attempt to place oneself in another's subjective mental state. If empathy is to achieve its goal, then interpersonal interaction must occur between the one-empathizing and the one-empathized-with. When the one-empathized-with responds to the interventions of the one-empathizing, a truly human connection can be established through interpersonal dialogue. Through dialogue, mediation of differences in perception and judgment can be accomplished and resolutions to shared moral difficulties sought.

To describe the empathetic give-and-take of dialogue, several sources describe empathy as the dialectical interplay between self and other (Levasseur & Vance, 1993;

Connelly, 1994; Haney, 1994; More, 1994; Vetlesen, 1994; Toris, 1994; More, 1996; Tong, 1997; Connelly, 1998). According to Carol Toris' (1994) article on empathy and its usefulness in physician-patient interactions, the goal of this dialectic interplay is understanding. Toris (1994) argues that understanding occurs through the creation of shared meaning: "meaning does not exist but rather emerges through the feedback system that characterizes conversational turn-taking" (p. 3).

With its focus on trying to establish a link between two individuals who must overcome the moral, linguistic, and epistemological landscape separating them, empathy can be seen as a fundamental way of relating to others. Such is the argument of philosopher Arne Vetlesen, which is important in several respects. It combines the features of a phenomenological approach to empathy that opened this chapter and brings it squarely to the realm of morality. Moreover, it establishes a precise sequence for empathy that can be operationalized to ethics consultation. A close examination of Vetlesen's work will facilitate the goal of this dissertation—to explicate a dual intrapersonal/interpersonal process to supplement ethics facilitation in times of emotional tensions that extends the conception of empathy beyond its ability to build rapport between ethics consultants and other consultation participants.

The survey of the empathy literature thus far suggests that empathy follows a specific sequence: perception, judgment, then action. Objects in the external world remain passive and at a distance from our direct conscious grasping until something triggers our attention. In this sense, empathy functions as a sense in addition to the usual five senses. What was passive and at a distance immediately becomes present through

empathy, which “delivers intuitions of presence in a sensory manifold” (Haney, 1994, p. 59). Empathetic feeling relays information to our consciousness, and we turn our attention to another’s plight. Such is the first part of the empathetic sequence, perception.

This initial perception requires evaluation, lest we charge headlong into action without forethought—what Fletcher and colleagues term “shooting from the hip.” During this second stage of the empathetic sequence, communication, including dialogue with the other, must occur. Moral intervention, the third and final stage of the sequence, requires that we respect the personhood of others. Dialogue intended to integrate our own subjective assessment of others’ situation with their own experience of it makes such respect operationally explicit. As the discussion of Code and Tronto has suggested, the sort of respect required by empathetic partners is best characterized by concern and caring, not the minimal type of respect that requires mere acknowledgment of the other.

“Shooting from the hip” can refer not only to acting on the basis of our initial perceptions, unevaluated by our faculties of moral judgment, but also to intervening on behalf of another without first checking our perception and judgment against what the other whom we intend to help has experienced. The first two parts of the empathetic sequence, then, concern distinctly intrapersonal abilities of moral assessment and judgment, and the third part requires interpersonal skills designed to facilitate an appropriate moral stance to other moral agents as subjects of respect and concern.

Vetlesen’s phenomenological account of empathy and how it allows both intrapersonal and interpersonal integration of emotion and reason represents a cross-disciplinary analog to Callahan’s psychological theory. Vetlesen, a Dutch philosopher

from the existential-phenomenological-hermeneutical tradition and a student of Jürgen Habermas, and psychologist Sidney Callahan, influenced strongly by Catholic values and moral traditions, seem like strange bedfellows. Nevertheless, on many levels, their work exemplifies an interesting cross-disciplinary trend regarding the integrative nature of morality. Both suggest that integration must be achieved through the active interplay of rational and emotive faculties of perception and judgment. Despite a few minor differences in terminology, Vetlesen's and Callahan's theories regarding integration are very similar. The only major difference is that Vetlesen's theory is phenomenologically based and thus not confined to personal decisions I make by consulting conscience.

Callahan suggests three elements must be equally balanced to achieve integration—emotion, reason, and will. Vetlesen's theory requires the dialectical interchange between moral perception and judgment in order to yield action, a sequence he terms moral performance. Moral perception relies on the capacity to sense certain situations as morally significant —that the welfare of another is at stake. Vetlesen terms this ability empathy and argues that it combines emotive *and* cognitive aspects of perception. Moral judgment requires cognitive and emotive processing of such rudimentary perceptions into considered moral judgments—cognitively analyzed and emotively balanced guides for action.

According to Vetlesen, our first grasp of moral phenomena is via empathy. Empathy supplies perceptions, "gut" emotional reactions, which we shape with cognitive processing to yield moral judgments. Implementation of such judgments yields moral action. The full cycle of Callahan's theory of conscience is present in Vetlesen's account.

Yet Vetlesen's account can accomplish a feat that Callahan's cannot. Basing moral perception on our ability to empathize provides Vetlesen's theory with a much-needed method to extend decision-making power beyond the intrapersonal to the interpersonal. Empathy involves both a reaching out towards another human being as a subject of moral concern as well as a reaching inward to one's own emotional and cognitive repertoire. The problem of intersubjectivity is still present, but empathy at least represents one attempt to mediate it. Moral interpretation is taking place during the process of perception and judgment. I am trying to interpret the interpersonal cues, verbal and nonverbal, of another using my own previous experiences in order to think and feel what the other is thinking, feeling, and projecting. Although it is imperfect and feelings are sometimes incorrectly interpreted, empathy requires not only internal harmony between emotion and reason à la Callahan, but also an emotional and cognitive reaching out towards others as subjects of respect and concern. In this way, if incorporated in ethics consultation, empathetic understanding might represent one way to bridge the interpersonal disconnect between emotion and reason that cases like Jamie's concern.

The fact that Vetlesen's account of empathy can extend Callahan's theory to the interpersonal provides an impetus for deeper investigation. If the two theories are so similar, how is that Vetlesen's account avoids the intrapersonal confines of conscience? In order to answer this question, it is necessary to understand Vetlesen's account of how emotions function, how the phenomenological process of empathy provides access to the moral domain, and how moral perception and moral judgment together constitute moral performance.

Vetlesen's View of Emotions. Vetlesen's view of emotions is very similar to those presented in Chapter Three. Rather than regarding emotions as something we must suffer and over which we have little or no control, emotions are active and "indispensable in disclosing to us that others' weal and woe is somehow at stake in a given situation" (Vetlesen, 1996, p.153). If emotions are indispensable for a complete account of the moral life and the function of perception and judgment in morality, why has emotion traditionally been seen as unreliable for generating moral judgments? According to Vetlesen, theorists influenced by Kantian cognitivist accounts of morality posit the role of emotion in morality incorrectly. As an example of a proponent of this incorrect view, Vetlesen cites author Lawrence Blum, who argues that since we do not choose to have our feelings, they cannot reflect on us morally. Blum, and other authors like him, typify a Kantian view of morality that links moral agency with responsibility and responsibility with the performance of particular moral duties, Vetlesen argues. The problem, according to Vetlesen (1994), is the move made by Kantians to exclude "that which cannot be made an object of obligation" from moral relevancy (p. 154). Emotions, of course, are by definition excluded from the Kantian outlook of moral agency: "their presence or absence…cannot reflect on a person morally, since they lie outside the scope of personal agency" (Vetlesen, 1996, p. 154).

Rather than including a role for emotion, most Kantians focus largely on the faculty of judgment and what moral duties flow from judgment. In effect, Vetlesen concludes, by excluding emotion and emphasizing judgment, theorists presuppose the subject being judged as the already-given point of departure for moral inquiry. In

examining the Kantians' concept of respect for persons, for example, respect is due to persons as a matter of moral duty. Vetlesen, however, would argue that the object of respect has already been "constituted" in the judgment that a duty of respect holds. Rather than judge that respect is due, Vetlesen would argue that some perception of the other must present itself to the subject before the subject can judge that respect is due. Empathetic concern for the other and his or her situation must come before the judgment that a moral duty binds the subject to the other.

Vetlesen suggests that separating a moral judgment from the subject doing the judging provides an opportunity to view the dynamic nature of emotion within particular moral judgments. As he states, "as far as *moral* judgment is concerned, the exercise of judgment *presupposes* and is *made possible* by our 'having' (or, better, having the ability to have) certain emotions" (Vetlesen, 1996, p. 157). What happens, for example, when we attempt to remove the emotional from the cognitive? Vetlesen's answer: objectivity, disinterestedness—the sort that a Kantian-influenced morality and moral metaphysics extols.

Such separation is a fiction, according to Vetlesen. Interest is a metaphor that accurately describes how emotions function. Emotions direct our attention and interest, allow us to "tune in to" particular situations, and intuitively grasp that such situations require moral action. Vetlesen discusses the example of shame to illustrate the fiction of separation between emotion and cognition.

The act of feeling, of having a perception, entails cognition, because absorbing and conferring significance on the situation entails making a judgment about the

situation. To be ashamed is to judge that a situation is shameful. I may not experience the distinction between a cognitive component and an emotional component *during* a shameful situation. Feeling shame (my face becoming red and my sudden and intense desire to hide from my peers) and judging the situation as shame-producing occurs in one indistinguishable gestalt. Only later, upon reflecting on the situation and the way I felt during it, can I separate the emotional and cognitive components. In this way, moral perception as well as moral judgment is, as Vetlesen (1994) terms it, a "two-fold, joint accomplishment: it is a piece of emotion that is also a piece of cognition, and vice versa" (p. 175).[31]

While emotions furnish an initial, intuitive grasping of situations as morally significant, these reactions require refinement and analysis before they can be used as guides for action, Vetlesen argues.[32] Moral perceptions are incomplete by themselves; although they contain unfiltered pre-reflected cognitive dimensions in the act of constituting the object of one's perception as significant, acting on impulse can sometimes have disastrous consequences. Recognizing that moral action is required is the first step in the process of moral performance. Reflecting and ruminating on which actions to perform, what consequences will result, and what means exist for acting requires that moral perceptions be subjected to evaluation by the faculty of moral

[31]Vetlesen's assessment of import and its seamlessness within the empathetic sequence again provides evidence that the distinction Darwall draws between empathy and sympathy is perhaps an artificial one. Furthermore, it should also be of interest that Vetlesen's account of empathy endorses a second-person orientation to others.

[32]Such a view captures the essence of Dafter's spectrum view of emotions presented in Chapter Three. Moral perception furnishes emotional information to an individual, but without cognitive processing, during which moral interpretation of the information occurs and normative content added or imputed to our emotional perceptions, using such information to guide action is incomplete and premature.

judgment.[33] Thus, moral performance, the implementation of actions, requires prior evaluation, which, in turn, requires prior perception that a situation requires moral action. Within this process, emotion and cognition are actively involved at each stage, and their interchange matches the movement that characterizes Callahan's cycle of conscience.

Moral perception depends on the human capacity of receptivity or attentiveness, Vetlesen argues. Perception is not self-arising and self-directing. Rather, "the primordial human capacity to be attentive, to be alert to," which is a "sensuous-cognitive-emotional openness to the world," provides moral perception with direction (Vetlesen, 1994, p. 162).[34]

Defining the relationship between moral perception and moral judgment as the former being prior to the latter is significant. In a sense, this process suggests that the subject of moral judgment is disclosed through moral perception. Thus, our abilities of receptivity and empathy must be essential in giving us primary access to the moral domain, where the welfare of another is at stake. To understand how it is possible for the two—our emotive apperceptive faculty and our cognitive reflective faculty—to work in concert, we require further elucidation of the relationship that holds between the two.

Vetlesen borrows from existentialist Charles Taylor's notion of import to explain the connection. As Taylor (1985) suggests, feelings incorporate "understanding of our

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[33]Like Callahan's implicit reference to Aristotle's notion of predispositions, it is possible on Vetlesen's account to tutor and refine our capacities for moral perception and judgment to such a point as to seem instantaneous. The difference between a well-meaning by-stander and a by-stander trained and certified in CPR, for instance, illustrates how training and practice can hone perception ("he's choking) and judgment ("he needs the Heimlich maneuver").

[34]Since Vetlesen defines empathy in terms of providing some sort of moral intervention on behalf of another human being in need, it is not surprising that many of the elements he posits for empathy are also involved in the ethic of care Joan Tronto presents.

predicament, and of the import it bears" (p. 62). By import, Taylor (1985) means "the way in which something can be relevant or of importance to the desires or purposes or aspirations or feelings of a subject; or otherwise put, a property of something whereby it is a matter of non-indifference to a subject" (p. 48). More simply put, Taylor (1985) argues that "the import gives the grounds or basis for the feeling" we experience (p. 49).

Vetlesen extrapolates this notion of import and argues that ascertaining the import of a situation requires two steps—a process that illustrates the necessary interplay (rather than separation) between emotion and cognition in moral perception and judgment. The first step is to identify the import of a situation. Vetlesen suggests that asking and answering the question "what in the situation makes me feel the way I do," represents the sort of cognitive evaluation of our feelings that characterizes the identification of import. Vetlesen cites Taylor for support regarding this view of import. As Taylor (1985) puts it, "feeling is an affective awareness of situation" incorporating feeling (perception) and knowing (judgment) (p. 61). Feeling ought not be opposed to knowing, according to Taylor (1985), but rather integrated: "what I know [about a situation] is also grounded in certain feelings.... I see these feelings as reflecting my moral situation as it truly is; the imports they attribute truly apply" (p. 61).

Identifying the import entails first explaining to myself why I am affected by the situation, drawn to it, or tuned into it, and, in the second step, determining the precise nature of what I feel by assessing the justification for feeling the way I do. Vetlesen argues that a feeling entails a particular judgment, because having that feeling also necessarily involves a cognitive assessment or articulation of the presenting situation.

The first step of identifying the import of a situation involves formulating an initial hypothesis regarding what I feel. The next step is to judge the validity or appropriateness of that feeling, according to Taylor (1985): "We can feel entitled to say on the strength of certain feelings, or inferences from what we see through certain feelings, that we know that *X* is right, or good, or worthy, or valuable" (p.62). The process of evaluating our feelings will either justify our initial interpretation or bring arguments to bear that the interpretation of our feeling is unfounded. If the latter occurs, our feeling will necessarily change.

Vetlesen offers several illustrative examples—shame, suffering, and racism—as evidence for the dual cognitive-emotive nature of ascribing import. Shame has already been discussed. One powerful example concerns the perception of suffering. Vetlesen argues that suffering requires a joint cognitive and emotional perception—the subject of the emotion, the one seeing the suffering of another, must regard the one-suffering as in a state of suffering.

Regarding suffering, Vetlesen argues "that to 'see' suffering as *suffering* is already to have established an *emotional bond* between myself and the person I 'see' suffering" (p. 159). In other words, through our perception of the other, we constitute the other as in a state of suffering. We observe the suffering, then ascribe the import of suffering to the other's situation. Thus, according to Vetlesen (1994), there can be no "'disinterested' access to the human reality of suffering" because it is not possible for suffering to be a "neutral" phenomenon (p. 159). The very word connotes an already pre-reflected moral attitude to the other as in a particular state. Lacking an emotional bond,

we will be indifferent to the other's experience of suffering. The suffering still exists as a phenomenon, but "to exempt our emotional faculty from this seeing is to undermine it, extinguish it, indeed to prevent its very emergence" (Vetlesen, 1996, p. 159).

Vetlesen spends a great of time analyzing the suffering of concentration camp victims in the Holocaust and how it was possible for Nazi soldiers to commit such atrocities. An important historical fact is that outright, full-scale killing in concentration camps did not occur until after German doctors had perfected their euthanasia program against the mentally retarded, congenitally deformed, and mentally ill patients in hospitals. Ever efficient in their killing, four or five camps were established to concentrate mental patients, perform medical experiments on them, euthanize them, and burn their bodies. After seeing the success of such programs, Hitler was quick to extend the method of killing to Jews in overcrowded ghettos. Soon, hundreds of concentration camps were established throughout German-occupied territories, where Jews and the other groups mentioned were brought in cattle cars, gassed, then burned.

How could such a quick progression occur from euthanizing the mentally incompetent to full-scale slaughter of entire sectors of society? The answer is by the careful inculcation of an "us" versus "them" mentality among German citizens, enforced through propaganda, terror, and bureaucracy. Philosophically speaking, Hitler and his Nazi party leaders were able to extinguish the ability of German citizens to "see" Jews and others as persons and thus establish emotional bonds to their suffering. Only persons could suffer, so if viewed as less than persons, as "not like me," then beatings, forced movement to ghettos, forced labor, and, finally, extermination could be justified. Once

Jews were categorized as non-persons, it was easy for many German citizens to numb their moral senses to the suffering before their eyes. In fact, documentary interviews with Nazi soldiers responsible for corralling Jews into boxcars for shipment to Treblinka, Auschwitz, and other concentration camps reported that the soldiers were usually drunk on duty—further numbing them to the suffering they were inflicting (Aviram, 1996).

Indoctrinated to hate Jews and other groups through political manipulation and propaganda, drunken Nazi soldiers could easily avoid seeing the suffering of others. According to Vetlesen, such inability to "*see*" the situation *as* endowed with moral significance represents a failure in perceptive abilities. As Vetlesen (1994) argues: "not perceiving suffering *as* suffering when witnessing it does not mean that we have no case of suffering here after all…; it is, instead, a matter of…[one] subject failing to do justice to [another]" (p. 159).

The suffering was real. The average Nazi soldier's murderous behavior indicates that his faculties of perception were numb. He was unable or unwilling to relate to the moral experience of another human being. Without the presence of the emotional faculty of empathy, he could view Jews and others as mere objects, as third-persons. Vetlesen draws from philosopher Peter Strawson's analysis to illustrate this point. The numbness the Nazis exhibited was the result of taking an objective, third-person attitude towards other persons. Adopting an "objective attitude," according to Strawson (1977), precludes "the range of reactive feelings and attitudes which belong to involvement or participation with others in inter-personal human relationships" (p. 9). Such an attitude, adds Strawson (1977), "excluding as it does the moral reactive attitudes, excludes at the same time

essential elements in the concepts of *moral* condemnation and *moral* responsibility" (p. 21). By numbing themselves to others, by objectifying others, the Nazis were able to expunge any inkling of moral responsibility from their actions and the German citizens any sense of moral outrage and condemnation to the chaos around them. Thus, again borrowing from Strawson, Vetlesen argues that accountability for one's actions falls squarely on a person's ability to "see" situations as endowed with moral significance.

Strawson (1977) distinguishes between three types of moral attitude: "we demand *of* others *for* others, as well as *of* ourselves *for* others, something of the regard which we demand *of* others *for* ourselves" (pp. 15-16, emphasis mine). Vetlesen adds a fourth type of moral attitude to the three Strawson identifies. Our ability to take a "participant reactive attitude" (Strawson, 1977)—engaging the other as a subject of our moral concern—requires an additional moral attitude. This fourth moral attitude, our attitude towards ourselves and our thoughts and feelings, a form of self-respect, requires the sort of moral self-reflection and self-evaluation that characterizes our ability to "see" certain situations as endowed with moral significance. Without this fourth attitude, according to Vetlesen, we would be unable to ascribe import to such situations and act morally towards others. This fourth attitude was the missing or excised from the collective Nazi moral consciousness. Without the ability or willingness to ascribe the import 'suffering' to the persecution of the Jews and other groups, the Nazis were able to perpetrate horrific atrocities against their fellow citizens and neighbors.

In a more concrete example, Vetlesen illustrates the fourth moral attitude in the example of a reformed racist.[35] A racist can, after reflecting on his past feelings and examining his emerging new non-racist attitudes, change his prejudicial attitudes towards others. As Vetlesen suggests, the "racist's desire to change his attitude toward others makes sense only insofar as he sees himself as responsible for the kind of attitudes he has" (pp. 162-163). The racist must "see" that his attitudes reflect morally on him, and he must alter his attitudes to match how he wishes others to view him. If he wants others to see him not as a racist, then he must alter those feelings of hatred. The fact that racism still exists, and the fact that other Holocausts have happened (e.g., Bosnia, Rwanda, Sierra Leone, and Chechnya), can be accounted for by the lack of the fourth moral attitude. The inability or unwillingness to see one's actions in terms of what one is feeling will numb that person to the plight of others, even when that person is the causative agent of the other's suffering.

Having separated the various components of moral performance for analysis and understanding, putting them all into one continuous process provides coherence to Vetlesen's theory and underscores elements that will be necessary to include in any morally integrative process, including ethics consultation. To start, an emotion "is a feeling, a being moved and affected by something, a first, intuitive grasp of the situation, one awaiting verbal articulation, one calling for further reflection, pondering, evaluation, and—if vehement—for self-control, restraint, and carefulness" (Vetlesen, 1994, p. 175).

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[35]The example is reminiscent of Gerald Dworkin's analysis of authenticity as requiring causal change in our desires, a subject to be discussed in the next chapter.

Emotions facilitate perception, which Vetlesen describes using such metaphors as directing our attention or allowing us to "see" that certain situations are endowed with moral significance. Thus, emotions are not static. They actively direct our attention, and, unless we irresponsibly let them, emotions do not dictate how we act. For Vetlesen (1994), emotions are "an open-ended dynamic mode of relating to the world, in particular to the human and thus eminently moral world" (p. 175).

As our fundamental, intuitive grasp of situations, emotions contain provisional interpretations of their intentional objects (both the matter and the form, the *noesis* and the *noema*, in Husserl's phenomenology). In order to guide action, our tentatively interpreted, gut reactions require further analysis and concentrated judgment. To borrow again from Harry Frankfurt as Callahan's description of conscience did, judgment consists in forming second-order interpretations of our initial, emotive interpretation. Forming such states of interpretation requires a genuinely non-static, dynamic relationship between our emotive and cognitive faculties of perception and judgment.[36]

Interpersonal Moral Performance. An important and interesting point only alluded to by Vetlesen concerns the ability of emotion and its subsequent processing into moral action to be a wellspring of authenticity for our moral choices. For example, as Vetlesen (1994) says of the racist, "the man may see his present [reformed] self as 'authentic' and condemn his previous [racist] one as 'inauthentic,' because of the impact of prejudice, ideology, and the like" (p. 161). The fact that an internal interplay exists

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[36]Vetlesen describes this relationship in terms similar to Callahan's depiction of conscience. The sequence of moral performance "is a back-and-forth movement" between perception, our initial emotional interest in and "seeing" the situation, on the one hand, and judgment, our reflective probing and evaluation of our initial interpretation of the situation, on the other (Vetlesen, 1994, p. 176).

within each of us between our moral perceptions of situations and our processing of those moral perceptions allows us to choose which emotions, judgments, and actions express us authentically. Vetlesen (1994), echoing Heidegger's (and Sherman's) analysis, suggests that emotions are "modes of relating to myself" (p. 173). The ability to relate to ourselves, to encounter ourselves, and to make choices on the basis of how we encounter ourselves expresses our ability to choose whether we act authentically or inauthentically. This form of intrapersonal authenticity—what Heidegger termed the ethical-existential question—must have an interpersonal, moral analog, according to Vetlesen.

For Vetlesen, the notion of import allows such an analogy to be made. Ascribing import to the way I feel about a situation I perceive and the manner in which I judge my feelings about my perception characterizes intrapersonal discourse. The inner dialogue has an interpersonal counterpart, however. The reason that such dialogue exists and that I attribute import to my moral perceptions is because I direct my empathetic faculty to interpreting the feelings of another human being who is experiencing pain, distress, travail, frustration, or some other emotional state. Furthermore, the impetus for such a perception is that I, through properly judging my perception, can act in a way to help that person—what Callahan refers to as the moral orientation conscience has towards goodness and Tronto as the care-giving impulse. Reaching out to offer help, recognizing the other as worthy of moral concern, and attempting to find out what the other is experiencing represents a truly interpersonal moral discourse between two moral agents.

The dual nature of empathy, as facilitating both intrapersonal and interpersonal authenticity, provides an appropriate context and starting place for the sort of integration

that must occur in ethics consultation. Not only must Rev. Williams, Mrs. Jackson, and Dr. Cassidy achieve internal integration, but the larger epistemological split between emotion and reason must be integrated. If the roots of Rev. Williams' emotional reaction are not explored and an opportunity for the expression and acknowledgment of his (and other) emotions provided, they could overwhelm the process or cause the parties to shut down emotionally or refuse to engage in constructive dialogue. The ability of the parties to explore not only their own emotional reactions but also to understand what their fellows are feeling and how these feelings are impacting their decision-making (what Jürgen Habermas calls overcoming one's own viewpoint) can help the process move forward while simultaneously respecting and addressing deeply held differences.

The discussion of Jamie's case thus far has helped reinforce the points made. Now, however, it is more instructive to present what should have happened, not what actually transpired, in Jamie's case. Unfortunately, without knowledge of how empathy might have transformed the dialogue between the parties in Jamie's case, the resolution to the case was engineered to "correct" the supposed factual misunderstanding of Rev. Williams and concentrate on educating Mrs. Jackson about the "proper" standards for surrogate decision-making. Thus, the consultation was quite one-sided, and there was little attempt to engender a shared understanding of the context that ethics facilitation and consensus requires. Here is the first part of what might have happened immediately after Rev. Williams' emotional outburst had the ethics consultants known how to foster empathetic sensitivity and understanding.

Part VI: Consultant-Directed Empathy and Jamie's Case

The silence lasted for what seemed an interminable time. Rev. Williams reached into his jacket pocket and unfolded a handkerchief, which he handed to Mrs. Jackson. She crumpled the handkerchief in her trembling hands, then dabbed at her eyes.

"Mrs. Jackson?" Kendra Davidson, one of the ethics consultants asked, breaking the silence.

Mrs. Jackson turned to Kendra. "Yes?" she sniffled.

"It is obvious that you love Jamie very much." Mrs. Jackson nodded. "It is also obvious that Rev. Williams feels very strongly about Jamie and cares about him, too."

"The Lord loves Jamie even more, doesn't He, Reverend?" Mrs. Jackson said, turning to her pastor.

Rev. Williams nodded. "Only the Lord can take Jamie," he said.

Another silence fell over the group.

Dennis McCullough, the other ethics consultant, cleared his throat. "Mrs. Jackson, Rev. Williams, we understand how important your faith is regarding Jamie. A good friend of mine, a pastor himself, once told me a story about his wife who died from ovarian cancer that might help you make sense of the present situation. Just like you, he was struggling with trying to be true to his faith but also true to his wife, who was in much pain in her last days. This pastor, Ben was his name, told me that he had decided to have the doctors withdraw his wife's nutrition and fluids. In his words, there wasn't any treatment—breathing machine or feeding tube—that, if taken away, could prevent God from creating a miracle."

Dennis paused a moment, seeing the effect of his words on Mrs. Jackson and Rev. Williams.

"Praise the Lord," Rev. Williams breathed, taking Mrs. Jackson's hand in his. Mrs. Jackson added an "Amen" for emphasis and squeezed her pastor's hand.

"Ben said that he prayed all night for such a miracle after the doctors stopped the food and water," Dennis continued. "A miracle did happen, Ben told me, but not the one he was praying for. His wife died peacefully in the morning. The staff did everything in their power to truly care for her throughout the night before she died. They treated her with dignity and provided medications to ensure that she did not experience pain. Ben later told me that withdrawing the food and water had put his wife's fate in God's hands, where it belonged, not in the hands of medical technology, which was just prolonging her agony. The situation with Jamie is very much the same, don't you agree?"

Rev. Williams smiled at Mrs. Jackson, who then turned her head to Dennis and nodded slowly.

"Mrs. Jackson," Dr. Cassidy spoke softly, "we would never abandon Jamie. Just like the pastor's wife, when we withdraw treatment, we do not withdraw care. The nurses will still monitor Jamie, and we will provide him with whatever comfort measures and medications we can so he dies with dignity."

Mrs. Jackson began to sob. Dr. Cassidy reached over and touched her shoulder lightly, then continued. "You and Rev. Williams can be there and even give him ice chips and keep his mouth moist with swabs with Vaseline on them."

"I need some time to think about all this," Mrs. Jackson explained.

Chapter Three illustrated that emotions often serve as a starting point for morality. Without the human impulse to care about our own actions and how they influence those around us, morality would be meaningless. Withdrawing treatment from a loved one is a very emotional issue. Jamie's situation is further complicated by a multitude of additional emotional factors. His mother, Mrs. Jackson, feels immense guilt. She feels responsible for Jamie's past behavior at school and feels worse that she was not able to spend quality time with him trying to repair their relationship before his accident. She is Jamie's mother, and she feels the need to protect him from harm.

During the ethics consultation Mrs. Jackson thought that if only she had not been at work, she might have at least made sure Jamie was wearing his helmet. "Maybe his injuries in the crash would not have been as bad," she thinks to herself. However, she seems quiet and often defers to Rev. Williams during the consultation. How can the ethics consultants acknowledge her feelings of immense guilt, which seem to be blocking her ability to integrate Jamie's grim prognosis, with her strong religious values, which, as the story Dennis related showed, can be a source of moral motivation and sustenance?

On some level, the story Dennis told regarding his pastor friend featured the same sort of guilt Mrs. Jackson is experiencing. Perhaps seeing it in another—in someone who Mrs. Jackson can identify with as a fellow religious person—and who has appropriately acknowledged and expressed the role of guilt in his own decision-making and decided it is not helping the subject of his moral concern, his wife, will help her in integrating her own feelings with the facts about Jamie's condition. In a sense, the story might help

begin the process of integration by focusing Mrs. Jackson's moral perception on the feelings of someone in circumstances somewhat similar to her own.

Rev. Williams has known Mrs. Jackson for many years and helped her through the death of her other son, Devon, by providing her spiritual support, prayer, and fellowship. His community efforts have netted some funds to provide home care for Jamie. The community is strong, but not wealthy. Mrs. Jackson will have enough funds to cover expenses until Jamie can qualify for Medicaid. Rev. Williams would rather see Mrs. Jackson take Jamie home than have him stay in the hospital and have the medical team withdraw his food and water. He is livid that the medical team wants to give up on Jamie. The ethics consultant's attempt to understand his moral distress and see his perspective, however, has helped. The story about the pastor and his wife has shifted his feelings on the subject and provided another interpretation for withdrawing food and water. "But do the doctors and nurses truly *understand* my concerns *from my perspective*?" he wonders. That is his worry.

The intern, Dr. Cassidy, has never taken care of a PVS patient before. She feels dumped upon and unsupported because her attending physician has not been much help and her chief resident has her own patients to manage. Withdrawing the feeding tube would not be her personal choice, but given that the antibiotics have not worked and that Jamie has developed a bowel obstruction, she sees few other options. She wonders why such discussions did not take place last month. "Surely the other residents and attendings saw this situation coming. They had (and have) just as much responsibility to address these difficult issues as I do and the present team does. Doris tried to raise the issues last

month, but perhaps since she is *only* a nurse (and perhaps a woman), the doctors ignored her. She could have asked for an ethics consultation, but without the support of the physicians, I wonder how successful that would have been and whether the doctors would retaliate against her in some way for 'going over their heads.' Dammit, now all this crap is on my shoulders!"

The nurse manager, Doris Evans, is concerned with Jamie and his suffering. If the antibiotics will not work, it is appropriate to withdraw them. He will die. If they have to keep feeding and hydrating him, she knows how Jamie's last days will be. He will become increasingly agitated, his abdomen will swell from both the fluid build-up from his lungs and the IV fluids as well as the gas build-up from his bowel obstruction, which could rupture and cause massive infection. "And Mrs. Jackson won't be there in the middle of the night to see him in such a state," she thinks to herself. "If she were, I don't think she would want to take her son home and provide care for him there—it would be too difficult for her given her level of guilt." In a sad way, she is relieved that Jamie's bowels obstructed. It forces the issues she has tried to raise over the past month or two, but in a way that avoids pitting her against the doctors, which is the way things have gone during Jamie's stay. "Maybe if doctors had more respect for the opinion and insights from nurses, situations like this would not have to reach a crisis point before being addressed," she laments to herself.

Dr. Cassidy and Nurse Evans are experiencing the same feeling of moral distress and frustration, but from different perspectives. The literature acknowledges the difficulty physicians have in addressing end-of-life issues (Richardson & Keay, 1993; Hansot,

1996; Lo, Quill, & Tulsky, 1999) and the fact that physicians and nurses often visualize moral difficulties in different ways (Gramelspacher, Howell, & Young, 1986). Nevertheless, focusing on the similar feeling of moral distress can be a uniting force in this case. If expressed to each other and to Mrs. Jackson and Rev. Williams, Dr. Cassidy and Nurse Evans can galvanize support to resolve the case through understanding and dialogue.

Rev. Williams and Mrs. Jackson "see" the case somewhat differently, but if they can understand that the health care professionals are just as morally distressed as they are, they can begin to acknowledge that the providers care about Jamie, too. The way each of them frames 'care' is different, but all parties share one moral endpoint—providing the best possible care for Jamie in the time he has left. For the health care professionals, who normally value saving or extending lives, their concern for Jamie manifests itself in wanting to provide him as comfortable a death as possible. They can no longer meet the norms that health care holds for individuals, so they must value dignity and comfort over needlessly and painfully prolonging the inevitable. Their decision to withdraw Jamie's feeding tube exhibits such a moral perspective.

For Mrs. Jackson and Rev. Williams such a prospect does not seem to respect their religious orientation to Jamie's life or the value placed on life, regardless of its condition. Although arrived at in anger and frustration, Mrs. Jackson's idea to provide home care for Jamie exhibits both her concern for her son as a person and her religious values of the sanctity of life. Focusing exclusively on the attempt to "correct" Rev. Williams' misunderstanding of the clinical facts about starvation and withdrawing food

and water will put the consultation in jeopardy. The feelings underlying each of the parties needs to brought out into the open for mutual perception, acknowledgment, and dialogue. If the ethics consultants can reframe the discussion to reflect what appears to be the common interest in caring for Jamie, then the parties can begin to focus on ethically acceptable solutions to address how best to provide care for Jamie.

Scientifically based health care often values the sort of emotional distance and lack of true empathy against which Code and Tronto argue. What harm would result to Dr. Cassidy and Nurse Evans from disclosing their moral distress and frustration? Perhaps fear, seeing health care providers as powerless, without all the answers, is one interpretation. However, seeing the vulnerability of the providers might provide the very ground on which to build mutuality and dialogue. Linda Daniel (1998) argues that mutual acknowledgment of vulnerability is one avenue for authentic dialogue. In fact, acknowledging our own vulnerabilities to ourselves and then to others requires the inner and outer moral dialogue that best characterizes the empathetic process Vetlesen outlines. Although I have laid some important groundwork in this chapter regarding the connection between emotion, empathy, and authenticity, the next chapter concentrates on the question of whether dialogue can indeed be a vehicle for authentic interaction.

In essence, Jamie's case involves several parties who have divergent perceptions of a moral event and have made their own moral judgment regarding what to do about the event. All parties, however, feel their choices are constrained, thus causing their different experiences of moral distress. In this chapter I have shown that empathy as a means to express our caring desires for another human being can provide a unifying and

transformative force when persons disagree about a shared moral event. By first allowing the full expression and mutual acknowledgment of the feelings present in the different perceptions and interpretations of the moral event, empathy can facilitate moral dialogue by opening up the moral terrain for creative problem-solving and option generation to meet the values of all parties.

The ethics consultants should strive to integrate the divergent frameworks. It would certainly involve a major procedural upheaval, but the endpoint—resolution of the case in a manner that respects the inherent personhood of all parties, including Jamie—will be better for the attempt. The ethics consultants would have to invoke an ancillary, supplemental process to their normal ethics facilitation, as I have illustrated in the reconstructed case. Moving directly into identification and analysis of the value conflict could potentially pose an obstacle to reaching consensus later in the process.

The analysis thus far has specified the sequence the ancillary process must take. First, the consultants would have to acknowledge and explore the underlying feelings about Jamie, how the option to withdraw food and water does not represent abandonment of Jamie, and the host of psychosocial issues surrounding his care. Only after that stage would they be able to use their more intellectual facilitation skills to identify and analyze the ethical issues, generate options, and build consensus.

Dennis has already started the process forward by showing respect, empathy, and concern for Jamie's situation and Rev. Williams' and Mrs. Jackson's feelings. Ethics facilitation suggests that showing empathy in this way can help persons work effectively with their emotions in sometimes tragic situations. The next step, however, is somewhat

less clear. It must be possible to get Dr. Cassidy and Doris Evans talking to Rev. Williams and Mrs. Jackson directly about the moral distress they are feeling and then attempt to come to some sort of emotional common ground. Dennis' show of respect and concern to Rev. Williams and Mrs. Jackson represents one form of empathy—consultant-directed empathy. Ethics facilitation does not provide guidance for what happens after consultant-directed empathy towards the parties occurs. The next step seems to require empathy and understanding among the parties themselves—party-to-party-directed empathy, or empathetic understanding for short. Vetlesen's account alludes to how such empathetic understanding can take place—first through empathy, followed by dialogue with the other. The next chapter takes Vetlesen's phenomenological account one step further and argues that dialogue with the other can be a form of authentic interaction. On the basis of this discussion, it will be possible to operationalize much of what has been discussed on a theoretical level to procedures and skills ethics consultants can rely on to help the parties achieve empathetic understanding.

Chapter Five

Dialogue: An Authentic, Integrative Form of Interpersonal Interaction for Ethics Consultation

"It is...a 'precarious' undertaking to compare the existentialists' with the applied ethicists' notion of authenticity."

—Jos V.M. Welie, 1994, p. 212.

Introduction

In Chapter Three I suggested that the intrapersonal integration of emotion and reason seems related to the expression of our most authentic selves. When fully engaged, we act on those feelings that uniquely express us. In such cases, our emotions become a wellspring of authenticity. However, does the same hold at the interpersonal level? By encountering ourselves emotionally, we can authentically choose to act upon emotions that express our genuine intentions. But, in situations where a decision must be made in collaboration with another, as ethics consultation requires, how is it possible to ensure that the decision reached is authentic?

One answer to this question can be found by analyzing whether the interpersonal elements involved in the sequence of empathy can ensure that the dialogue between persons is authentic. Thus, perhaps it makes more sense to say that the process used to reach a joint decision is authentic, rather than the decision itself is authentic. According to Vetlesen, empathy first involves an inward turn to our own thoughts and feelings, where we encounter ourselves and can, if our moral perceptions are integrated with our

moral appraisals, authentically choose which actions to implement.[37] Vetlesen's account of empathy also requires an outward turn to the other, the subject of our moral concern. Dialogue with the other ensues, and if the dialogue is sincere and genuine, it is possible for each individual to authentically relate to the other and engage in joint problem-solving. Whether the dialogue is authentic depends on several preconditions—that each party has intrapersonally integrated emotional and cognitive faculties of perception and judgment and views the other as worthy of respect and concern as a moral equal.

Part I: Callahan, Authenticity, and Character

The concept of authenticity finds its philosophical genesis in the phenomenological and existential literature. However, traditional explications of authenticity limit it to intrapersonal contexts, much like Callahan's theory of conscience, and suggest interpersonal authenticity is a form of bad faith, a lie to oneself. Such limitation seems to doom authenticity from playing the interpersonal role this dissertation seeks. Nevertheless, building on the arguments I provided in the last chapter regarding the necessity of interpersonal dialogue for true empathy, I will argue in this chapter that the traditional existential explication of authenticity is a false dilemma when applied to interpersonal contexts. Truly empathetic dialogue, which requires intrapersonal as well as interpersonal integration of emotion and reason, allows mediation between two persons intent on reaching a joint decision. It is therefore possible to illustrate the extension of

[37]Recall Vetlesen's example of the racist from the last chapter. A person desires that others stop viewing him as a racist. Recognizing that his former self was inauthentic by reflecting on the feelings he had and the judgments he made about others different from him, the person consciously chooses to feel a different way and to avoid making the same judgments about others.

intrapersonal authenticity—the self-consciously self-avowed nature of conscience to which Callahan refers—into interpersonal authenticity. On the basis of this discussion, it is possible to take Callahan's and Vetlesen's theories one step further and offer a theoretical foundation to operationalize the intrapersonal and interpersonal integration of emotion and reason in ethics consultation.

Passages from Callahan's book on conscience link her theory of conscience to the philosophical concept of authenticity. She argues that by paying conscious attention to our feelings we can choose to act upon those emotions that express the way we wish to act and be perceived. In this way, Callahan's theory of conscience can be said to involve a mechanism for choosing to act authentically, to be true to our selves, as she states it.

Understandings of authenticity differ depending on particular philosophical traditions, however. Existentialism, which coined the term, defines authentic existence in terms of owning our freedom and responsibility. Authenticity requires embracing the ambiguous nature of our existence, constrained by factors beyond our control (such as our birth, our upbringing, our education, and our past) yet open to our interpretation by freely choosing to overcome any limitations such factors play in our decisions. In contrast, I will survey several sources from the bioethics literature that suggest authenticity is but one facet of autonomous decision-making. We act autonomously when our decisions accord with our past values and character. The existentialist tradition would deem the bioethical conception of authenticity as bad faith. When we identify our choices with our past values and character, the ambiguity of choosing is avoided such that the action implemented represents something other than our own ability to freely and

consciously overcome our past selves. The stark tension between these two conceptions of authenticity indeed makes applying existentialist understandings of authenticity to the applied ethicists' a precarious undertaking, as Welie suggests. However, in an odd but intriguing way, passages from Callahan correlate with both the bioethical and existentialist conceptions, suggesting that perhaps, like the integration of emotion and reason, existentialist and bioethical conceptions of authenticity can be integrated. However, for the purposes of this dissertation, rather than spending a great deal of time exploring the areas of departure between the bioethical and existentialist conceptions of authenticity, this chapter concentrates on elucidating how Callahan helps to establish the possibility of an interpersonal view of authenticity. Before analyzing these passages from Callahan, however, it is necessary to understand the existential and bioethical conceptualizations of authenticity in more detail. Authenticity has its philosophical genesis in existentialism and its most relevant application to morality in the work of Jean-Paul Sartre.

Existentialism and Authenticity. Any analysis or application of Sartre's existentialism requires extensive explication of his often difficult and bewildering ontological terminology. Ontology is the study of being, and Sartre makes a direct connection between being and freedom in his book *Being and Nothingness*.

Freedom, for Sartre, describes not a moral state of being, such as the freedom to perform a particular action or the right to freedom, but rather a fundamental ontological state of being. He characterizes freedom in terms of consciousness (the for-itself) transcending itself and its own factual existence (its facticity) to achieve being-for-itself.

Being-for-itself is nothingness, according to Sartre—not in the sense of not existing, but in the sense of the for-itself exhausting itself in its attempt to achieve being-in-itself, a process Sartre calls transcendence. Being-in-itself refers to the transcendent being of objects and events, the phenomena themselves—what Husserl terms *noemata* (the plural of *noema*). Being-for-itself, consciousness, can impart *meaning* to objects and events, what Sartre refers to as intentionality, but by itself, it cannot impart *being* to such objects. This process is akin to what Vetlesen referred to as the ability of moral perception to ascribe *import* to the intentional object, the moral phenomenon, by the faculty of moral judgment.

In other words, consciousness, which is intrapersonal, must direct itself towards objects that are extrapersonal, outside of one's mind. The objects have being; they exist independently of our consciousness. For example, I am sure that my eyeglasses do not simply disappear from my nightstand when I go to sleep, only to miraculously reappear when I awaken. Consciousness, however, imparts meaning to objects. I know that those are my eyeglasses, and I know what their purpose is. In this way, the being of the object must be grasped by consciousness (not only the matter, the *noesis*, but also the form, the *noema*, in Husserl's terminology). Or alternatively, consciousness must direct itself to the perception of the object. In this way, consciousness transcends itself by directing itself outside its intrapersonal domain to the extrapersonal world full of its objects. Again, an analogy from Vetlesen is helpful and striking. Vetlesen argues that empathy is a form of transcendent, emotional consciousness, directing moral perception to objects imbued with moral significance.

Consciousness sets us apart from other non-animal objects in the world. However, the human being is unique, according to Sartre. Since consciousness is always directed toward an object, consciousness can be self-directed. However, consciousness is not disembodied; we are mind and body. Sartre terms our bodily existence facticity (the in-itself). Facticity not only includes the body and its physical limitations, but also other facts of existence—one's birth, education, upbringing, class, values, and history. Sartre characterizes human existence as a *tension* between consciousness and existence, between meaning and being. Many (wrongly) identify the meaning of our being as our facticity ("I am what I was taught or learned" or "I am who I am because of the way I acted in the past"), a form of what Sartre calls "bad faith." For this reason, Sartre argues that existence involves tension between transcendence and this facticity. Freedom, in its non-moral, ontological sense, consists in transcending our facticity, interpreting our factual existence and choosing not to succumb to its influence.

The existential tension is most apparent in the contrast between facticity and transcendence. Human beings are simultaneously attempting to be what they are (their facticity) and what they are not (by transcending facticity). By describing human existence in terms of opposites—the for-itself and the in-itself, transcendence and facticity, being what one is and being what one is not—Sartre suggests ambiguity, angst, and anguish define the human condition. This ambiguity is central to adapting Sartre's ontological concept of authenticity to morality, for giving into the ambiguity and embracing our facticity instead of transcending it leads to inauthentic existence.

Philosopher Linda Bell (1989) explores the relationship between ambiguity and authenticity. She suggests that the "uneasy tension of opposites" makes "being human…itself a challenge many would prefer to avoid" (p. 32). In Sartre's ontology, freedom requires responsibility—taking responsibility for our facticity despite our inability to control the circumstances of our birth or upbringing. However, since freedom *is* transcendence, we have the ability to interpret, impart significance to, and either accept or reject our factual situation. The recognition of this central ambiguity in human existence—that in order to be free we must impart meaning to our actions—leads to what Sartre calls anguish or angst. Some would rather flee than recognize the ambiguity inherent in their condition. According to Bell, this impulse to flee is the goal of bad faith; it leads to inauthentic existence.

According to Sartre, bad faith is a lie to oneself in an attempt to resolve the tensions that being-for-itself and being-in-itself create through their ambiguous opposition. Identifying oneself with one's bodily existence is less ontologically and morally burdensome than transcending facticity to reach the being of consciousness, a nothingness. To deceive oneself regarding the fundamental condition of human existence is to live inauthentically, in bad faith, as Sartre calls it. The "flight" from responsibility involves one of two forms of bad faith: (1) either identifying oneself with one's facticity or (2) believing that one's transcendence has substance, much like a soul or psyche.

Commentator Vilhjálmur Árnason explores the first kind of bad faith for its moral implications. Árnason (1994) argues that when we "see our situation as endowed with ethical meaning independently of our choice," our tendency is to see meanings and values

as belonging to our facticity rather than our transcendence (pp. 228-229). Existentialists regard assigning value to choices independent of the act of choosing as bad faith; Sartre (1956) labels this instance of bad faith "the spirit of seriousness" (p. 556). Facticity has being-in-itself, the kind of being objects in the world possess. Only creative acts of consciousness, transcending factual existence, can assign value or meaning to choices.

In contrast, existentialists argue against traditional accounts of morality, which suggest that we act on the basis of particular values or that particular values motivate our actions. Existentialism turns this traditional theory of human action on its head by suggesting that acting imparts meaning to our actions. The value and the meaning of our actions cannot be determined apart from the action itself: "Rather than being imposed upon human agents, all standards of behavior and models of life arise, therefore, within the structure of interpretations created by human activity" (Árnason, 1994, p. 228). That is, values are not fixed properties that justify our actions, as many accounts of morality presume; values are created in the act of choosing particular actions. To parallel Callahan's discussion of conscience, value ought not be considered a noun, an "it" that refers to some moral state of affairs or proposition. Rather, value ought to be considered an active verb, an action that describes the process of making particular choices.

Such a view holds provocative implications for morality: "Insofar as individuals direct their lives in accordance with values which they uncritically receive from without, as it were, they are living inauthentically: denying their freedom and individuality" (Árnason, 1994, p. 229). Such denials are instances of bad faith. Rather than adhering to norms of conduct from ethical theories, religious precepts, political authorities, or social

consensus, existentialism requires that "submission to rational laws and external authority" be "replaced by[38] personal integrity and resoluteness" (Árnason, 1994, p. 230). The focus of morality changes from the content, consequences, or outcome of a choice to the choice itself and the act of its choosing. Thus, for existentialists, the "character" of the choice and its chooser are morally definitive. Existentialist John McQuarrie (1972) echoes this sentiment. He argues that it is "not so much the content of the decision as simply its character as a personal act, fully and intensely appropriated by the agent…[which] matters" (p. 187).

As the previous discussion shows, an existentialist view regards character more as part of one's facticity and less a part of authenticity. In fact, the notion of character helps make a one-to-one comparison of existentialist and bioethical conceptions of authenticity. In contrast to the existentialist notion of character, several bioethical accounts of autonomy view the relationship between character and authenticity differently.

Bioethics and Authenticity. Several articles in the bioethics and medical literature on autonomy, psychiatry, and long-term care link authenticity to character. In their article "Authenticity, Autonomy, and Mental Disorders," Linda Ganzini and Melinda Lee (1993) define authenticity as the extent to which our decisions reflect the self, which they characterize in terms of individual uniqueness, traits of character, individual integrity, and consistency among these three elements. Inauthenticity, the polar opposite of

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[38]The fact that the phrase 'replaced by' is used here, rather than a phrase, like 'integrated with,' which indicates the miscibility of external and internal moralities, adds credence to the claim that existentialism presents a false dilemma. Presenting morality as an either/or option rather than a both/and option illustrates that, at the level of the language, not just conceptualization, existentialism is committed, falsely I argue, to intrapersonal authenticity.

authenticity, involves making decisions out of sync with any or all of the characteristics of self—when our choices appear inconsistent with our personal history, previous choices, and our personal style. As the title of their article suggests, authenticity and autonomy are tightly connected. In fact, Ganzini and Lee reduce authenticity to a necessary but insufficient condition for autonomy. For these authors, an authentic decision requires that other moral agents respect it as the autonomous expression of a person's character and values.

Bart Collopy's article, "Autonomy in Long Term Care: Some Crucial Distinctions," also links character and authenticity. However, he describes authenticity and inauthenticity as one of six polarities that help provide a richer account of autonomy. Collopy contrasts the two ends of the polarity. Authenticity consists in choices and actions that accord with the elements of one's character, whereas inauthenticity consists in those that contradict our character. Collopy (1988) embraces authenticity as a concept that moves "beyond issues of rational competency to those which involve the wider repertoire of the self: individuality, character, personal integrity and coherence" (p. 14). Thus, for Collopy (1988), authentic autonomy consists of "choices and behavior that are deeply in character, that flow from past moral career and ethical style, as well as from present values and immediate self-shaping" (p. 14). In contrast, inauthentic autonomy "consists in choices and activities that are seriously out of character, discontinuous with personal history and present values, lacking self-possession and self-understanding" (Collopy, 1988, p. 14). Although Collopy expands the notion of autonomy, his six

polarities suggest authenticity is but one measure of autonomy, the very conclusion endorsed by Ganzini and Lee.

Gerald Dworkin's (1976) work on moral independence presupposes a definition of authenticity that prompts interesting analysis. Dworkin (1976) suggests that autonomy is equivalent to authenticity plus independence: "The autonomous person is one who does *his own* thing" (p. 24). For Dworkin, the word 'his' describes authentic behavior and 'own' describes independence. Dworkin cites the faculty of reflection as a mechanism to achieve authenticity. Reflecting on one's choices, desires, habits, deliberations, and decisions yields the formation of certain preferences. Dworkin (1976) illustrates this process with an example of a smoker: "Thus a person may not only desire to smoke. He can also desire that he desire to smoke." (p. 24).

Dworkin's account of reflection as the formation of second-order desires directly complements Callahan's and Vetlesen's account of conscience and moral reflection, respectively. As an example, consider Dworkin's example of a person who becomes motivated to change a behavior and wants to quit smoking. Recognizing its harmful effects, the smoker introduces what Dworkin terms a causal structure or influence, similar to what Harry Frankfurt calls a second-order desire, to effect the change in his behavior. For Dworkin, the introduction of such a causal influence amounts to an act of embracing the behavior change as authentic: The smoker "views the causal influences as 'his.' The part of him that wishes to stop smoking is recognized as his true self" (Dworkin, 1976, p. 24). A similar analysis holds for Vetlesen's example of the racist.

Despite his reduction of authenticity to a necessary condition for autonomous choice in his formula 'autonomy = authenticity + independence', Dworkin's conceptualization of authenticity as reflection and willingness to actualize certain preferences of character parallels the framework offered by another moral philosopher, Bruce Miller. Miller (1981) describes four senses of autonomy: autonomy as free action, autonomy as authenticity, autonomy as deliberation, and autonomy as ethical reflection. Autonomy as free action requires voluntariness and intentionality. An action is voluntary if coercion, duress, or undue influence either are absent from or do not influence the performance of an action. An action is intentional if the agent consciously wills it.

Miller equates autonomy as authenticity with consistency. We act authentically when our actions resonate with our outlook on life, our morals, habits, and long-term goals. In order to label an action as inauthentic, Miller (1981) argues that "it has to be unusual or unexpected, relatively important in itself or its consequences, and have no apparent or proffered explanation" (p. 24).

Miller distinguishes the two preceding types of autonomy from autonomy as deliberation. This type of autonomy requires not only a choice or decision between two alternatives, but an evaluation of the alternatives, their relative benefits and harms, and the consequences each would have before one option is selected. Autonomy as deliberation is distinct from autonomy as free action; one can act freely but impulsively. Moreover, acting from habit may represent an authentic action, but since habits do not

require deliberation, autonomy as deliberation is distinct from autonomy as authenticity, according to Miller.[39]

The final type, autonomy as moral reflection, implies that agents accept, consciously reflect on, then act on the basis of certain moral values. The source of such values does not matter, according to Miller. The definitive feature of moral reflection is that the values be "one's own" in the sense of self-examination and self-authorization, a characterization much in line with Dworkin's (Miller, 1981, p. 25). Miller distinguishes this autonomy from effective deliberation, for one can deliberate and choose among available alternatives without reflecting on the moral qualities that form the basis for the decision during the deliberative process. Nevertheless, the process of moral reflection, which requires rigorous self-assessment, self-awareness, and self-commitment, is related to authenticity. The process of moral reflection can determine one aspect of "what sort of person one will be...in comparison to which one's actions can be judged as authentic or inauthentic" (Miller, 1981, p. 25).

Vetlesen's view regarding the role of emotions, as a way of encountering ourselves and choosing to act authentically or inauthentically, parallels Miller's and Dworkin's emphasis on the reflective nature of authenticity. As I discussed in the previous chapter, Vetlesen presents an example of a racist recognizing his previous self

[39]Arguing that our habits do not require deliberation leads to controversy. Consider the interpretation of authors like Sherman or Callahan, who argue that habits represent dispositions of choosing built up, tutored, and ingrained in our consciousness. Such a view holds that deliberation is not absent from such actions, but that over time, our previous deliberations have created deliberative "short cuts." When confronted with choices about which we have previously deliberated and determined which outcome is best, the need for prolonged deliberation is unnecessary. In this way, habits may indeed represent authentic choices, but only if those habits were properly ingrained through previous deliberations. This is likely the sense to which Miller refers in suggesting that some habits may be authentic but not require deliberation.

as hateful and consciously choosing and devoting himself to change his feelings. Only after evaluating our moral perception of a particular course of action or way of life, and consciously authorizing those decisions that uniquely describe the kind of person we wish to be does authenticity emerge. Miller's description echoes Vetlesen's: authenticity depends not only on perception, but also on reflection and judgment. We choose to enact those choices that we deem authentic for us.

The preceding discussions link authenticity and character. Existentialism regards the character of an action, the freely appropriated expression of one's authenticity, as fundamental. The sources from the bioethics literature views authenticity as arising from or according with the character of the decision-maker in the process of autonomous decision-making. These two conceptions of authenticity clash. For existentialists, character resides in the action and the act of choosing whereas bioethical accounts view character as traits or dispositions that determine whether particular actions are authentic. Passages from Callahan's book *In Good Conscience* suggest that both conceptions have validity.

Callahan and Authenticity. Emotion plays a vital role in authenticity. In fact, Callahan suggests emotion can be a wellspring of authenticity. Since emotions are vital signs from ourselves to ourselves, Callahan argues that self is responding to self and respecting the genuineness of that self. This focus on emotion as the source of authenticity parallels the existentialist emphasis on the subjectivity of experience, the interpretation of one's existence and assignment of meaning. Callahan (1991) argues:

> Without emotions or affects to amplify physiological drives and infuse cognitive processing with subjective meaning, human beings would not

> care enough to stay alive, much less mate, nurture offspring, create kinship bonds, or pursue art, politics, science, literature, and moral philosophy. We do things because we emotionally care about them and are personally invested; when we stop being moved, we stop moving (pp. 100-101).

Our emotions help us to assign subjective meaning to our experiences through self-conscious reflection, followed by the intentional enactment of our most authentic emotions—those expressing us uniquely, intimately, and essentially.

Through reflection on our emotional history, we can assign meaning to our emotions and actions much like the process the existentialists describe as transcending one's facticity. Callahan equates the cultivation of good dispositions of character, including the positive shaping of emotions, with decisions made in conscience.[40] Emotions are something we can shape and control. Just as existentialism regards it as an essential feature of human existence that we never need to passively endure our condition, emotions are not something that happen to us involuntarily. Responsibility, according to existentialism, requires not only acceptance of, but also an ability to freely interpret, one's facticity. Likewise, decisions made in conscience require the tutoring and testing of emotions to determine which ones reflect our most authentic selves.

However, conscience, and thus authenticity, is more than rational control of the emotions. Existentialism, with its emphasis on freedom as authenticity, echoes this claim:

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[40]Much could be made of the differences between Callahan's account of conscience, based *perhaps* in large part of her personal moral orientation as a Catholic, and the existentialist's, which would deem the basis of Callahan's moral orientation as a sort of bad faith. However, my reading of Callahan's book, although it contains allusions to Catholic moral diction—use of terms 'goodness' and 'conscience'—does not contain the theological background. The compelling aspect of Callahan's book is that her arguments and evidence are persuasive without the theological and philosophical baggage of the Catholic moral tradition she personally avows. I take such an argument to be the case with H. Tristram Engelhardt's views in *The Foundations of Bioethics*. Engelhardt's arguments are devoid of the theological assumptions that comprise his personal moral views. Thus, the comparisons I make between Callahan's understanding of authenticity and the existentialist's should be assumed not to contain the Catholic background views.

"We do not become free by escaping all 'natural effects' and by subjecting the passions to the rule of reason. Rather than excluding or repressing part of ourselves, we can fully be ourselves only by assuming the totality of our being" (Árnason, 1994, p. 228). Callahan describes the same phenomenon, but in terms of the integration of emotion and reason: our most enduring beliefs represent a tightly integrated and powerful mixture of reasoning, argumentation, evaluation, and intuitive perception. The bond that holds these elements together is the self-conscious expression of our most personal selves. There is a core of being, containing both rational and emotive elements, that reflects our life experiences, essential values, and those elements we identify as uniquely 'us'.

In addition, Callahan's account of responsibility parallels features of the existentialists'. She describes conscience in terms of good faith, the opposite of inauthenticity. Such commitments, representing authentic expressions of self-conscious reflection, deliberation, and willing are hard to overturn: "Here we stand, because we can do no other and be whole persons true to ourselves and the goods that we serve" (Callahan, 1991, p. 137).[41]

In addition to good faith, Callahan also describes instances of what she considers bad faith. Inner conflict and discord between heart and mind mean that decisions cannot be made in conscience. Callahan (1991) argues that the natural tendency to avoid the anxiety that accompanies moral indecision often results in "flight and avoidance" of the

[41]Again, it must be stressed that despite what appear to be allusions to Catholic moral buzzwords, the "goods" to which Callahan refers must be authentically chosen by reflecting on what we perceive to be our essential feelings. The fact that Callahan stresses such a self-based mechanism to choosing which goods to serve liberates her thesis from the theological confines of the goods commonly associated with Catholic moral theory and theology.

decision-making onus and responsibility on the one hand and "ungrounded leaps into decision" on the other (p. 138). Both are morally unjustified in Callahan's opinion. Her reason captures the spirit of existentialist conceptions of freedom and responsibility as a means of avoiding bad faith by fleeing from our decisions in angst: "Our moral freedom should not be squandered by arbitrary endorsements in order to relieve the anxious burden of indecision" (Callahan, 1991, p. 138).

For Callahan, the integration of reason and emotion assumes deliberation and reflection. We consult reason to reflect on emotions brought through to consciousness and to deliberate between the choices that confront us. The implementation of the emerging decision, a decision made in conscience, implies a resoluteness, a transcendence of one's emotional facticity. This process of self-authorization Callahan (1991) terms "will" (p. 14).

The parallel between an existentialist understanding of authenticity and Callahan's coheres on the procedural as well as the substantial level. For existentialists, the process of acting authentically requires that a moral agent "has reflected about his or her own values [i.e., his or her facticity] and consciously underwritten them" (Welie, 1994, p. 215). Since conscience is a uniquely intra-mental process combining rational tools of assessment with emotional acceptance of one's inner essence, it accords with the existentialist conception of authenticity as arising from within.

Callahan suggests that uncritical acceptance of moral guidance from trusted friends, parents, or ethical codes can lead to bad faith. Blind acceptance of religious dogma and moral precepts represents a form of bad faith to Callahan just as it does to the

existentialist tradition. She suggests asking several reflectively critical questions of ourselves to evaluate such advice, including whether we or they are "biased, blinded, careless, or maturely formed in personality" (Callahan, 1991, p. 135). The result of this question-asking skepticism is a personal, affective assessment of the integrity of our own emotional reactions and rational justifications. Moreover, such a process accords with the existential admonition about uncritical acceptance or adherence to norms from without. Callahan's procedure of consulting our emotional reactions, not only to our own emotional reactions and rational justifications, but also to the moral guidance we receive from others, helps provide a self-authorized mechanism to ensure that the decisions we reach represent our own thoughts and feelings. To borrow from Dworkin and Miller, such decisions must be "our own."

On the other hand, discordance in emotions often signals inauthenticity and prompts further searches for concordance. Callahan (1991) suggests that we should "continue to probe emotional reactions, seek information and arguments, reasonably assess our processes, listen to hunches, test them, take counsel with others, and be guided negatively and positively by our feelings and thoughts" (p. 137). This self-reflective cycle inevitably yields agreement, then authorization through the force of our will.

Callahan's work on conscience seems to coincide with several features of an existential understanding of authenticity. Where the two diverge, however, remains a problem. It is a necessary condition that our decisions are made in conscience when they reflect our personal values history, our character. In contrast, existentialism regards the character of the action, not the agent, as definitive of authenticity. Consulting our values,

emotions, and reasons to determine if choosing a particular action coheres with our character risks identifying our choice with our facticity. Sartre and Heidegger both regard such identification as bad faith. Authenticity must come from within, but does that necessarily exclude all interpersonal interactions from authenticity? I argue, along with Árnason, that the conception of authenticity underlying Sartre's existentialism not only makes interpersonal authenticity impossible, but it also perpetuates a false dilemma.

Part II: Interpersonal Authenticity or Bad Faith? Bridging the Gap between Bioethics, Existentialism, Callahan, Vetlesen, and Ethics Consultation

As philosopher Jos Welie (1994) has warned, adapting an existentialist conception of authenticity to applied ethics is a precarious undertaking. Each tradition construes the role of norms in guiding action differently. Existentialism seems to deny any place for norms that are not one's own—from within. However, examination of this claim, and a charitable interpretation of it in light of evidence from Vetlesen, Callahan, Miller, Dworkin, Árnason, and later even Welie and Sartre, suggests a way to move beyond the false dilemma presented by a strict existentialist account of authenticity.

Árnason presents the false dilemma in attempting to adapt authenticity to the clinical interaction between physician and patient. According to a strict existential account, authenticity must come from within. We must either transcend our facticity or succumb to inauthentic external influences. These are the only two alternatives existentialism offers, according to Árnason. The anxious burden of authenticity must be shouldered by each of us; third persons cannot achieve authenticity for us. According to

Welie (1994), "existential tensions cannot be annulled by a third person" because they are not our "tensions that are to be resolved" (p. 218). Thus, interpersonal attempts at moral dialogue, like ethics consultation, since they involve inserting a third person into a problem-solving role for difficulties others are experiencing, would be deemed futile instances of bad faith, according to this traditional interpretation of existential thought.

I argue, along with Árnason and supported by Vetlesen, Callahan, Miller, and Dworkin, that another possibility for authenticity exists within interpersonal contexts. Each author frames the discussion somewhat differently. But to state the case briefly, the capacity for interpersonal authenticity turns on a prior act of intrapersonal authenticity, a self-conscious integration of emotional and rational faculties in order to reflect on the influence our values have on our ability to make choices and the will to authorize them. Once we have consciously reflected on which valued decision represents us authentically, interpersonal authenticity requires the direct engagement of the other who is the subject of our concern in dialogue. This conception of interpersonal authenticity blends the theoretical accounts of empathy, emotion, and reason presented in the previous chapters with a charitable interpretation of the traditional existential explication of authenticity, influenced by phenomenological accounts of the role of dialogue in morality.

Callahan explicates authenticity in terms of decisions made in conscience. She discusses conscience as a filter through which norms received from outside—advice from friends, values from past actions, values from our upbringing and education—can be transformed into internal expressions of our authenticity. Not only must we use our rational faculties to reflect on such norms, but we must integrate our rational processes

with our intuitive and emotional skills to judge which norms represent our own sense of self. Thus, although we may receive norms from without, the process of self-consciously evaluating and authorizing them provides an intrapersonal mechanism to ensure that our choices represent us authentically.

Callahan's process for achieving authenticity parallels Miller's discussion of autonomy. Miller argues that the source of one's values does not matter. What does matter is that we consciously reflect on the values and choose only those that can help us to determine what sort of person we wish to be and authorize those actions which we judge as expressing us authentically. To borrow from Dworkin and Frankfurt, values we receive from without represent first order desires *to us*. Despite the fact that some values we receive from others may seem like second order desires—"I should want to call my mother every week"—individual authorization is the hallmark of a second order desire. For me, my mother's desire that I should want to call her every week is still only a first order desire. I do not desire that I should want to call her until I have consciously authorized that action and indeed set aside time each Sunday to call her. Thus, in order to make a value "one's own,"[42] a process of evaluation ensues. We form a second order desire—we desire that we desire to quit smoking, for instance. Introducing this sort of causal influence is equivalent to making a decision in conscience—we consciously will into action those choices about which we have reflected, both rationally and emotionally.

[42]The importance of authenticity in ethics consultation announces itself in the discussion of making decisions "one's own." The concept of moral ownership plays an important role in the writings of ethics consultants who view facilitation and the primacy of the autonomy of the parties to "own" the issues they bring to the consultation (Baylis, 1994; Lynch, 1994).

Miller's view parallels Gerald Dworkin's view about authenticity as making decisions "one's own" through reflection and evaluation; moreover, the procedure for achieving authenticity finds its most detailed expression in Vetlesen's work on moral performance. Moral judgment of our perceptions, both of ourselves and others with whom we relate, first requires intense scrutiny and evaluation. Our moral perceptions can provide a wellspring for authenticity. Through emotion we encounter ourselves, ascribe import to the situations we encounter within and without, and consciously authorize, through moral judgment of our emotions, our choices. According to Vetlesen we use our emotions, in combination with cognitive assessment about how we feel, to choose actions that represent us authentically. Through ascribing import, even to those values we receive from without, it is always me, an "I," who does the ascribing. Thus, all my choices and the values that serve as their foundation, even those with an interpersonal component, must still be processed intrapersonally. Ascribing import demands that I consciously authorize my decisions. Hence, as Miller argues, the source of our values does not matter. Rather, if it is always I who ascribes import to values (and in so doing consciously authorize those I wish to implement), then I act in good faith and avoid acting inauthentically.

Even existentialists like Árnason endorse the role of critical reflection in achieving authenticity. Uncritical acceptance of societal values, political authority, or moral codes represents inauthentic existence, he argues.[43] Critical reflection, on both our

[43]Even Callahan admits this much, for conscience requires self-reflection and self-authorization. Moreover, the type of reflection is similar for the existentialist and for Callahan. Reflection must integrate emotional and cognitive faculties of perception and judgment.

own values and those we receive from without, provides a mechanism to ensure that such values represent me authentically. However, Welie concludes that authenticity, in its existential instantiation, cannot provide such a foundational principle. Our existential tensions cannot be obliviated by third persons. Perhaps in the technical sense of the problem of intersubjectivity, this statement is true. However, authenticity can function in an interpersonal context. Vetlesen's distinction between empathy and sympathy illustrates that much.

As I argued in Chapter Four, an authentically human attempt to mediate the existential tensions of another can be accomplished through empathetic understanding, an interpersonal form of authentic interaction. Empathy respects the existential notion of inner authenticity. However, it attempts to mediate the problem of intersubjectivity, the fact that my existential tensions cannot be annulled by a third person, by suggesting that the ability to reach out, morally, and connect with the other through dialogue is a part of embracing our freedom and responsibility.

The difference between empathy and sympathy concerns identification, Vetlesen suggests. Empathy, by his definition, avoids completely identifying oneself with the lived emotional experience of another. I presented several of the moral dangers associated with this form of empathetic imperialism in Chapter Four. Empathy is an incomplete perception of what another feels and what I interpret the other as feeling. It can assist us in our attempt to understand what the other is experiencing and provide the impetus to help, but it cannot produce the exact emotional state and all its accompanying physiological manifestations in us. In order to complete the sequence of empathetic

understanding, dialogue with the other is necessary to check whether our interpretation of his or her inner experience is indeed correct and the intervention we plan to implement appropriate.

The ability to perceive a situation as endowed with moral significance is one of our responsibilities—a responsibility on both an ontological and moral level. The suffering that I observe is not only my ascribing the import of suffering to the situation, but also suffering itself in its bare existence as a phenomenon in the world.[44] Recall Vetlesen's example of the Holocaust from the last chapter. The suffering of Jews and other groups persecuted by the Nazis existed independently of the failure of German citizens to morally perceive its moral significance. In fact, it is a moral triumph that some citizens did perceive the suffering as morally significant and intervened at personal cost to their lives to hide Jews or help them escape through underground resistance movements.

The upshot of this line of argument suggests that in order for me to help remove the existential tensions of another who is the subject of my moral concern, I must interact with that other (as a second-person) to determine what they are experiencing from his or her perspective. As Joan Tronto has argued, our ability to relate to others as second persons determines our ability and competence to care: "caring requires that one start

[44]To abstract the process of ascribing import to a situation from our attempt to engage the other in dialogue represents a bad faith attempt at empathetic engagement. According to Vetlesen, the first stage of ascribing import is an intrapersonal judgment based on an intrapersonal perception. The next step engages the other in dialogue to determine if our perception and judgment are correct ("Are you okay? Do you need help?") before devising precisely how such help will be rendered. The two-part sequence minimizes the chances that I will use my values and experiences as the sole basis for helping another and thus impose my interpretation on the other without first trying to understand the unique circumstances of the other.

from the standpoint of the one needing care or attention. It requires that we meet the other morally, adopt that person's, or group's, perspective and look at the world in those terms" (p. 19). As I presented in the previous chapter, to view another from his or her own first person perspective is to adopt the attitude of respect and concern for the personhood of that other—the moral orientation required by second person thinking.

The attempt to adopt a caring attitude from the perspective of the other whom I intend to help presumes that I have morally perceived the need for my moral intervention, cultivated a moral judgment regarding this moral perception, and decided to intervene. Thus, while empathy cannot "annul" the existential tensions of another, it exemplifies a distinctly interpersonal mode of authenticity.

Vetlesen's argument provides a charitable interpretation for the existential condition of intrapersonal authenticity, but it also extends authenticity to the interpersonal realm without simultaneously violating intrapersonal authenticity. According to Vetlesen, both work in tandem; just like moral judgment cannot exist without a prior moral perception, interpersonal authenticity cannot exist without a prior act of intrapersonal authenticity.

Árnason's arguments build on Vetlesen's and bring authenticity to the clinical enterprise. Árnason suggests that the realities of the physician-patient relationship, both its interpersonal necessity and its delineation of a professional role for the physician, makes traditional existentialist conceptions of authenticity "far too demanding, monological and individualistic to be suitable in the context of health care" (Árnason, 1994, p. 227). For Árnason, conversation and dialogue, which aim at mutual

understanding and authenticity, represent an additional option to the false dilemma posed by a strict existentialist account. By tracing Árnason's argument and supplementing it with additional evidence on the dialogical nature of the healing alliance between patient and physician, I contend that this same interpersonal analog, along with Vetlesen's notion of moral performance, provides a firm basis for achieving authenticity in terms of ethics consultation.

Árnason: Existential and Interpersonal Authenticity. Ethics consultation is a microcosmic instance of the larger moral universe. In light of the relationship between autonomy and authenticity, respect for autonomy, one guiding ethical principle of ethics facilitation, implies a correlative duty. We should respect another's decisions if and only if the decision-maker has reflected on his or her own values and character and has consciously authorized such values. For both Callahan and Vetlesen, this process necessarily involves the active integration of emotional and rational faculties of perception and judgment.

What happens, though, when one or more parties in an ethics consultation cannot achieve the authentic expression of their own values and the authentic understanding of others' values due to overpowering, intrapersonal barriers? What happens when, in Callahan's terms, our affective system overtaxes our ability to integrate emotion and reason or, in Vetlesen's terms, we fail to judge our moral perceptions of events? What skills and processes can ethics consultants rely on to help such persons achieve authenticity—what skills can either lessen or prevent overtaxing the affective system or help parties to refocus their moral perception on previously misjudged moral reactions? If

a person can achieve personal authenticity by integrating emotion and reason, what process or skills can ethics consultants use to expand intrapersonal authenticity into interpersonal authenticity? Is it even possible or appropriate for one human being to help another to achieve a goal that is as fundamentally intrapersonal as authenticity? Or, to borrow Sartre's terminology, is such an attempt in bad faith?

The discussion regarding existential applications of authenticity to morality provides two interesting answers to these questions. First, moral values are not fixed principles that justify actions. Such a position implies a strange approach to the concept of character. Rather than suggesting that our actions build character, character is part of our facticity, and individual actions do not accord with character in the traditional sense. Rather, authenticity consists in always reinventing ourselves by assigning meaning to our actions. Thus, it is the actions that *have* character. The second fact—that directing our life according to norms received from without is a form of bad faith—suggests that authenticity can only be attained through self-reflection. There is no such thing, according to a strict existential interpretation, as interpersonal authenticity. Welie (1994) makes this conclusion explicit when he argues that third persons cannot annul our existential tensions and so help us achieve authenticity. Such a conclusion seems both to doom any attempt at moral discourse or other interpersonal modalities of moral decision-making and to reduce efforts to resolve shared moral conflicts to instances of bad faith.

Several of Sartre's commentators have suggested the possibility, if not the necessity, of a moral, and thus interpersonal, analog to authenticity (Bell, 1989; Taylor, 1992). Sartre himself offers being-for-others as a type of interpersonal ontology. Others

can judge our conduct, just as we can judge our own through being-for-itself, self-consciousness. Even Welie (1994), who argues the impossibility of interpersonal authenticity on the basis of Sartrean ontology, recognizes the necessity of interpersonal interactions and suggests a radical reconfiguration of authenticity in his article. Rather than focusing on the negative aspects of our ambiguous condition, Welie (1994) embraces Gabriel Marcel's emphasis on hope and trust as opposed to anxiety and tension as the "quintessence of human existence" (p. 221).

Árnason's (1994) article exemplifies the kind of hope to which Welie and Marcel allude—hope construed as trust (Welie, 1994, p. 224). Welie argues that the sort of hope to which Marcel refers is hope in a better future. Although Marcel's example concerns the hope experienced by concentration camp victims in Nazi Germany, the notion of hope in a better life also characterizes the motivation for patients and physicians to initiate a healing alliance. The patient's goal is to overcome illness and heal to the extent possible. The physician's goal is to restore the patient to his or her normal functioning to the extent possible. Certainly these mutual goals represent hope in a better life. The patient places hope and trust in the physician to use his or her skills to better the welfare of the patient. Such is the configuration and rationale behind the ethical principle of beneficence that governs the physician-patient alliance.

Árnason uses this component of the physician-patient relationship to determine if authenticity can have an interactional, interpersonal component. If Árnason's account can plausibly entertain an interpersonal counterpart to authenticity, then attempts to resolve moral difficulties in ethics consultation avoid bad faith as long as intrapersonal

authenticity can be assured prior to attempts at fostering it in interpersonal contexts. Or, phrased somewhat differently, individuals can reach a joint decision in an authentic manner after assuring intrapersonal authenticity. Intrapersonal authenticity can be assured through recognition of situations as morally significant followed by evaluation of one's own moral perceptions. Interpersonal discussion of moral judgments, which can differ and cause tensions or impasses in reaching joint decisions, completes the sequence.

Specifying such a procedure, one of the goals of this dissertation, would effectively extend intrapersonal authenticity to interpersonal authenticity. The first test is whether Árnason presents a plausible account for the failure of a strict existential understanding of authenticity within the healing alliance between physician and patient. The second and third test is whether Árnason's account can be adapted to ethics consultation in general and Jamie's case in particular, respectively.

Part III: Interpersonal Authenticity and the Integration of Emotion and Reason in Ethics Consultation and in Jamie's Case—Three Tests

The First Test: Interpersonal Authenticity within the Physician-Patient Relationship. Árnason distinguishes between three modes of physician-patient interaction. He argues that an existentialist critique of the first model, paternalism, supplies the rationale to reconstruct authenticity in terms of interaction, a kind of interpersonal authenticity. Árnason characterizes paternalism as a relationship between a patient who does not have the knowledge or ability to treat himself and a physician who has such knowledge and skills. The physician is duty-bound to use his or her expert

knowledge to make treatment decisions in the patient's best interests. The patient does not play an active role in the decision-making process.

According to the tenets of existential authenticity, the paternalistic model of interaction "condemns the patient to inauthentic existence by making him or her unable to exercise personal freedom" (Árnason, 1994, p. 232). Authenticity requires two obligations. First, the physician should refrain from subjecting the patient's decision to undue control or influence. This negative duty implies a correlative positive duty. Patients should be adequately informed so that the second obligation—allowing the patient to participate autonomously in the decision-making process—can be fulfilled. Thus, Árnason argues, the paternalistic model of interaction is antithetical to the existential notion of authenticity.

The autonomy model, the opposite of paternalism, also fails the existential test of authenticity. The autonomy model stresses the patient's positive right to control bodily integrity. The physician provides expert knowledge and skills, but the choices and decisions remain in the patient's power to accept or reject. Just as paternalism fails the existential test, so too does a strict autonomy model because it "threatens the integrity and authenticity of the professional" (Árnason, 1994, p. 233). According to the autonomy model, the professional risks becoming a pure technician with expert knowledge and skills, but little, if any, standing as a moral agent.[45]

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[45]Albeit somewhat of a caricature, in reaction to highly educated patients, some providers believed that their role was to provide expert interpretation of the patient's condition and outline the options available, leaving the decision solely up to the patient. Viewing autonomy as an absolute principle, offering a recommendation would unduly influence the patient's ability to make their own decision. Such a model of interaction reduces the health care provider to a mere technician and results in inauthenticity.

Árnason acknowledges that health care requires a different kind of physician-patient relationship, one based on the authentic interaction between the two. However, existential authenticity does not help in trying to delineate the process or content behind such a model of interaction. Árnason (1994) argues: "By laying all emphasis upon the resoluteness of the individual decision it offers no mediations between two or more individuals in the process of reaching a common decision. But in the context of health care this is the most important task" (p. 233). In order to salvage the concept of authenticity from this conceptual dilemma, Árnason argues that consistency requires that existentialism account for the authenticity of both persons in the relationship. Because the autonomy model stifles the authenticity of the provider and the paternalistic model does the same for the patient, Árnason's (1994) alternative is to encourage a model of interaction that fosters "mutual authenticity" (p. 235). Árnason develops this concept of mutual authenticity in terms of the third model of interaction, the cooperation model.

The cooperation model has its basis in dialogue. One goal of dialogue is to inform—the patient informs the physician of his or her values and preferences, and the physician informs the patient of diagnoses, prognoses, results of tests, options for treatment, and risks and benefits attendant on each option. Another goal of dialogue is joint construction of conversation aimed at some mutual goal—agreement, consensus, resolution, understanding, explanation, and so on. This second goal of dialogue provides the metaphor Árnason seeks in order to offer a form of mutual authenticity for patient-provider relations. He argues that cooperative dialogue generates mutual authenticity: together "in a spirit of *mutual trust and responsibility* created in a truthful dialogue," the

patient and physician reach joint decisions that respect the authenticity of each (Árnason, 1994, p. 237). Thus, "dialogue is not a strategic device which is employed in order to let the patient cooperate, but an inter-personal mode of being...[called] *authentic conversation*" (Árnason, 1994, p. 237).

Árnason (1994) quotes hermeneuticist Hans Gadamer's observation that conversation "opens up the treatment and accompanies healing" (pp. 235-236). In essence, conversation can treat both partners as persons. As I argued in Chapter Four, the interpersonal component of empathy requires each subject to adopt a second-person orientation to the other so that authentic attempts to engage in dialogue can commence.[46] Árnason (1994) quotes from Jay Katz' explication of the dialogical nature of informed consent in *The Silent World* as especially significant for elucidating the necessity of conversation: "Informed consent requires conversations because the equalities and inequalities of the partners in the dialogue complement one another: 'Physicians know more about disease. Patients know more about their needs'" (pp. 236-237). In essence, conversation facilitates what Howard Brody has called transparency. Brody argues that all patient-provider interactions require the sort of conversation necessary to ensure that the patient's values, emotions, and needs are expressed to the provider and that the provider's values, recommendations, and rationale behind the options become clear to the patient. Sometimes, as Julia Connelly argues, such transparent understanding can only

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[46]A fascinating literature has emerged on the role of conversation and dialogue as authentic modes of interaction within multiple contexts of the physician-patient relationship (Rosenberg & Towers, 1986; Brody, 1987; Marta, 1996; More, 1996; Suchman, 1997; Tong, 1997; Lo, Quill, & Tulsky, 1999). Dialogue has also been a recurrent motif throughout the ethics and ethics consultation writings of Richard Zaner (1990; 1993; 1996).

occur once the patient has had an opportunity to express his or her feelings and the physician has made a genuine effort to acknowledge them.

This is precisely the form of dialogue endorsed by Carol Toris in her negotiation model of empathy. Empathetic understanding, she argues, exists neither in the head of the patient nor provider, "but in the emerging interaction that takes place between them" (Toris, 1994, p. 3). Conversations or dialogues aimed at increasing physician understanding of patient preferences and needs and patient understanding of realistic expectations of treatments should feature the practice of empathetic understanding (More, 1996; Suchman, 1997; Tong, 1997; Lo, Quill, & Tulsky, 1999). In this context, empathetic understanding involves a similar dialectical exchange between self and other which characterizes Vetlesen's account of empathy. If both patient and provider maintain the proper moral stance to each other as second persons, respecting each other, and collaborating together to create a shared moral understanding of their clinical encounter, then, as Árnason (1994) suggests, dialogue is the vehicle for their authentic interaction. That is, dialogue should serve as "a mid-wife of a shared decision which respects the integrity of both" the patient and the provider (Árnason, 1994, p. 237).

Traditional existentialist explications of authenticity cannot sufficiently account for authentic conversation. Not only are such formulations of authenticity too "monologically constructed" because they exclusively focus on the solitary individual, but also because existential conceptions of authenticity present a false dilemma. As Árnason (1994) argues: "Either I am the master of the situation or I succumb to external influences. In genuine human interaction these are not the [only] alternatives. The

[existential] demand for individual sovereignty destroys conversations which are aimed at mutual understanding" (p. 237).

Without its interpersonal context, authenticity would doom any attempt at moral understanding between Mrs. Jackson, Rev. Williams, Dr. Cassidy, and Nurse Evans. Jamie's case provides a paradigmatic instance for the necessity of interpersonal authenticity and how authenticity in interpersonal contexts requires prior attempts at fostering intrapersonal authenticity. Before they can authentically discuss options for resolving the underlying clinical dispute—whether or not to discontinue Jamie's feeding tube—the parties need to integrate emotion and reason in their own moral perceptions and judgments.

The Second Test: Ethics Facilitators as Midwives for Ethically Authentic Dialogue. For Árnason, the midwife metaphor provides an alternative to the false dilemma within the continuum of authentic decision-making:

> The "magic" of a good, authentic conversation is precisely that we do not control it as individuals but are caught up in it and give in to its own movement, which is governed by the subject matter. The phenomenon of conversation shows us the primacy of the subject matter over the individual subject. At the same time, the individual is most truly himself—most authentic according to my account—when he forgets himself and opens up to the other in dialogue (Árnason, 1994, p. 237).[47]

[47]Jürgen Habermas argues that the ability to overcome one's own viewpoint and understand the interests of the other is central to establishing authentic consensus. In very much the same way, Árnason's suggestion that each party in dialogue must "forget himself and open up to the other" signifies the necessity to overcome a first- or third-person orientation if dialogue is to succeed. Dialogue is the second, interpersonal step in the process of ensuring authenticity. Each party is still required to have reflected on his or her perceptions and judgments. Interpersonal authenticity cannot be established if intrapersonal authenticity (self-reflection) has occurred. Openness to the other cannot occur unless each party is open to encountering him- or herself first.

The midwife metaphor for authentic conversation parallels the facticity-transcendence structure of existential accounts of freedom, responsibility, and authenticity. Authentic conversation transcends its subject matter, its facticity, in an attempt to reach interactional authenticity: the freedom that the being of the conversation possesses when the parties commit themselves to the goal of dialogue and reaching a joint decision. Interestingly, dialogue as a midwife for decision-making metaphorically captures not only what Árnason calls authentic interaction, but also the spirit of the ethics facilitation approach. Ethics consultants should use their knowledge and ability to facilitate, or act as midwives for, authentic ethical discussions and consensus.

Core Competencies locates ethics facilitation on a continuum between two extremes—pure authoritarianism and pure facilitation. *Core Competencies* finds both of these approaches lacking. The pure authoritarian approach substitutes the expert knowledge of the ethicist for the moral authority and autonomy of patients, surrogates, and clinicians, much like Árnason's description of the paternalistic form of patient-provider interaction. The ethics consultant brings knowledge of ethical theories and concepts to bear on the resolution of moral dilemmas. However, this approach necessarily usurps the autonomy of the parties to determine the outcome. Likewise, the pure facilitation approach, which only seeks agreement or resolution, does not rely on social consensus, ethical theory, or bioethical principles for what is considered an ethically acceptable outcome. Outcomes of such consultations could, in fact, violate the autonomy of an incapacitated patient or the professional integrity of the health care providers. In such a way, these two extremes of ethics consultation mirror Árnason's analysis of

inauthentic interaction. The authoritarian approach precludes authenticity and autonomy, and the pure facilitation approach threatens authenticity by not ensuring the ethical integrity of the outcome.

Core Competencies offers ethics facilitation as a middle ground between these two extremes. Ethics facilitators seek first to identify and analyze the value uncertainty or conflict that underlies a consultation request. After that, ethics facilitators seek to establish a consensus as to the outcome of the consultation. Ideally, the parties who "own" a difficulty would overcome their own viewpoints and treat each other as moral equals. When integration of perceptions and judgments is not possible, it does not violate the authenticity of the parties to have someone help set the proper atmosphere for consensus to occur. Thus, the forging of consensus most approximates the goals of authentic interaction. Ethics facilitators use their communication, mediation, and listening skills to "help facilitate the building of morally acceptable shared commitments or understandings" among the parties (ASBH, 1998, p. 7).[48]

In terms of Árnason's analysis, the metaphor of midwife should vividly capture the role of ethics facilitators. They ought to guide the discussion with specialized skills in communication and ensure the integrity of the outcome by creating an atmosphere where the parties can generate a range of options and decide on the one that most approximates their shared interests. The options should satisfy each party's own values and preferences

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[48]A recent article on the role of consensus in ethics consultation uses Habermas' discourse ethics to justify the role of the ethicist in helping to forge consensus (Casarett, Daskal, & Lantos, 1998). The thrust of the article suggests that the ethicist does indeed play the role of a mid-wife for conversations—by structuring a safe moral space for such discussions to take place. The moral authority of the ethicist, then, is neither authoritarian nor purely facilitative. The authors suggest that the metaphor of a mediator (cf. Walker, 1993) best captures the activities in which the ethicist engages.

as much as possible within the boundaries of accepted norms of ethics and law. The ethicist should add knowledge of the ethics literature, health law, and institutional policy to help the parties assess the ethical acceptability of the options. The ethicist ought to be an active participant in the process, but that participation should be facilitative, informational, and process oriented. If conducted thusly, ethics facilitation would respect the mutual authenticity of the parties by placing primacy on fostering authentic dialogue.

Regarding ethics consultation, Edmund Pellegrino has argued that joint decision-making implies joint decision-making responsibility. The ethicist has particular responsibilities—to ensure the ethical integrity of the outcome, to provide educational information, and to foster authentic dialogue. The dialogue must be between the patient, surrogate, and clinicians. The ethicist should act as a translator and "represent the views of involved parties to others" to facilitate understanding of differences in values and in interpretations of a shared moral event (ASBH, 1998, p. 14).

Core Competencies, however, as a document spelling out the responsibilities and competencies of consultants, is silent regarding what responsibilities patients, surrogates, and clinicians shoulder. Pellegrino argues, supported throughout the ethics consultation literature, that the rationale underlying ethics consultation is to respect the autonomy of the patients, surrogates, and clinicians to jointly arrive at an ethical resolution. The question is, based on the role *Core Competencies* endorses for ethics consultants, can ethics facilitation live up to the midwife metaphor? Does ethics facilitation offer consultant responsibilities such that the ethicist has more responsibility for the moral work of the consultation—determining the options, their ranking, and comportment with

the values at stake—than the patient, surrogate, and clinicians? If it does not, then the ethics facilitation may in fact violate the very autonomy and authenticity it purports to uphold.

A charitable interpretation suggests that ethics facilitation embodies the midwife metaphor in spirit, but not wholly in deed. Analysis of the role of the consultant throughout both stages of ethics facilitation illustrates that the ethicist has sole responsibility for cultivating many of the preliminary steps necessary for authentic dialogue. Certainly, my critique of how *Core Competencies* construes empathy as consultant-directed is a prime example of the largely consultant-based responsibilities. The same holds for authentic dialogue. The challenge is to how to supplement ethics facilitation's early stages, which place greater responsibility on the consultant than the patient, surrogate, and clinicians.

To begin, the first stage of ethics facilitation features the consultants identifying and analyzing the nature of the value conflict or uncertainty rather than guiding a process in which the patient, surrogate, and clinicians identify and analyze it. In refutation of the potential rebuttal that my criticism is merely a matter of semantics, the words of the Report speak most clearly on this matter. According to *Core Competencies*: "the ethics consultant must: (1) gather relevant data; (2) clarify relevant concepts; (3) clarify related normative issues; and (4) help to identify a range of morally acceptable options within the context" (ASBH, 1998, p. 6). The primacy seems focused on skills consultants use to accomplish the goals of ethics facilitation.

The approach would indeed be more balanced if, in addition to these consultant-based responsibilities, *Core Competencies* discussed the responsibilities of patients, surrogates, and clinicians. If the ethicist gathers relevant data, then patients, surrogates, and clinicians must present their understanding of the data as truthfully as possible. If clarification of concepts and normative issues is involved, patients, surrogates, and clinicians must be willing and able to discuss and integrate such clarification into the emerging dialogue. Willingness to do so means that each party has adopted the proper moral stance to each other as second persons. The ability to do so means that emotional tensions and other barriers have been addressed by engendering empathetic understanding among the parties. Since *Core Competencies* addresses both of these elements in terms of consultant behavior—being attentive to the affective dimension of ethics consultation, learning to express empathy, and so on—it is necessary to translate these responsibilities to what patients, surrogates, and clinicians must do.

The most problematic aspect of the first stage of ethics facilitation concerns the fourth responsibility of the ethicist. Although the ethicist can *help* identify options, this stage of the process must belong to the patient, surrogate, and clinicians. By immediately analyzing the ethical acceptability of each option, the consultant could stifle creative efforts at problem-solving or alienate one or more parties from participating sincerely in the process. The former was certainly the case when the ethics consultants minimized the importance of addressing the emotional aspects of Rev. Williams' judgment that removing Jamie's feeding tube would starve him to death. By immediately launching into a cognitive explanation of how Jamie would not starve to death, the consultants

effectively aligned themselves with the clinicians, thus creating a power imbalance and mistrust in what should have been an open and impartial discussion.

Option generation should be an open brainstorming process, followed by assessment of the ethical justification (or lack thereof) for each option. Based on this information, it should be the job of the patient, surrogate, and clinicians to agree on how to best rank the options in terms of their shared values. The consultant's "help" should concentrate on option assessment. If the patient, surrogate, and clinicians are stalled at option generation, then it may be necessary for the consultant to help start, guide, or finish the brainstorming of options. Nevertheless, the consultants should always be cognizant of the power they wield in helping to generate options and assessing their ethical justifiability. One way to build such recognition into the process is to separate the option generation phase from the option assessment phase. The consultant can and should play a greater role in the latter, but to play a dominant role in the former can infringe on the autonomy and authenticity of the patient, surrogate, and clinicians.

Since the second stage of ethics facilitation involves "building…consensus among involved parties" and utilizes the ethicist's more interpersonal skills, consensus comports more with the goal of the midwife metaphor (ASBH, 1998, p. 7). The difference in language used for the skills endorsed at this stage of ethics facilitation compared to the first underscores my claim that first-stage consultant-based responsibilities are not a matter of mere semantics. Reaching consensus requires that the ethicist do his or her best to "ensure that involved parties have their voices heard" and "assist involved individuals in clarifying their own values" in relation to the options for discussion (ASBH, 1998, p.

7). The tenor of the consultation changes from consultant-directed activities during the first stage to more involvement from the patient, surrogate, and clinicians during the second stage.

Nevertheless, too much consultant responsibility in the early stages of ethics facilitation can destroy attempts to foster authentic dialogue later in the process. Richard Zaner has long argued that the proper role of an ethics consultant is to foster dialogue, to midwife conversation and authenticity (1990; 1993; 1996). His most recent article on the subject, "Listening or Telling? Thoughts on Responsibility in Clinical Ethics Consultation," explores the connection between dialogue and authenticity. In his title, Zaner alludes to an important point regarding ethics facilitation. If the proper role of the consultant is a midwife of dialogue, then listening, as opposed to telling, should be the forte and main goal of the ethicist in the early stages of ethics consultations, Zaner argues. A form of active listening, briefly described in a footnote in Chapter Three of this dissertation as a first step in fostering empathetic understanding, can facilitate authentic dialogue. Consultants act as translators for different interpretations of a shared moral event, thus helping the parties understand what values are at play in the consultation and engendering a sense of shared responsibility for the emerging dialogue. Active listening is a form of participation that places considerable responsibility on the consultant to listen and translate, but it also places considerable responsibility on the patient, surrogate, and clinicians to relate, listen to, and process what others say. The next chapter describes in more detail how active listening during the early stages of ethics facilitation is essential for fostering authentic dialogue and consensus.

The fact that dialogue requires a certain amount of vulnerability—a simultaneous forgetting of oneself and opening up to the other in dialogue, as Árnason argues—suggests that the ethicist's role should be to protect against exploitation of vulnerabilities. In order to prevent exploitation of the vulnerabilities inherent in engaging in dialogue, Zaner (1996) suggests a role for the ethics consultant very similar to Árnason's midwife: "at every moment of interaction with patients and their loved ones, as well as with health professionals, the clinical ethics consultant is, or ought to be, the constant reminder of the moral freedom which is authentic dialogue" (p. 271). Thus, the consultant should guide, not control or engineer, the dialogue in order to prevent exploitation and inauthenticity.[49] Use of particular communication techniques, such as open-ended questions, active listening, reframing or translation of statements to others to ensure understanding, and acknowledgment of emotions, help in nurturing dialogue. In essence, the consultant ensures that parties in dialogue maintain the proper moral stance to each other as second persons, responsive to and responsible for the outcome and the process used to reach that outcome.

Autonomy as authenticity, to borrow from Bruce Miller, and collaboration are essential ingredients in authentic dialogue. As Zaner (1996) concludes in his article: "in

[49]Interestingly, an article from the nursing literature explores the connection between authenticity, dialogue, and vulnerability. Nurse Linda Daniel stresses the importance of mutual vulnerability as a vehicle for authenticity. Much like Sidney Callahan's view of emotions as the wellspring of authenticity, Daniel (1998) argues that we can achieve authenticity by "listening to the discourse of positive and negative desires of our embodied selves, making it possible to hear the desires of another" (p. 191). Being attentive to our own vulnerabilities allows us to be attentive and authentic to the vulnerabilities of others whom we intend to help. Thus, only by first recognizing the vulnerability in ourselves can we hope to overcome the bad faith inherent in using the vulnerability of another as a means of exploitation or domination. As Daniel (1998) suggests: "when we seek to protect our vulnerability by numbing ourselves to another's, we are susceptible. When we are no longer able to recognize our own pain in the pain of others, then we are capable of inflicting pain on others" (p. 191).

dialogical engagement, the participants *collaborate* in each other's freedom. The one who responds enables the one who needs to know freely to continue seeking through questions; each recognizing, welcoming, the same by the other" (p. 274). In this sense, the consultant is the midwife for the ensuing conversation, ensuring the proper moral balance of the dialogue and that the interlocutors maintain respect for each other. It will be impossible for the parties to collaborate in each other's freedom if they do not first have empathy for each other and a willingness to engage in moral dialogue.

Thinking about the principle of respect for autonomy in terms of authentic interaction supplies a new rationale for ethics facilitation. Each party, to borrow from both Dworkin (1976) and Árnason (1994), must fashion solutions to an ethical difficulty that are "*his* or *her own*." However, as Árnason acknowledges, a strict interpretation of authenticity must be reconstructed to allow intersubjective authenticity to emerge. Thus, solutions that represent the individual values of each party must be transformed into options that incorporate a shared sense of the dialogue. Options are no longer singular in person—"his or her own"—but plural, "their own."[50] Such options may start as "his or her own," but individual positions must be transformed into common interests in order for consensus to be reached. As Habermas defines consensus, each party must overcome

[50]Susan Rubin and Laurie Zoloth-Dorfman (1994) explore ethics consultation in terms of making the transition from individual to group decision-making responsibility. Using the word 'we' to signify the joint responsibility of the consultants, the patient, the surrogate, and the clinicians, they argue: "We must be honest about our responsibility for and our engagement and embodiment in the process of ethical discourse. In such a setting, ethical dilemmas are approached from the perspective of the 'we' and are not perceived as the psychological problem of the objectified 'other.' That the grammar is plural and possessive is intentional: it is the dilemma that is collectively experience by the community. Our struggle to hear the values, perspective, and narrative of each individual is the way that we make moral meaning possible in human community confronted with tragic choices" (p. 53).

his or her own viewpoint and understand the interests of the other. The ethicist should play this vital function in the ethics facilitation approach. The ethicist, in a sense, encourages authenticity in each party by bringing knowledge, skills in clarifying values and communication, and a process that allows authenticity to emerge in a dialogical form. The key indicator that this has occurred is a jointly-reached, stable consensus—a decision that incorporates elements of what would be solely "our own" solution in light of the uniquely moral needs and interests of other parties.

Transformation is indeed a helpful metaphor to describe the shift in perspective that occurs in a party's view of the situation and of each other. Not only does it describe the process for expanding the concept of empathy from a consultant-based to a collective responsibility, but it also describes the process for fostering authentic dialogue. For if true consensus has emerged, then authentic dialogue has helped the parties jointly reach a decision. In order for dialogue to be authentic, intrapersonal authenticity must have been expanded into its interpersonal counterpart. Emotion and reason must be integrated and empathic understanding established in order for authenticity to be assured. As Vetlesen's sequence of moral performance suggests, interpersonal authenticity implies a prior act of intrapersonal authenticity. In this sense, like moral performance, true consensus is a consciously authorized, joint accomplishment.

Implicit in Zaner's article is a critique of ethics consultation models in which the consultant plays a dominant role and takes responsibility for much of the dialogue. The role of the clinical ethics consultant, according to Zaner, is to help avoid the dangers associated with exploitation of authentic dialogue. For Zaner, the ethicist can pose just as

much danger to the possibility of authentic dialogue as other features cited in this dissertation—emotional tensions, interpersonal conflicts, uncertainty, and so on. Ethics facilitation, while its second stage seems to comport with the midwife metaphor, emphasizes the role and responsibilities of the consultant above those of the patient, surrogate, and clinicians who supposedly "own" the moral difficulty during its early stage.

Since the goal of authentic dialogue is to transform individual positions and options into shared ones, TEC provides ethics consultants with assurance that authentic interaction has occurred and places the decision-making responsibility on the shoulders of those who "own" the moral difficulty. TEC supplies specific skills and techniques, based on the theoretical discussions of empathy and the integrative nature of morality entertained thus far, to ensure mutual authenticity emerges. Thus, the third test, whether the expansion of intrapersonal authenticity into an interpersonal context in Jamie's case can overcome the emotional impasse and lead to resolution, must wait until after more fully developing the two steps of TEC in Chapters Six and Seven.

Chapter Six

From Intrapersonal Authenticity to its Interpersonal Counterpart: A Transformative Model for Ethics Consultation

"When an emotional tone predominates, attention to emotion is generally more effective than pursuing an intellectual discussion."

—Julia Connelly, 1998, p. 228.

Introduction

The chapters thus far have each dealt with the theoretical components necessary to supplement the first stage of ethics facilitation. In Chapter Two I discussed a case involving strong emotional tensions and suggested that identifying and analyzing a value conflict might not result in as stable a resolution as first addressing underlying emotional tensions. The first stage of ethics facilitation requires supplementation in order to ensure that emotional tensions are addressed first and do not evolve into impasses that could prematurely terminate the consultation. In Chapter Three I explored the role and nature of emotion and argued for the integrative nature of morality. Moral decisions are best made when emotion and reason are tightly integrated.

As one way to achieve integration, on both the intrapersonal and interpersonal levels of moral discourse, I presented a phenomenological sequence of empathy in Chapter Four. This form of empathy begins with moral perception and, if engaged, this perceptive faculty should help yield an integrated moral action when evaluation of our moral judgment follows our perception. Emotion and reason are tightly interwoven throughout both of these steps. The sequence of empathy first involves intrapersonal assessment of our moral perceptions and judgments, followed by an interpersonal attempt

at moral dialogue with other decision-makers. Thus, an authentic attempt at interpersonal dialogue must first have an intrapersonal counterpart—the authentic integration of emotion and reason in assessing our moral perceptions and judgments.

The separation of the intrapersonal from the interpersonal within the sequence of empathy and the integration of emotion and reason suggests a natural sequence for the steps of the supplemental process presented in this chapter and the next. Empathy originating from within, characterized by intrapersonal integration of perception and judgment, must be expanded to empathy with others. As the phenomenological sequence of empathy implies, the authentic extension of the intrapersonal to the interpersonal requires viewing others as second persons worthy of respect and concern. As a facilitator of moral dialogue, the role of the ethics consultant is to facilitate this shift in empathy. Unsupplemented, ethics facilitation endorses a narrow role for empathy—the consultant expresses empathy for and with one or more of the other parties. This consultant- directed form of empathy is only the first step, however. The consultant expresses empathy as a means of modeling the sort of empathetic interaction that must take place between the patient, surrogate, and clinicians—what I term party-to-party-directed empathy, or collective empathy.

Despite the detail of the discussion thus far, several practical questions regarding the extension of empathy in ethics consultation remain. When in the consultation process ought ethics consultants begin the process of showing empathy? In terms of techniques or processes, how do ethics consultants ensure the extension of empathy into a collective responsibility and what effect does such empathy have on the consensus reached? Lastly,

since I draw many of the techniques of transformative ethics consultation (TEC) from mediation practice, is TEC equivalent to mediation and thus vulnerable to the criticisms raised against it in bioethical discourse? In chronological order, these questions represent the topics of the next three chapters.

Part I: The First Step of TEC

In Chapter Three I argued that splitting emotion into positive and negative categories contradicts the nature of emotion as neurophysiological signals. Emotion itself is neither positive nor negative, but whether and how we express emotions can have negative or positive consequences on our decisions and actions. In order to encourage the more positive elements of our emotive nature—as a force to galvanize the willingness and ability to engage in moral dialogue—emotions must be explored and expressed by all parties, then each party must come to understand what others are feeling. Such was the conclusion I endorsed at the end of Chapter Three.

In Chapter Four I suggested that philosopher Arne Vetlesen's sequence of empathy provides a heuristic for accomplishing these three separate but related emotional tasks. Vetlesen argues that by integrating our faculties of moral judgment with our moral perception of events, we can authentically explore and express our emotions. The understanding and validation of our inner moral assessment of perceptions can then be achieved by engaging in interpersonal dialogue with others regarding our assessments.

The combination of these two arguments—one regarding the nature of emotion, the other regarding how to authentically process our emotions—suggests the sequence for

the first step of TEC. The moral work of processing our emotions must be our own, Vetlesen argues, in order for such work to be truly authentic. Some moral perceptions, however, as psychologist Sidney Callahan argues, can distort our very ability to achieve this intrapersonal assessment and processing. In ethics consultation, the result of this inability can turn what starts out as an emotional tension into an emotional impasse—one that can derail the consultation process. An ethics consultant trained to recognize the first signs of an emotional tension can help keep the process on track by facilitating self-reflection, expression of the emotions, and re-examination of strong emotive reactions in terms of articulated and analyzed moral interests and values.

In essence, the engagement between the consultant and the patient, surrogate, or clinician during this first step of TEC represents a "safe" form of interpersonal dialogue. This form of interpersonal dialogue is designed to achieve intrapersonal integration of emotion and reason for each person experiencing an emotional tension. The ethics consultant acts as a surrogate for moral integration. Their involvement helps to provide the elements required for integration which are missing from each party experiencing an emotional tension. If the emotional tension is strong, like Rev. Williams', then the consultant must help explore the meaning of the emotive reaction in terms of the participant's value system, encourage expression of the emotion, and foster interpretation of moral perception in terms of more cognitively based, reflected, and articulated values. Consultant-to-party dialogue models the type of self-reflection required for intrapersonal integration of emotion and reason and conforms to the type of interpersonal interaction later stages of ethics consultation will require. Once this "safe" form of dialogue has been

accomplished, and the person feels comfortable exploring and expressing his or her emotions, the consultant can guide that person towards the next step—moving the dialogue from within to without, between the other parties.[51] Thus, the first step of TEC attempts to build empathy so that the parties can later engage in joint dialogue and so achieve collective empathy. Strong emotive reactions and emotional tensions tend to make people emotionally gun-shy or vulnerable, and thus they avoid confrontations. Consultant -directed empathy attempts to build trust and rapport so that each person feels like an integral part of the process. Such an attempt respects the second personhood of all parties and represents a form of moral empowerment.

Securing the collective willingness and ability of the parties to engage in moral dialogue is the key to the second step of TEC. If parties view each other as second persons, worthy of respect and concern, different moral perceptions of the same event can be discussed and deep differences in values acknowledged and reframed in terms of shared interests. The interpersonal dialogue that characterizes this second step of TEC represents a means for the parties to truly own the process and outcome of the consultation. As Glover and colleagues (1986) assert regarding joint decision-making, resolutions reached will be more durable if the parties truly feel they equally control the

[51]A mediation technique, a separate meeting, or "caucus," between the party experiencing an emotional tension and the consultant, can ensure maximal "safety." In a separate meeting, consultants can focus their attention on helping each party experiencing an emotional tension to explore and express his or her feelings. Such a meeting can, if properly conducted, build trust and rapport between the consultants and the party. Experiencing strong emotions, such as anger, can cause parties to think that their fellow problem-solvers do not understanding their perspective, their values, or experiences. Ensuing dialogue between each party and the consultants regarding these feelings clearly shows the consultants care about and take a second-person attitude towards each party. After the separate meeting, the consultants need to shift the dialogue so that the other parties take the same moral stance to the party experiencing an emotional tension.

process and its outcome. I present the details of the second step of TEC in the next chapter.

In addition to providing the outline of steps necessary to supplement the first stage of ethics facilitation, the arguments from Chapters Two, Three, and Four suggest an answer to the question to be entertained in this chapter: when in the ethics facilitation process ought the exploration, expression, and validation of emotion be initiated? The fact that moral perception begins Vetlesen's process of moral performance and our entrée to the realm of moral dialogue with others suggests an answer. The fact that a change in feeling is often required in order to achieve a change in action provides additional support. The fact that we are sensuous creatures who feel, then act on the basis of our feelings (whether cognitively evaluated or not), suggests that, in cases like Jamie's that feature a strong emotional component, attention to emotion should be the first step in any process designed to foster authentic decision-making.

Core Competencies certainly endorses the ability of the ethics consultants to deal effectively with emotional aspects of ethics facilitation, but TEC adds an important qualification. In cases with a strong, early emotional component, emotion should be dealt with first, when it is encountered, even if it means halting or postponing the identification and analysis of the value conflict or uncertainty. In addition to Vetlesen, Midgley, Callahan, and Sherman, abundance of evidence from moral philosophy, bioethics, and other sources support the claim that exploration, expression, and validation of emotion should be the first step in any morally integrative process, including ethics consultation. I survey these sources in this chapter in order to defend the goal of the first step of TEC.

Part II: TEC and Ethics Facilitation Compared

Before launching into a discussion of additional frameworks that support the contention that emotion should be the first order of business in ethics consultations with emotional tensions, comparison of the steps of TEC and ethics facilitation yields several additional points of departure. Both points flow from the integrative nature of morality I advanced in Chapters Three and Four. The first point concerns the fact that perception precedes judgment in the sequence of moral integration; this ordering suggests that the stages of ethics facilitation are reversed. The second point concerns the fact that intrapersonal integration precedes interpersonal integration; the lack of focus on the intrapersonal suggests that ethics facilitation risks conflating these two distinct but related elements of integration by endorsing only interpersonal skills.

The Role of Emotion in Moral Integration. In Chapter Three I presented Mary Midgley's unity of the moral enterprise. This framework suggested that a change in action[52] requires a prior change in our understanding of the facts, which in turn requires a prior change in perception or feeling. Viewing the stages of ethics facilitation in terms of Midgley's framework, the goal of the first stage of ethics facilitation concerns achieving a change in the understanding of the facts, which is the second stage in Midgley's framework. The consultants need to be able to gather facts, clarify concepts and

[52] I equate a change in action with the resolution or outcome of an ethics consultation. Regardless of whether the consultation concerns a value conflict or uncertainty, the parties may each have an idea of how the problem should be solved before the consultation process commences. The goal of ethics consultation is to analyze whether those ideas are ethically acceptable, to generate yet more options, and to decide which option best approximates the shared interests and values of the parties. Thus, the outcome inevitably is to reach a change in the action originally considered or provide reasoned justification for the action originally considered.

normative issues, and help identify options—in essence to use their cognitive abilities and bioethics knowledge to identify and analyze the nature of the value conflict or uncertainty. The first stage of ethics facilitation involves finding out what the facts are and then supplementing a shared understanding of the facts with options, derived from both bioethics knowledge and the values the parties have regarding the facts, to resolve the case.

The second stage of ethics facilitation concerns achieving a change in action, which corresponds to the third stage in Midgley's framework. The second stage takes the options from the first stage and attempts to reach a consensus as to which one will be implemented. Consensus requires the sort of assessment characterized by interpersonal dialogue, which must authentically integrate affective and intellectual dimensions, according to *Core Competencies*. How do the parties feel about the options? Have they been able to voice their concerns with the options? Which ones match their assessment of the facts and their own values? As I suggested in Chapter Three, a change in action requires both a prior change in feeling, followed by a change in our understanding of the facts. Ethics facilitation, I argue, places procedural primacy on achieving a change in the facts (judgment) over feelings (perception). Thus, ethics facilitation wrongly places primacy on judgment. In certain emotionally charged consultations, attention to perception before judgment will allow the authentic reintegration of emotion with reason. The chart in Figure 3 that compares the stages of ethics facilitation and the steps of TEC in terms of Midgley's terminology clearly illustrates that a stage designed to achieve a change in feeling is absent from ethics facilitation.

Ethics Facilitation

I. Ethics Consultation Request:
A Value Uncertainty or Conflict Exists
(need **a change in action**)

II. Stage One: Identify and Analyze the Nature Of the Value Uncertainty or Conflict
(designed to achieve **a change in the understanding of the facts**)

III. Stage Two: Forge Consensus
(designed to achieve **a change in action**)

IV. Implement Decision
(**a change in action**)

TEC

I. Ethics Consultation Request:
A Value Uncertainty or Conflict Exists
(need **a change in action**)

II. Transformative Stage (if an emotional tension is detected): Explore, Express, and Validate Emotion, then Generate Collective Empathy (designed to achieve **a change in feeling,** on an intrapersonal level, followed by a change on the interpersonal level)

III. Stage One: Identify and Analyze the Nature Of the Value Uncertainty or Conflict
(designed to achieve **a change in the understanding of the facts**)

IV. Stage Two: Forge Consensus
(designed to achieve **a change in action**)

V. Implement Decision
(**a change in action**)

Figure 3: Ethics Facilitation and TEC Compared

Stage one of ethics facilitation attempts to achieve a change in our understanding of the facts without necessarily ever achieving a change in feeling. In order to prevent emotional tensions from erupting into emotional impasses and to achieve stability in the outcome reached, ethics facilitations with strong emotions must first attempt a change in feeling during a stage prior to identification and analysis of the value conflict or uncertainty. Thus, there is a need to supplement the first stage of ethics facilitation with the two steps of TEC.

Conflation of the Intrapersonal into the Interpersonal. The comparison in Figure 3 seems to suggest that the first stage of ethics facilitation does not or cannot involve consultants addressing emotional tensions at all. To be charitable, consultants are not prohibited from addressing certain affective features during the first stage of ethics facilitation. In fact, *Core Competencies* encourages them to do so. In fact, by including only 'interpersonal' skills to address the dual intrapersonal and interpersonal dimensions of ethical difficulties, ethics facilitation risks conflating the intrapersonal with the interpersonal. For example, *Core Competencies* suggests that emotions such as "guilt over a loved one's sickness or impending death" can prevent the analysis and acceptance of certain moral options (ASBH, 1998, p. 3). As a means to address what is essentially an interpersonal barrier *caused by* an intrapersonal difficulty, *Core Competencies* argues that interpersonal skills designed to help the consultant work with people and their emotions in sometimes tragic situations is the key. As I have suggested, when ethics consultants encounter an emotional tension, they should focus on acknowledging emotion. While the label 'intrapersonal skill' would parallel the interpersonal skills *Core Competencies*

identifies for addressing emotional dimensions, it is more precise to say that skill in establishing empathy helps parties intrapersonally address their emotions. The goal of intrapersonal attention to emotion is to facilitate the ability of parties to engage authentically in the moral dialogue needed to reach consensus later in the process.[53]

Core Competencies suggests that the consultant should have the ability to show empathy and respect, elicit the values underlying emotional positions, represent the values of one party to the other parties, and so on. As I argued in Chapter Five, the ethics consultant seems to do much of the moral work in the consultation, to the detriment of the parties and their ability and need to "own" the process in a way that will ensure durable resolutions and their authenticity. The consultant is not one of the primary decision-makers in the process; he or she will not have to live with the decision reached in the same way that the parties will. The use of the term 'interpersonal' skills to refer to the consultants' ability to address the emotional needs of the parties seems to conflate the fact that the consultant also needs skills designed to help the parties address emotional tensions through self-reflection. The consultant should act as facilitator, as the name of

[53]*Core Competencies* also argues that ethics consultants should have particular virtues. Surely, the consultants must have certain character traits to conduct successful ethics consultations—honesty, forthrightness, moral courage, compassion, and so on. But what about the parties? If, as I have argued, the parties must own the process and outcome by being willing and able to see others as second persons and engage in moral dialogue, they should have perseverance, moral courage, and practical wisdom, shouldn't they? However, *Core Competencies* argues that the consultant requires certain traits, not that the consultant should strive to cultivate an environment where the parties display certain traits to one another. Once again, the consultant seems to be doing the important work of the consultation rather than facilitating an atmosphere where the parties are doing the work themselves. For instance, *Core Competencies* reasons that certain character traits allow the consultant to use the interpersonal and process skills effectively. Traits such as tolerance, patience, and compassion "help welcome people with difficult problems...who may be emotionally distraught, or...who have minority views, so that...[they]...can be fully and respectfully heard. Compassion helps the consultant to work constructively with feelings in sometimes tragic situations" (ASBH, 1998, p. 22). Surely the goal of compassion should be to help the parties, not the consultant, work constructively with their own feelings in somewhat tragic situations.

the approach suggests, but this facilitation should be directed towards helping the parties achieve the goal of self-reflection, self-reliance, empathetic understanding, and mutual problem-solving. The moral work of the consultation cannot and should not be done by the consultant. As the accumulated evidence has suggested regarding the integrative and authentic nature of morality, intrapersonal integration is a necessary condition for interpersonal integration. Hence, it is surprising that *Core Competencies* acknowledges that ethical difficulties can have intrapersonal and interpersonal dimensions, but then concentrates on skills the ethics consultants will need rather than on what the parties must do to ensure they can participate in the moral dialogue necessary to reach a resolution.

The lack of ethics facilitation skills for addressing the intrapersonal dimension of shared moral difficulties means that there may be a mismatch or a lag between where the parties and the ethics consultants might be emotionally or cognitively in the process. Such was the case when the ethics consultants attempted to understand Rev. Williams' interpretation of the facts underlying Jamie's clinical condition. Rather than addressing the intrapersonal emotional aspects of the case, namely, Rev. Williams' outburst, the consultants followed the ethics facilitation approach. The consultants embarked on a largely cognitive, interpersonal attempt to adjust Rev. Williams' intrapersonal misunderstanding. They tried to correct Rev. Williams' judgment that withdrawing Jamie's feeding tube would starve him to death before ensuring he had an opportunity to explore and understand the connection between his emotional outburst and his strong religious values and perhaps even his distrust.

In sum, it seems that the ethics consultant does much of the cognitive work in gathering facts and generating options during the first stage of ethics facilitation. But if the parties have not explored or expressed any emotional tensions they may be feeling, they may not be ready to engage in the moral dialogue necessary to reach consensus. Attempts to facilitate consensus will largely fail or the consensus reached will not be as stable or durable as one reached by first ensuring that the patient, surrogate, and clinicians are at the same place emotionally and cognitively as the consultants guiding the process.

The lack of skills posited for consultants to address intrapersonal dimensions of affective difficulties and the lack of a specific time early in ethics facilitation for addressing such difficulties affirms the case for a process to supplement the first stage of ethics facilitation. Thus, TEC should be used for any ethics consultation featuring an immediate and/or underlying emotional tension or dimension. If not addressed on the intrapersonal level first, such tensions might create barriers in the ability of parties to hear and process the moral views of others, express their own views, or generate and evaluate moral options to resolve the situation. *Core Competencies* suggests that consultations featuring the withdrawal of life support are especially emotional, and those that feature interpersonal clashes result in emotional conflicts. I claim that TEC can be useful to diffuse emotional situations or address emotional tensions before the analysis of ethical options and building of consensus occurs in ethics facilitation. In terms of Midgley's framework, TEC can help achieve the change in feeling or perception needed before a change in the understanding of the facts can yield a change in action.

Part III: Exploring, Expressing, and Validating Emotion—The First Step in Ethics Consultations with a Strong Emotional Component

That Midgley bases our entrée into morality on our perceptive abilities suggests that addressing emotion should be the first stage of ethics consultations involving emotional tensions. Vetlesen's phenomenological account of empathy suggests the same conclusion. In order to achieve a change in action, our emotional and cognitive faculties of perception and judgment must be integrated. For this reason, TEC has two steps. The first step, which is the focus of this chapter, emphasizes the exploration, expression, and validation of the emotions underlying emotional tensions via consultant- directed empathy. The second, covered in detail in the next chapter, concentrates on the generation of collective empathy among the parties themselves. Sources from the bioethics literature clearly document that the exploration, expression, and validation of emotion is an important step in ethics consultation. The challenge to TEC is to argue that in certain ethics consultations involving emotional tensions it should be the first step. Fortunately, several ethical frameworks lend support to the argument to meet this challenge.

The evolution of facilitation presented in Chapter Two and the related incorporation of intellectual and interpersonal elements in *Core Competencies* clearly documents the need for exploring, expressing, and validating emotion in ethics consultation through empathy. I argue an important addition to this claim: in certain ethics consultations featuring emotional tensions these three emotional tasks ought to be the *first* step. The rationale for this claim can be found, most simply, in Julia Connelly's

(1998) statement that "when an emotional tone predominates, attention to emotion is generally more effective than pursuing an intellectual discussion" (p. 228). Several additional sources of support add credence to my claim.

The first is that emotion is a necessary, key component of moral life—often its starting place. I have already presented the work of Fletcher and colleagues, who suggest that the ability to feel conflicting emotions and obligations help us recognize the presence of a moral dilemma. Such a claim captures the essence of TEC. If the "capacity to empathize with another person...is needed to be moral," then resolving moral dilemmas requires the generation of empathy between moral stakeholders (Fletcher, et al., 1998, p. 11). In order to accomplish this feat, barriers to achieving empathy need to be removed by exploring, expressing, then validating the emotions that underlie emotional tensions so they will not evolve into impasses.

Fletcher, et al. also help to identify why emotional impasses occur and what role emotion and empathy can play in removing them. The moral ambiguity created by our ability to feel conflicting emotions and obligations can sometimes lead to inappropriate emotive reactions—such as when we "shoot from the hip" by not fully reflecting on our feelings (Fletcher, et al., 1998, p. 11). "Shooting from the hip" can sever the process of ethical deliberation and interfere with our ability or willingness to solve moral difficulties. Since "shooting from the hip" short-circuits effective ethical deliberation, re-integration of our cognitive and affective capacities are necessary for proper moral problem-solving to proceed. Since emotion is often the starting point for moral decisions, in shared decision-making it makes practical sense to validate the role of emotion and

attempt to transform emotional tensions into a positive, empathic stance towards a mutually shared moral difficulty. Thus, the need in certain cases, for TEC.

When not enough attention has been paid to emotions, either within ourselves or because consultants are not trained to recognize their signals or effects, evolution of emotional tensions into full-blown emotional impasses is possible: "When the concerns of those involved cannot all be satisfied, decisions...are made with emotion and conviction. It is at this point that ethical dilemmas may evolve into conflict...[and] communication often breaks down as well" (Broom, 1991, p. 354). When emotion and reason are not integrated in one person during moral problem-solving, an interpersonal emotional impasse between the problem-solvers is often the result. The remedy for such situations, as TEC illustrates, is to have a process for moral decision-making that integrates reason and emotion on both the intrapersonal and interpersonal levels of moral discourse. Exploration, expression, and validation of emotion often represents the first task in such processes.

Psychiatrist John Hayes (1986) offers such a framework, building on the ideas of moral philosopher Henry David Aiken (1962). In addition, the work of Larry Churchill and Alan Cross (1986) illustrates the importance of emotion in resolving moral difficulties and encouraging self-reflection. Third, several articles in the bioethics literature suggest that mediation, a problem-solving process involving a third-party mediator, might function as an effective ethics consultation tool. Configurations of the mediation process include a stage designed to explore, express, and validate the emotions of the mediation parties. Validating emotion through mediator-to-party directed empathy

and using other communication techniques allows the parties to achieve a problem-solving stance towards a mutually shared problem and forms the basis for collective empathy.

Henry David Aiken: The Integration of Emotion and Reason.[54] Psychiatrist John Hayes (1986) postulates that one reason for the tendency to make decisions on the basis of emotion and conviction "is precisely because physicians and patients have no knowledge of a process whereby the most ethically sound decision can be made" (p. 415). Hayes provides such a process and traces it to the four levels of moral discourse expounded by philosopher Henry David Aiken (1962) in his book *Reason and Conduct*.

Aiken posits the four levels of moral discourse as a reply to the tendency of moral theory to be monistic and reduce all moral judgments to one governing principle. The result of ignoring the integrative nature of morality, Aiken argues, is to misunderstand the role of several features of the moral life and put ethical discourse into interminable, irreconcilable, and profitless debate. Aiken's framework incorporates the features of moral life that he finds lacking in other theories. Many accord with Callahan's, Midgley's, and Vetlesen's depiction of moral decision-making as involving integration of emotion, reason, and will.

First, Aiken argues that a moral framework must acknowledge both the cognitive and emotive elements in moral decision-making and avoid the tendency to focus merely on one aspect or the other as determinative of morality (à la cognitivism versus

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[54]I am indebted to Mary Faith Marshall, Ph.D. for introducing me to the work of Henry David Aiken and its relationship to clinic ethics while I was a Fellow at the Medical University of South Carolina.

emotivism, respectively). The same holds for subjectivity and objectivity; moral discourse has elements of both, and our theories should recognize this fact. Moreover, moral discourse must acknowledge the importance of reason but also recognize its limits.

Aiken equates the first level of moral discourse with our unreflective, gut reaction to situations. He terms this the expressive-evocative level. Expressions of pleasure and displeasure vent our emotional reactions to events or situations. Shock at receiving a serious medical diagnosis, fear and uncertainty when confronted with one's own mortality in battling a terminal illness, and a mother's joy after delivering a healthy child are examples of expressive-evocative responses.

Aiken (1962) argues that normally there is no need to evaluate or reflect on such expressions of emotion; they are just personal manifestations of our pleasure or displeasure, "the venting of contrary—or perhaps merely different—emotions" (p. 69). Thus, to seek justification or to ethically evaluate the inherent wrongness or rightness of an emotive reaction is either senseless or it immediately shifts moral discourse to an altogether different level. This shift in moral discourse shows Aiken understood that to morally evaluate an emotive reaction requires more cognitively sophisticated tools of moral discourse. That is, effective moral problem-solving requires the use of rational tools of ethical reflection and deliberation in evaluating emotive reactions. Sophisticated tools of moral evaluation are needed in order to ask the question "Why it is that I feel a certain way about my moral perception of an event?" It is necessary for me to interpret the significance of the moral event in terms of the values I have consciously authorized in the past.

The shift from the expressive-evocative level to more cognitive levels of processing suggests that, for Aiken, emotion and cognition are connected in a way similar to Callahan's and Vetlesen's description. The second level of discourse, the moral level, involves seeking justification for the "goodness" or "badness" of our expressive-evocative statements. Aiken identifies at least two factors that moral agents utilize in justifying such statements. The first factor combines an appraisal of the facts of the matter, the means of achieving the various moral outcomes, and the consequences that result from each. The second factor, the search for the rules or procedures that establish the relevancy of our appraisals, provides initial justification for particular moral actions. Aiken argues for the necessity of both elements. In the following passage Aiken alludes to the necessary interplay between, and integration of, reason and emotion at the moral level of discourse:

> When...the role and relevance of factual premises in our inferences to moral conclusions is overlooked, the distinction between what is and what ought to be becomes a total diremption [*sic*], with the consequence that "insight," as in the case of Prichard, or "sentiment" as in the case of Hume..., is substituted, at the wrong place, for rational reflection (Aiken, 1962, p. 71).

Our emotive reactions at the first level require factual appraisals and consideration of consequences that Callahan describes as the testing of our emotions in terms of directed, rational processes and that Vetlesen describes as subjecting our moral perceptions to moral judgment.

Substituting Hume's "sentiment" or Prichard's "insight" for an approach that utilizes rational reflection is, according to Aiken, wrong-headed. Thus, it is nonsensical to base judgments about one's conduct or actions solely on the basis of our emotive

reactions. Our emotions are often strong, producing equally strong outward expressions, and, if we allow them, such expressions can control our decisions. The result can often be harmful, especially if we are trying to make decisions with others. To *decide* moral matters of conscience on the basis of our emotive reaction circumvents later stages of moral discourse and imposes barriers to rational reflection and ethical deliberation. To use existentialist language, deciding moral matters on the basis of one's emotive reaction, without the full, integrated processing of its cognitive content, risks acting in bad faith. The question remains how to either avoid the tendency to act on the basis of one's emotive reactions or to dismantle the barriers created once such "shooting from the hip" has occurred (Fletcher, et al., 1998, p. 11). Answers to such questions must be sought at Aiken's fourth and final level of moral discourse. The other two levels between these first and final levels will be introduced somewhat later.

Fletcher and colleagues described moral ambiguity as the uniquely human ability to feel conflicting emotions and obligations. While moral ambiguity is normal, in morality "decision is king": moral questions require answers and action (Aiken, 1962, p. 87). Aiken frames the solution to moral ambiguity by asking the paradoxical question "Why should I be moral?" He terms this fourth level "the human level" because the ability to answer this question depends on the human capacity to be moved. As Callahan argues, morality only makes sense when human beings *feel* moved to act morally; and, as Vetlesen argues, morality is possible only when agents perceive events as endowed with moral significance. Interestingly, as the parallel I have drawn between Callahan, Vetlesen, and authenticity in Chapter Five showed, Aiken (1962) finds an existentialist

explication of freedom most revealing for elucidating the moral features of this human level. In particular, Aiken (1962) argues that this fourth level concerns finding motivation for the human heart:

> I am "satisfied" and the question is "answered" not when some objective conditions have been met but when my practical indecision or doubt has been removed.... Here the only sort of justification possible is of the subjective sort which provides an "exciting occasion" capable of motivating the will (p. 86).

Asking "Why be moral?" prompts examination of the motivations that human beings feel: to act morally, to express moral feelings, to define the terms of their moral rules, to seek justification for such rules, and finally to avoid lapsing into ambivalence or indifference regarding the essential practical character of moral life. In this sense, the question "Why should I be moral?" provides the human heart reasons for continued moral discourse and action when reason and emotion fail to motivate the will (Fletcher, 1998, personal communication). Thus, the ability to transform an intrapersonal emotive reaction into an ethically justifiable, authentic resolution requires more than the ability to bring rational tools of ethical analysis to bear on the essentially practical nature of moral questions. It requires the strength of will to persevere beyond the experience of conflicting emotions and obligations that such procedures generate. If the decision to be reached involves others, as decisions in ethics consultations often do, then maintaining respect and concern for others—seeing them as second persons—becomes all the more important for remaining engaged in moral dialogue.

The first and last levels of Aiken's framework provide the subjective, emotive elements of moral discourse. To counterbalance these, Aiken's second and third levels

include cognitive, reasoning elements. The second, moral level of discourse concerns the rational evaluation and search for the rules that justify our emotive reactions at the first level. Although normally most moral discourse need not proceed beyond the moral level, Aiken recognized that sometimes the rules can be in direct conflict or the options for action reached might be unethical. When such situations confront us, Aiken (1962) suggests their effect is "to throw doubt upon the validity of the rules themselves. And in that case, there is usually no alternative to a fundamental reconsideration of the whole moral code" (p. 75).

Justification of an entire moral code occurs at the third, ethical level of moral discourse. Aiken terms this process ethical criticism. Even here, at the pinnacle of metaethical analysis, the concern remains practical—the resolution of contradictory reasons for implementing a particular moral decision, the removal of moral ambiguity. But, as Aiken has argued, removing our practical doubts requires not only the rational tools of ethical deliberation, analysis, and criticism, but also the human impulse that motivates the will into action and facilitates our intuitive grasp that events require our moral attention. According to the framework Aiken outlines, morality begins with our emotive perception of events, which require moral justification and the dissolution of the ambiguity inherent in moral experience.[55]

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[55]In terms of Midgley's unity of the moral enterprise, Aiken's fourth level completes the cyclical model from Figure 2 that begins with a change in feeling, proceeds to a change in the facts, and ends with a change in action. Aiken's first and second levels attempt to transform an initial emotive reaction into a morally justifiable decision. When that process fails, Aiken's third level attempts to bring about a change in the understanding of the facts (the rules of the moral game). The fourth level acknowledges that all of this effort presupposes a practical resolution—a change in action.

John Hayes: The Validation of Emotion. Aiken's first and fourth levels of moral discourse clearly document the need to integrate the exploration and expression of emotion with rational attempts to justify moral actions. Hayes' framework not only parallels Aiken's argument for the integration of emotion and reason, but he extends Aiken's argument to suggest that cases with an early emotional tension require the validation of emotion at the first stage of moral discourse.

Like Aiken's expressive-evocative level, Hayes' first level relates gut-level, intuitive responses to individual cases. Despite the fact that "the best decision is often intuitively obvious to all concerned, and little or no conflict arises," Hayes (1986) argues that when the right thing to do is not clear, decision-makers jump to the next level in his model (p. 416). This second level appeals to rules, laws, or customs to settle ethical quandaries—Aiken's moral level. When appeal to applicable rules fails, justification for one of the conflicting rules, laws, or customs must be made at a third level. Corresponding to Aiken's third, ethical level of moral discourse, Hayes suggests that ethical considerations of results (utility) and duty (deontology) help frame the debate. Since these two ethical traditions often yield conflicting moral judgments, yet another level of ethical debate might ensue. Hayes (1986) terms this the metaethical level, which involves "looking for the source, meaning, or justification of a principle" from the third level (p. 416).

Hayes (1986) suggests that ethical conflicts erupt because "emotionally charged appeals to metaethical principles are taking place before other levels [of the framework] have been adequately explored" (p. 416). By first taking the time to fully explore gut-

level, emotional reactions to moral difficulties, ethics consultants can use Hayes' framework to "insist that each level be exhausted before jumping to the next level. Such an approach often restores order, calms emotions and allows acceptable resolution" (Hayes, 1986, p. 416).

Hayes' argument assumes that careful exploration of each level of moral discourse can achieve resolution to ethical disputes. Since "value-laden situations may give rise to emotional outbursts," the ethics consultant must ease the "emotional tension" at the first level so that systematic consideration of the emotional-ethical dimensions of the case can occur at subsequent levels (Hayes, 1986, p. 415). Ordering the process to ameliorate the tendency of emotional tensions to forestall cognitive processing avoids the tendency to make decisions solely on the basis of emotive reactions. Therefore, applications of Hayes' process should prevent the tendency to make decisions solely on the basis of emotion and encourage the more authentic integration of emotion and reason.

Authenticity requires self-reflection and conscious authorization of our decisions. Hayes argues that the first task in many ethical difficulties involves easing emotional tensions. Without easing such tensions, subsequent conscious reflection and authorization cannot occur. What if such tensions cannot be eased? What if, according to Callahan, our reaction is strong enough to overcome our ability to personally integrate emotion and reason? Larry Churchill and Alan Cross (1986) outline a process that includes a stage designed to revisit strong emotional reactions, describe the values underlying them, and re-integrate this newly interpreted moral experience into the emerging dialogue.

Churchill and Cross. According to Churchill and Cross (1986), one job of the ethicist is to help clinicians in four basic ethical problem-solving tasks: (1) describe their moral experiences, (2) elicit the assumptions underlying such moral experiences, (3) help them consider multiple alternatives, and (4) justify the choices. The process of moral reflection Churchill and Cross outline operationalizes Vetlesen's process for re-assessing a moral perception. Thus, it is also useful as a heuristic for the first stage of TEC.

Ethics consultations bring together numerous parties, all of whom have their own particular perception and interpretation of a moral experience—an experience endowed with moral significance. Although Churchill and Cross do not clearly define what they mean by a moral experience, they argue that the process of describing it relies on emotion as a starting place. The role of the ethicist is to help people "recognize how they feel about the issues—to acknowledge their gut responses or affective reactions" (Churchill & Cross, 1986, p. 9). The goal at this stage of the process, to use Callahan's language, is to encourage the active and self-conscious application of attention to one's affective system and its reactions. This tutoring of emotion provides the data against which our moral experiences can be rationally tested in subsequent stages of moral reflection. The ethicist's role is analogous to a sounding board. Rather than be a fellow problem-solver, the consultant encourages the authenticity of the person who "owns" the moral difficulty: "the essential role…is affirmation of the predicament and sympathy with the dilemma. Responses such as 'That's no problem', disenfranchise another's moral experience and discourage the sort of work which is necessary for moral self-understanding" (p. 9).

Churchill and Cross's framework for moral reflection argues that the acknowledgment of one's gut responses and affective reactions to moral problems precedes judgment about the problem. Moreover, like Aiken, they argue that descriptions "which remain at the emotive level...are as unproductive as descriptions of moral experience which neglect the emotive level altogether" (Churchill & Cross, 1986, p. 10). The goal of such a descriptive process is to reach the next stage of moral reflection where the presumptions that underlie our moral perceptions are examined.

Thus, to parallel the steps of TEC, the first stage of Churchill and Cross' framework is to express emotion and the second is to explore how the emotion is related to or contains one's values or moral interests. Consultant- directed empathy first allows persons to recognize their own emotional reactions and determine how they are causing tension or impasse. For example, Rev. Williams is able to calm down somewhat and open up to the dialogue after consultant Dennis McCullough affirms his strong feelings for Jamie and reframes them in terms of putting the decision into God's hands with the story about the pastor and his wife. Rev. Williams will now be better able to reassess his moral perception that withdrawing the feeding tube would starve Jamie in light of a new understanding of the clinical facts and so erase his misunderstanding and misconception of withdrawing the feeding tube. The attempt to effect a change in Rev. Williams' understanding of the facts before exploration and expression of his emotive reaction is in bad faith. After exploration and expression, if Dennis guides Rev. Williams through the process of explaining the facts and asks him to re-evaluate his previous moral judgment in light of these facts (a process known as reframing), Rev. Williams will be more likely

to "see" his misinterpretation and attribute it to a quick temper, mistrust, or simply not thinking matters through thoroughly and authentically. Validating his emotions and working with him to reassess his initial moral perception, rooting out the assumptions he was making, characterizes the intrapersonal work of the first step of TEC and provides the foundation for the interpersonal work of the next step.

According to Vetlesen, moral perception and judgment are agent-dependent. My perception of and judgment about a situation might differ drastically from someone else's and can cause interpersonal moral barriers. When two or more persons have opposing perceptions and descriptions (read, judgments) of a moral experience, a value conflict results. The challenge, posed in terms of Árnason's existential framework, is how to engender authentic interaction—mediation of divergent moral experiences that simultaneously respects the authenticity of all parties and their moral experience but also attempts to render dialogue into resolution. To borrow from Vetlesen's argument, empathy enables such mediations—on both the intrapersonal level, where one must subject a conflicting moral experience to reassessment, and the interpersonal level, where empathy allows understanding and dialogue to emerge between two or more persons who differ regarding a moral experience but who must make a decision together. Empathy describes a moral stance we take toward others. We recognize others as agents with equal moral standing, as second persons deserving of respect and concern. *Core Competencies* (1998) suggests that engendering empathy is one goal of ethics facilitation; however, it merely suggests that the ethics consultants must show respect, empathy, and interest

towards the parties in order to establish a trusting atmosphere (p. 14). The parties do not have to trust each other; they just have to trust the ethics consultants.

Empathy, however, can be a transformative force in ethics consultation. The first step of TEC attempts to create the sort of empathy *Core Competencies* endorses but then to expand consultant- directed empathy into collective empathy. Exploring, expressing, and then validating emotions creates empathy between the ethics consultants and the parties, but empathy also facilitates intrapersonal reassessment of conflicting moral judgments. The second step of TEC attempts to engender empathy among the parties themselves. In so doing, the ethics consultants transform what were self-interested moral judgments into opportunities for shared problem-solving and resolution. Empathy describes the stance that ethics consultation parties should take towards a shared moral difficulty—as second persons, fellow "I's". Vetlesen's sequence of empathy acknowledges that the difficulty is a shared one and puts the parties in a frame of mind to mediate the differences in moral perception and judgment that might be preventing moral discourse.

Bioethics Mediation. Although Churchill and Cross' framework does not address elements of interpersonal decision-making, the steps of moral reflection are not inconsistent with the empathetic process Vetlesen outlines. Mediation processes can be seen as an expansion of the framework Churchill and Cross outlines, for they concentrate on the interpersonal elements of decision-making. And like Churchill and Cross' framework, mediation processes have a stage devoted to the exploration, expression, and validation of emotion. Mediation generally has four stages: (1) an introduction that

establishes the ground rules for the session, (2) an information gathering and sharing stage, (3) option generation and evaluation, and (4) option implementation (Hoffmann, 1994a).

The information gathering stage allows the parties to describe, in their own words and without interruption, their view of the situation. Facts, values, and emotions are often blended together in such narratives. In order to ensure that all parties understand the information and to ensure its accuracy, mediators use a variety of communication techniques to rephrase and reframe the information received. Such techniques are similar to those *Core Competencies* suggests ethics consultants use to represent the views of one party to the others and to ensure that each party has been heard.

One particular mediation technique, active listening, involves the acknowledgment and validation of the emotional content of a party's narrative. Emotions, such as anger, fear, frustration, envy, confusion, and mistrust, are acknowledged with frank statements. An ethics consultant using this technique might have said, "You seem angry, Rev. Williams," to acknowledge Rev. Williams' feelings when he thought that the medical team wanted to starve Jamie to death. Such a statement nonjudgmentally attempts to label an emotive reaction so that the party can move from the experience of the emotion to its processing and its connection with a thought or view of the situation. If the mediator's label does not fit, a dialogue ensues to match the emotion to a label precisely. Often the acknowledgment of an emotion causes the release of additional emotional statements, each of which should be explored, expressed, and acknowledged in the same nonjudgmental fashion.

The goal of active listening is two-fold. It allows the parties the opportunity to be heard, to vent their emotions (Dubler & Marcus, 1994, p. 23). Moreover, it allows trust to build between the mediators and the parties (Dubler & Marcus, 1994, p. 25; Connelly, 1998). Acknowledging emotions demonstrates empathy, and empathy is central to establishing trust (Baylis, 1994; ASBH, 1998; Connelly, 1998). The goal is impartial acknowledgment. The nonjudgmental technique allows empathy to emerge, but it avoids overtly sympathizing or agreeing with the emotional statements. Impartial acknowledgment avoids transference of the party's feelings to the mediator—the "taking up" of such feelings as the opinion or view of the mediator.

Active listening involves more than mere validation of emotion; it also features "mirroring"—the representation of one party's view to others, an interpersonal technique endorsed by *Core Competencies*. Not only does mirroring ensure accuracy, but it helps to extend empathy—from the empathy and trust established among the mediators and the parties through the exploration, expression, and validation of emotion to empathy between the parties. This expansion of empathy from the mediator or ethics consultant to the parties themselves helps form the basis of what Vetlesen calls moral performance—the willingness of persons to recognize others as moral agents worthy of respect and concern. Moral performance characterizes a moral orientation to others as second persons, each of whom are willing and able to engage in moral dialogue, that ethics consultation parties need in order to reach consensus. TEC attempts to build empathy—between the ethics consultant and each party through the exploration, expression, and validation of emotion in the first step, then among the parties themselves through active

listening and mirroring in the second step. In the next chapter I explore the role of empathy and dialogue in the second step of TEC in more detail and present the conclusion of Jamie's case to illustrate the complete TEC model.

The following case illustrates the importance of validating emotion as an initial step in ethics consultations featuring a strong emotional component. Although the ethics consultants resolved the underlying clinical issues in this case, an unexplored and unresolved emotional tension between the parties remained. My argument is that the steps of TEC can help achieve a more durable and satisfactory resolution to ethics consultations that feature an underlying and/or unexplored emotional dimension. Failure to explore and validate the role of emotion in such a case represents a missed opportunity to open moral dialogue, heal relationships, and remove barriers to interpersonal and interprofessional collaboration (Broom, 1991; Wocial, 1996).

Part IV: The Case of Mr. Sullivan[56]

The nurse manager of a long-term care unit in a public hospital affiliated with a large teaching hospital requested ethics consultation for Mr. Seamus Sullivan, an 89-year-old man who refused surgery for a fungating mass on the side of his head. Psychiatrists had deemed Mr. Sullivan incapacitated to make treatment decisions due to mild dementia.

[56]This case is based on an actual ethics consultation. The names and features of the case have been changed to protect the confidentiality of the patients, surrogates, clinicians, and consultants.

Mr. Sullivan's son, James, became worried when his father refused to see a doctor for the growing mass on the side of his head. Mr. Sullivan had a history of mental institutionalization. Both this experience and his bout with pleurisy as an adolescent caused Mr. Sullivan to fear and distrust the medical system. James asked the sheriff in his town to go to his father's home and bring him to the doctor. Mr. Sullivan was transported to the public hospital against his wishes, the open and bleeding tumor on his head bandaged, and a surgical evaluation performed by a team of Ear, Nose, and Throat (ENT) surgeons. The surgeons determined that surgery was medically necessary to stop the spread of the tumor. In their evaluation, the risk/benefit ratio was small since they felt confident in their ability to excise the tumor successfully. Mr. Sullivan was scheduled for surgery, and his son, acting as his surrogate decision-maker, signed a consent form. However, when ambulance personnel arrived to transport him across the street where the surgery suites were located, he vociferously refused to get on the gurney.

Concerned about his refusal, the nursing staff decided not to force Mr. Sullivan to get on the gurney. The surgery was rescheduled. One of the ENT surgical residents, knowing the medical necessity of the procedure, became openly hostile to the nursing staff for allowing the patient to not be transported. One of the nurses explained that the nursing staff was ethically and legally uncomfortable forcing a patient to receive treatment against his wishes. The resident threatened that he would order sedation for the patient the next time transportation was arranged so that the patient could not refuse. Mr. Sullivan had been declared incapacitated, his son had signed a consent form authorizing the surgery, and removing the tumor was in his best interests. Instead of arguing with the

angry resident and making the situation worse, the nurse asked to convene a care conference with the other nursing staff to discuss the care of Mr. Sullivan. The meeting allowed the nurses an opportunity to explore their turbulent experiences with the ENT service in the past and consolidate their collective resolve. One nurse recounted a frustrating experience she had had with another ENT resident and a female surgical patient. This resident was paged to surgery during his interview with the patient. The resident hurried through the explanation of the consent form she needed to read, understand, and sign, then dashed off to surgery before allowing the patient to ask any questions. Just as the elevator arrived, he shouted for the nurse to get the patient's signature because he was needed in surgery. On the basis of their experience with the ENT service, the nursing staff arrived at a consensus: they would unilaterally refuse to sedate Mr. Sullivan just so that he could be transported for surgery he did not want. The nurse manager requested the involvement of ethics consultants.

A team of three ethics consultants—a physician, a philosopher training in bioethics, and a community member of the ethics consultation service—reviewed Mr. Sullivan's chart, interviewed him regarding his refusal of treatment, and spoke to the nursing staff caring for him. Review of the chart revealed the psychiatrist's note deeming Mr. Sullivan incapacitated to make treatment decisions due to mild dementia. The ethics consultants interviewed Mr. Sullivan. Communicating with him was difficult because bandages covered one of his ears and he was lying on the other. In addition, he spoke haltingly and responded to questions very slowly, taking nearly 30 seconds to respond.

Mr. Sullivan apparently did not know why he was in the hospital or the serious nature of the tumor on his head, but he did say that he did not want to die.

The ethics consultants decided to interview Mr. Sullivan's younger brother, Robert, who had taken responsibility for transporting the patient to the food store before he became ill. Robert reported that his brother disliked and feared doctors by recounting Mr. Sullivan's painful experience with pleurisy when he was about ten years old. He had to have a rib removed to treat the pleurisy. Robert mentioned that after that incident, his brother became fearful of doctors, medical equipment, and especially the stretchers used to transport patients in ambulances. The patient equated stretchers with all of his previous traumatic experiences with the health care delivery system. Robert also told the ethics consultants that despite his brother being very independent, his condition had rapidly deteriorated in the last few months. Robert seemed to know his brother, his preferences and values, quite well. However, the son James had been the one to sign consent forms and was in the process of seeking legal guardianship.

The ethics consultants spoke with the nurses caring for the patient. They expressed hesitation in providing sedation, regardless of Mr. Sullivan's mental status and capacity. The nurse manager provided the history of the patient's arrival and the ensuing conflict. The ethics consultants suggested that a joint meeting between the nurses and ENT physicians, facilitated by the ethics consultants, might help resolve the underlying issues. The nurses agreed. The attending ethics consultant, the physician, attempted to coordinate the meeting. The surgery had been rescheduled for the next week, and the consensus of the ethics consultation team was that the meeting should be arranged before

the surgery. In the meantime, the ethics consultants wrote a note in Mr. Sullivan's chart. The note documented their involvement, listed the ethical and legal issues involved, and outlined their plan to review the case with the rest of the consultation service. The case review resulted in the decision to consult known experts from outside of the institution regarding the use of sedation for an incapacitated decision-maker whose surgery would be in his best interests.

Due to an out-of-town conference that the ENT surgeons attended, it was not possible to arrange the joint meeting of the nurses and doctors until after the next time surgery was scheduled. The ethics consultants feared that the conflict situation between the nurses and physicians would only intensify if the patient again refused surgery. So they decided to meet with the nursing staff and provide them with both the information received from the outside experts and the ethical consensus the consultation service reached. That meeting was scheduled for the shift change between the night and morning nursing staff. In the meantime, James had finalized the legal guardianship, and a copy of the documentation was placed in Mr. Sullivan's chart. The son acknowledged that the surgery was in his father's best interests given what the doctors and nurses had told him. James seemed to be appropriately applying the legal and ethical standards for surrogate decision-making based on the benefits and burdens presented by the ENT surgeons.

The ethics consultation team held the meeting with the nursing staff and solicited their perspective of the situation. The ethics consultants thought it important to praise the nursing staff's moral courage. They also reported the consensus of the experts regarding the use of sedation for an incapacitated patient refusing surgery deemed to be in his best

interests. The experts and the ethics consultation service as a whole agreed that sedation is an ethical option in this case based on the balance of benefits to the patient over the burdens. The consultants provided the nurses with an opportunity to discuss the implications of this information. Several nurses expressed relief, and the primary nurse caring for the patient said that the nursing team would not have a problem administering the sedation given that such treatment was ethically and legally sound.

The consultants, however, suggested that the nurses might be able to help Mr. Sullivan overcome his anxiety about the surgery. His deep-seated fear (and thus his refusal) stemmed from his early and traumatic experience with pleurisy and his institutionalization later in life. Both episodes involved forced transportation using ambulance stretchers. Thus, it was no wonder that Mr. Sullivan refused to get on the gurney to be transported to surgery. It wasn't the surgery he was objecting to, but the forced nature of the transportation. In his demented state, perhaps he was equating the stretcher with the relived experience of those previous traumatic episodes. The consultants suggested that perhaps Mr. Sullivan's son or brother could be present when they sedated the patient and transported him to surgery. The nurses countered that they would feel better if one of them could accompany Mr. Sullivan. A nurse whom the patient had come to trust agreed to be with him when he was sedated and ride with him in the ambulance before surgery. Despite resolving the immediate clinical issues, a meeting between the surgeons and nurses was never arranged to ameliorate the underlying morally emotive issues that sparked the case.

This case illustrates the idea that uncomfortable emotions might indicate moral conflict (Broom, 1991; Jameton, 1993; Wocial, 1996; Purtilo, 1999). The nurses felt uncomfortable forcing the patient to surgery and even more uncomfortable sedating Mr. Sullivan. Their feelings of moral distress manifested in moral action—refusal to sedate. This emotive moral response polarized tensions between what seemed to be unspoken attempts to justify appeals to professional integrity: the nurses' professional duty to advocate for their patient (American Nursing Association, 1985) and the surgeons' professional duty to act in their patient's best interests.

Philosopher Andrew Jameton first articulated the concept of moral distress in his classic book on nursing ethics, *Nursing Practice: The Ethical Issues*. He defined moral distress as the feeling one experiences "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6). Broadly construed, the hierarchical nature of health care delivery and the subordinate status of nurses within that hierarchy represents one such institutional constraint for many nurses who wish to "do the right thing."

As nursing researcher Judith Wilkinson (1987) asserts, nurses in particular are susceptible to moral distress because of their "peculiar position in the health care power structure, and because of their conflicting loyalties and responsibilities—to licensing bodies, employing institutions, physicians, other nurses, patients, and patients' families" (p. 16). Wilkinson (1987) argues that the moral responsibility as ever-present and hands-on advocates for patients' moral choices poses an extreme paradox for nurses who are "rarely in a position to control the actions of others" (p. 16). Such paradoxes often result

in a form of distress characterized by "the psychological disequilibrium and negative feeling state when a person makes a moral decision" but cannot follow through by performing the moral behavior indicated by that decision" (Wilkinson, 1987, p. 16).

The nurses caring for Mr. Sullivan made a moral choice in refusing to consider the option of sedating the patient. But, if the physicians made good on their threat and actually wrote orders to sedate Mr. Sullivan, would the nurses be able to follow through with their moral choice not to sedate? As one nurse stated in exasperation at the end of the consultation, "Doctors write orders, and nurses follow them." Such a statement indicates that, for this nurse, her moral agency would surely be compromised in a struggle of wills.

This case also emphasizes many stages in Hayes' and Aiken's framework. Certainly, the emotive responses of both the nursing staff and the surgical resident represent expressive-evocative moral decision-making, instances of "shooting from the hip." However, the unspoken and perhaps unwitting appeals to professional integrity that the emotive responses seem to be making represent attempts at second and perhaps third stage moral discourse. It is unfortunate that an opportunity to discuss the emotive moral appeals to professional integrity with both camps never materialized. Such an attempt may represent a failure to reach Aiken's post-ethical and human level of moral discourse. It certainly represents what Hayes terms emotionally charged appeals to metaethical principles taking place before other levels of moral decision-making have been adequately explored. The nursing literature acknowledges that a chronic and recurrent feeling of moral distress can hamper the willingness or ability or persons experiencing

moral dilemmas to engage in the dialogue or problem-solving necessary to resolve them. Thus, perhaps it should not be a surprise that a meeting to resolve the underlying emotional and interprofessional issues was never arranged.

It is interesting to note that the nurses' affective reaction—their refusal to sedate Mr. Sullivan—was removed by a change in the understanding of the facts and re-interpretation of a moral judgment made in haste after allowing the expression of and validation of emotion. Only after consulting outside experts in bioethics were the nurses able to understand the ethical arguments in favor of sedating the patient. Since a chance to share these facts with the ENT team never materialized, perhaps this missed opportunity to change their understanding of the facts helps explain their reluctance to address the underlying emotional issues.[57] Communication about how the nurses and doctors perceived their roles might have explained their emotional responses and helped ease reconciliation since feelings of resentment, power, and anger were still present. At the very least, understanding the ethical implications of their respective emotive responses might have prevented hard feelings from interfering in the professional relationships that these two groups must maintain.

One interesting feature of this case concerns the use of experts outside of the institution to provide justification for the use of sedation. The ethics consultation team was divided regarding the ethical feasibility of sedating a patient so that surgery could be performed. There was no argument that the surgery was in Mr. Sullivan's best interests

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[57]It is also interesting to note that one of the ethics consultants' opinion of the case—his own affective barriers—were removed with this outside advice as well, a sort of change in his understanding of the facts.

and that his son was acting according to the ethical and legal criteria for surrogate decision-making. The point of contention concerned whether it might be possible to ascertain Mr. Sullivan's own values regarding the surgery so that a substituted judgment could be applied. This option, however, was not possible. The use of the outside experts represents an attempt to provide justification for the lack of facts about the patient's own values—a jump from Aiken's moral level to his ethical level. The ethics consultation service and team, using the ethical justifications from the outside experts, engaged in ethical criticism—an attempt to provide justification for a course of action when the moral rules or facts are not certain or yield contradictory conclusions.

Perhaps the most telling feature of this case concerned how an initial emotive rejection of sedation was well received by the nurses and accepted after understanding its ethical justification. The consultants brought the results of their ethical deliberations back to the nurses for their consideration. Once they grasped the ethical and legal justification behind sedating Mr. Sullivan, it was possible to resolve the immediate clinical issue of the patient's surgery. However, the underlying emotive issues—why the nurses felt the way they did, why the physicians responded the way they did, and the various moral and ethical justifications for their responses—were not adequately addressed. As suggested, this failure represents an inability of the parties to reach Aiken's fourth level of moral discourse. Perhaps a separate meeting with the physicians to discuss this case, followed by a joint meeting with the physicians and nurses, might have provided a forum for handling the residual effects of the failed attempt to reach this ultimate stage of moral discourse.

This case involves what some bioethicists term a "defined dispute" (West & Gibson, 1992; Spielman, 1993; Dubler & Marcus, 1994; Hoffmann, 1994b). Emotional reactions caused polarization of conflict between two parties. Denial, refusal to engage in dialogue, entrenchment of positions, and strong emotions such as anger, suspicion, resentment, and frustration can often hinder resolution and sever professional relationships (Broom, 1991; Dubler & Marcus, 1994; Wocial, 1996). This case showed some of these affective barriers. The physicians seemed reluctant to participate in meetings with the nurses. Perhaps issues of power and refusal to see the nurses as second persons, moral equals within the health care delivery system, produced the surgeons' reluctance to engage in dialogue. Such professional power differentials needed to be addressed. Despite hearing the ethical justification for giving sedation at the meeting with the nurses, one nurse sighed in resignation that "doctors give orders, and nurses follow them" to vent her frustration with the case.

The missed opportunity to address the underlying emotional tension could have been ameliorated by a change in the ethics consultation process. Instead of proceeding directly to fact gathering and sharing, as the ethics consultants did in this case, a joint meeting with all of the parties should have been scheduled. The purpose of such a meeting would have been to explore, express, and validate the emotions present among both parties and generate empathy and trust between the parties and ethics consultants so that future meetings to explore the moral difficulties and options could have occurred—the goal of TEC's second step and the focus of the next chapter.

Chapter Seven

Engendering Collective Empathy: The Second Step in Transformative Ethics Consultation

"Empathy…exists neither in the head of the sender nor the receiver, but in the emerging interaction that takes place between them."

—Carol Toris, 1994, p. 3.

Introduction

Several sources argue that empathy is a skill necessary for conducting ethics consultations (Baylis, 1994; Dubler & Marcus, 1994; Lynch, 1994; SHHV-SBC, 1997; ASBH, 1998). Many of these sources narrowly construe empathy as directed from the ethics consultants to the parties. This form of empathy helps the parties and ethics consultants—often moral strangers—build a level of trust and rapport necessary for the consultants to facilitate the meeting. But, as I argue, empathy can also be expanded into a transformative interpersonal force to galvanize collective will among the parties and to help "mediate…deeply felt differences while honoring them" (Moreno, 1991b, p. 195). In this chapter, I argue that expanding the notion of empathy to a mode of authentic interpersonal communicative interaction provides the parties with an opportunity to transform their positional stances to moral conflict into a shared opportunity for moral dialogue.

Part I: Empathy as a Collective Responsibility—Motivating the Argument

There are two ways to establish that the expansion of empathy into a collective responsibility represents the proper moral atmosphere for consensus to emerge in ethics

consultation. One is a straightforward approach, and sources from the bioethics mediation literature help provide this argument. As I introduced in Chapter Six, the mediation process includes a stage designed to elicit the emotions of the parties and provides parties with an opportunity to explore, express, and have their emotions validated by others. Mediators then attempt to transform individual positions, interests, and values into common interests in the hope of opening up dialogue and creative problem-solving. The adaptation of such a process to ethics consultation would involve the building of empathy and rapport between consultants and parties (the first stage of TEC) and its expansion into collective empathy (the second stage of TEC).

Alternatively, working backwards from the goal of ethics facilitation, if consensus is the goal of ethics facilitation, what must happen earlier in the consultation to make consensus possible to achieve? An interesting literature has recently emerged suggesting that consensus is not merely an end or product, as *Core Competencies* largely construes it, but also a process. In the first part of this chapter I will examine this literature in some detail, for it will become plain that consensus as both process and product has several preconditions that must be present for it to emerge authentically. These preconditions are, in essence, the elements that characterize the second step of TEC—the ability and willingness of parties to engage in moral dialogue.

If empathy, characterized as a dialectic between self and other, is a precondition for consensus, then moral decision-making should be less concerned with abstract theories to practical problems and more with how to engender empathetic moral dialogue. Theories certainly play an important role in the process, but successful moral dialogue

rests on the ability and willingness of persons to share stories. This conception of moral dialogue provides the connection between the first and second parts of this chapter. The goal of morality, and by extension ethics consultation, becomes how to relate to and live in social harmony with others who may not necessarily share our moral views. What then becomes of the ethicist? His or her role is to help structure the moral space where dialogue about divergent views regarding a shared moral difficulty can be explored and consensus ideally reached. The metaphor of midwife becomes a compelling description of the ethicist's function. Although *Core Competencies* presents a similar facilitation role, the parties must shoulder significant moral responsibilities to each other. *Core Competencies* focuses exclusively on the moral responsibilities of the consultant and largely ignores the responsibilities of the parties. In this way, ethics facilitation requires supplementation.

One author, Margaret Urban Walker, puts forth the mediator role to describe the ethicist's purpose, for a mediator is trained to recognize the need for empathetic attunement to self and others for successful moral dialogue. Empathetic attunement to self and its expansion into collective empathy are the preconditions necessary for parties to explore their different views and reach a resolution, whether it be consensus, understanding, or merely acknowledgment of differences. The willingness and ability of parties to do so successfully will depend in large measure on the ability of the ethicist to create the proper atmosphere for moral dialogue. TEC supplies the elements necessary for the proper structuring of the moral space for such dialogue and encourages the parties to have the proper moral respect and concern for each other they need to reach consensus.

Part II: Consensus and Its Preconditions—The Ethics of Discourse

The goal of ethics facilitation is consensus—agreement by all parties, according to *Core Competencies*. Reaching consensus requires several preliminary steps. First, the parties must know the moral positions of their fellows. This knowledge requires that the parties have listened, heard, and understood the values and interests of others. Strong emotions, a common component of interpersonal difficulties, can sometimes prevent people from listening, hearing, and understanding others. Second, the parties must be willing to settle on a solution that most approximates a collective sense of the values at stake. Consensus requires willingness to compromise.[58] The decision reached may not be the ideal that each party would want, but it is one that all parties can "live with." Consensus requires both a *willingness* and *ability* to put aside differences and reach a solution—a shift from a "I win, you lose" position to a "we are both in this together" position. In order to achieve both the willingness and ability to reach a solution, respect and concern are required. Empathic understanding is a mode of interpersonal communicative interaction characterized by authentically listening, hearing, understanding, and respecting the concerns, emotions, and needs of others. Cultivation of empathetic understanding in the second step of TEC provides the preconditions for consensus, the goal of ethics facilitation.

In some interpersonal value conflicts, strong emotions may polarize the conflict such that each side has his or her own view of the situation and a meeting designed to

[58]Moreno (1995) argues that consensus and compromise are inextricably linked but often confused. "One source of confusion," he argues, "is the fact that consensus involves reaching agreement on one of a number of theoretically available compromises" (Moreno, 1995, p. 45).

fashion a resolution becomes a struggle to assert individual wills and positions over those of competing parties. Such egocentrism and the unwillingness to overcome it and achieve respect and concern can often hide vulnerabilities—loss of face, fear of angering others, lack of education or power, or fear of having one's most cherished values scrutinized and challenged. However, if early in the process the consultants can elicit underlying feelings—anger, fear, intimidation—and acknowledge that both sides may be experiencing similar vulnerabilities and emotions, individual positions can be transformed into shared opportunities for problem-solving. Once shared values and shared feelings are acknowledged and trust established that the consultant will fairly guide a process of dialogue (step one of TEC), parties can shift from advocating their own positions to considering opportunities to move toward a collective sense of moral responsibility. As I described in previous chapters, what is required for this shift is the integration of emotion with reason through a dialectic process of building empathy, first from within each party, then between them. Thus, in ethics consultations involving emotional tensions or attempts to decide the case without first integrating emotion and reason, the second step of TEC represents a way to authentically transform intrapersonal integration of emotion and reason into shared opportunities for interpersonal moral dialogue and resolution. In this chapter, I endeavor to describe precisely how this step can be cultivated.

Consensus as Product, Process, or Both? In Chapter Two I discussed the goal of ethics facilitation—consensus regarding one of the options generated after identifying and analyzing the ethical conflict or uncertainty. This outcome for ethics consultation is

controversial for several reasons. *Core Competencies* seems to define consensus—"agreement by all involved parties"—in terms of end product (ASBH, 1998, p. 7). But it is obvious that many steps must occur beforehand to increase the likelihood of agreement. Thus, is consensus a product, a process, or both? Does "true" consensus exist regarding particular issues in bioethics among individual bioethicists? If agreement is paramount for achieving consensus, does consensus avoid the use of ethical principles or moral theories to guide discussion and agreement? In other words, if consensus is more concerned with agreement, on what philosophical, principled basis do such agreements rest? Such questions are dissertations in themselves. Moreover, my concern in this chapter is to argue that conditions antecedent to consensus can make or break the ability of the parties to achieve the goal.[59]

Sources in the bioethics literature focus on what conditions must be met in order to say that a "true" consensus has been reached. The focus of *Core Competencies* is on the end product, not on how the individual parties should interact with one another during the process of reaching consensus. My analysis delves somewhat deeper to the question of what preconditions must exist early in ethics consultation so that the parties achieve the proper moral stance to each other in order for consensus to emerge. Thus, my analysis will seek to uncover what conditions must exist for consensus to emerge as the end product.

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[59]Debate rages regarding whether consensus is even an appropriate goal of ethics consultation. This topic is not central to the claims I wish to make regarding the transformative nature of empathy. Moreover, consensus is at least one among many possible outcomes of ethics consultation. And since TEC supplements the first stage of ethics facilitation, and consensus is the outcome sought in that process, consistency dictates that consensus be assumed as the end of TEC.

I argue that establishing a trusting atmosphere during the early stages of ethics consultation and fostering an environment in which parties are both willing and able to engage in moral dialogue represent three preconditions for consensus to emerge. The first precondition should be established during the first step of TEC, a subject covered in the previous chapter. The second and third preconditions, hopefully developed during the second step of TEC, are the subject of this chapter. As the next few sections will show, sources from the philosophical and bioethical literature on consensus as process aver the latter two preconditions.

The Moral Authority of Consensus and the Role of the Ethics Consultant. A recent article by David Casarett, Frona Daskal, and John Lantos (1998) explores the moral authority of consensus and the role of the ethics consultant. These authors use Jürgen Habermas' discourse ethics as the basis for arguing that consensus represents not only a description of what ethics consultation is (the product) but also a model for conducting it (the process). In addition to arguing why consensus represents a legitimate product of ethics consultation, Casarett and colleagues also allude to several process elements and conditions needed for consensus to emerge. These preconditions, strikingly similar to elements in Vetlesen's sequence of empathy, establish an explicit connection to TEC. Before drawing this connection, it is necessary to understand Habermas' view of consensus and how it relates to ethics consultation.

Discourse Ethics: Habermas on Consensus. Habermas' discourse ethics starts with the assumption that sometimes agreement on particular moral decisions in a pluralistic democratic society cannot occur. In order to salvage ethics and moral theory

from the relativism inherent in such a state, Habermas attempts to ground ethics by taking consensus to be the foundation of a moral theory that provides justification for decisions.. For Habermas, consensus represents a moral equilibrium. Habermas critiques such thinkers as John Rawls who stipulate equilibrium as a theoretical endpoint of abstract judgments made behind a veil of ignorance. Rather, the discourse to reach such equilibrium is practical and immediate—between actual persons in dialogue, not ideally situated and objective persons stripped of social context in an "original position." Thus, rather than abstract rules of justice governing the deliberations, Habermas endorses rules of discourse or discourse ethics to govern the interaction between individuals intent on reaching agreement.

Discourse ethics has two rules, the simultaneous satisfaction of which facilitates the achievement of agreement. The first rule concerns equal respect for individuals, and the second involves concern for the common good. Both rules have ontological roots in Kant's metaphysics and parallel the two preconditions of TEC, but before embarking on such a discussion, it is necessary to understand how the two rules function in discourse.

Habermas operationalizes equal respect for the integrity and dignity of each individual in terms of the ability of parties to consent to or veto particular interpretations of norms in question. Concern for the common good requires reciprocal perspective-taking very similar to the sort I presented in Chapter Four for achieving second-personhood. Habermas characterizes such perspective-taking as overcoming one's

viewpoint.[60] As I asserted in Chapter Four, empathy is required in order to accomplish this complex perspective-taking: "without empathetic sensitivity by each person to everyone else, no solution deserving universal consent will result from the deliberation" (Habermas, 1990, p. 202).

While discourse ethics derive much from Kant's moral metaphysics, Habermas offers several important points of departure. Like Kantian morality, discourse ethics is concerned with universalization. However, the universalization with which it is concerned is unlike the sort posed by Kant's system of morality. The rules Habermas uses to describe how to achieve agreement are ones that should hold between all individuals in discourse. Moreover, the consensus reached should be one to which all parties would universally assent. The universe, in a sense, is small—it applies only to the parties engaged in a particular discourse, and the scope of the norms agreed upon apply only to those in discourse. It is the *process* of reaching consensus that is universally applicable in Habermas' discourse ethics, not the norms debated during the discourse.

The universality of the consensus process can be stated more formally by recasting Kant's categorical imperative, Habermas argues. Rather than describing a moral principle as valid only when one can will it to be a universal law, discourse ethics regards the validity of a moral principle as interpersonally determined and applicable only to those persons affected by a particular norm. Thus, consensus is achieved—and norms are

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[60]Habermas (1990) describes second-personhood in terms very similar to Annette Baier: "Members of our species become individuals in and through being socialized into networks of reciprocal social relations, so that personal identity is from the start interwoven with relations of mutual recognition. This interdependence brings with it a reciprocal vulnerability that calls for guarantees of mutual consideration to preserve both the integrity of individuals and the web of interpersonal relations in which they form and maintain their identities" (p. x).

accorded validity—when the "consequences for the satisfaction of everyone's interests...[is] acceptable to all as participants in a practical discourse" (Habermas, 1990, p. viii). Habermas refers to this proposition as the universalization principle of consensus.

Habermas traces the derivative nature of discourse ethics from Kant's categorical imperative and system of morality to two metaphysical conditions for discourse. Discourse is an actual process used to reach universal assent; the categorical imperative is an abstract principle of the formalism derived from Kant's metaphysics, which dichotomizes two elemental features of morality—rational judgment and sense experience. Following Hegel, Habermas suggests Kant's dichotomy misconstrues the essential and basic nature of moral phenomena by advocating two separate dimensions, each with opposite governing principles, to describe moral experience. Habermas argues that Kant's distinction between the noumenal realm of duty, reason, and free will and the phenomenal realm of sense experience must be abandoned. Habermas argues, following Strawson, that moral feelings have as valid a place in morality as pure reason. "The concept of practical discourse postulates the inclusion of *all* interests that may be affected," Habermas (1990) concludes (p. 207, italics added for emphasis). For Habermas, moral feelings provide a wellspring of moral intuitions that help determine what our interests are and how to recognize the interests of others with whom we discourse. Discourse must integrate these features in order to be truly authentic and representative of the actual moral dispositions and interpretations of the parties.

Habermas points to the nature of discourse as a means to justify collapsing the dichotomy between reason and feeling, duty and inclination, and objectivity and

subjectivity. Discourse integrates the intrapersonal with the interpersonal; the categorical imperative is exclusively intrapersonal. Parties in discourse must interact with one another and translate their intrapersonal subjective experience of the world into a form others will understand. The categorical imperative asks each person to consult reason and determine if the principle in question would be one all persons would adopt. As Habermas (1990) argues, the emphasis on interpersonally integrative discourse "shifts the frame of reference from Kant's solitary, reflecting moral consciousness to a community of moral subjects in dialogue" (p. viii).

This essential difference between the categorical imperative and discourse ethics is metaphysically based. Discourse requires mutual understanding, the use of language, and the integration of rational faculties with moral intuitions, subjective inclinations, and other supposed non-moral features of human existence that Kant banishes to the phenomenal realm. Discourse is not possible without communication regarding what each party takes to be his or her interests. Interpretation thus must occur on two separate moral levels—the intrapersonal level of the individual and his or her own moral consciousness and the interpersonal level, where intrapersonal interpretations must be translated to others with whom we must make a decision.

Communication facilitates understanding, and understanding is required so that parties adopt the perspective of their fellows and take into account the interests of others during the emerging interaction. Communication and understanding occur through language, Habermas argues. However, by "locating the common core of morality in the normative presuppositions of communicative interaction," Habermas' (1990) theory

encounters a problem of intersubjectivity similar to the one Husserl's phenomenology confronts (p. xi). How is understanding possible between two persons when their experience of the world is based on their own unique, intrapersonal interpretation of phenomena? For Habermas, morality is intersubjective, but, as existentialism suggests, each person constructs an inner world of personal, subjective meaning, supposedly inaccessible to others. As a solution to this problem, Habermas, like Husserl, argues that language and empathy are necessary for transforming individual subjective experience into intersubjective understanding.

For Husserl, empathy provides a way of understanding the inner world of another person. This need is equally present for Habermas' discourse ethics, for morality requires the coordination of experiences between individuals inhabiting different moral worlds. One way to coordinate these divergent experiences is by communication and, ultimately, consensus. Without the ground rule of respect and concern, such communication is not possible. Hence, if moral reality is intersubjective, and joint decision-making requires respect and concern for others, then the conclusion is the same as the one I offered in Chapter Four. Empathy must be a precondition of moral dialogue and thus consensus.

Habermas posits hermeneutics as the method for achieving communicative interaction and understanding. Hermeneutics "serves as (a) an expression of the speaker's intention, (b) an expression of the establishment of an interpersonal relationship between speaker and hearer, and (c) an expression about something in the world" (Habermas, 1990, p. 24). The goals and process of hermeneutics parallel those of empathy as

introduced in Chapter Four to overcome the problem of intersubjectivity inherent in Husserl's phenomenology.

Husserl's student, Edith Stein, argued that language is necessary to bridge the subjective worlds of individual phenomenal experiences. One's own experience of the world must be described using words and gestures and transmitted to others with whom we intend to communicate, and they must decode our meaning and intention by translating the language. The sequence of empathy—as a dialectic between self and other, a reaching out from within to another human being in order to establish dialogue—is similar to hermeneutics. The attempt to communicate expresses the speaker's intent and meaning regarding something encountered in the world. The process requires the transmutation of an intrapersonal interpretation of our moral experience into an interpersonal description of that experience designed to establish a common or shared understanding of the experience. Discourse is achieved when the roles of speaker and hearer blend together—when the speaker also becomes a hearer and vice versa—and when the meaning and intent of each individual becomes transparent to the other. Just as empathy is designed to share subjective experience and overcome moral solipsism, hermeneutics "watches language at work, so to speak, language as it used by participants to reach a common *understanding* or a shared *view*" (Habermas, 1990, p. 25).

The goal of hermeneutics is understanding, and our ability to understand one another depends on perception. In the attempt to understand each other, sometimes communication reveals that interpretations of the same moral phenomena yield contradictory appeals to the same norm or even different descriptions of a shared moral

experience. Moral perception is inherently perspective-relative, and as imperfect perceptual creatures, perceptions of a shared moral experience by different individuals will sometimes clash. Thus, moral conflict can sometimes occur. Habermas' intersubjective view of morality poses significant challenges for the conception of morality as requiring agreement, consensus, or universally accepted value claims. If morality depends on individual subjectivity, and my perception or interpretation of moral phenomena may in fact differ from another person's, how is reconciliation possible? In such instances of "disruptions of consensus," Habermas (1990) argues that a process of moral argumentation must ensue to repair the disruption and re-establish consensus (p. 67).

Moral argumentation requires one of two endpoints, according to Habermas (1990): either the restoration of "intersubjective recognition" of a norm "after it has become controversial" or the assurance of "intersubjective recognition" for a new norm "that is a substitute for the old one" (p. 67). Habermas (1990) describes the process used to reach these endpoints as expressing "a common will," a notion that suggests shared responsibility must exist between interlocutors during moral discourse (p. 67).

Moral argumentation, despite the connotation of a heated debate or argument, requires cooperation, respect, and concern, the very elements posited for the second step of TEC. As a specific form of communicative interaction, moral argumentation is designed to restore disruptions in consensus. Habermas argues that cooperation and empathy are required if moral argumentation is to produce consensus: "it is not enough for [one] individual to reflect on whether he can assent to a norm.... What is needed is a

'real' process of argumentation in which the individuals concerned cooperate" (p. 67). The "real" process to which Habermas refers is authentic moral dialogue—dialogue in which the parties are willing and able to engage each other as second persons who respect one another.

Willingness to engage in discourse corresponds to Habermas' emphasis on concern for the common good. The ability to engage in dialogue depends on whether the parties are able to adopt the perspective of their fellows. As Habermas argues, the task of morality is two-fold. Discourse

> must solve *two* tasks at *once*. [It] must emphasize the inviolability of the individual by postulating equal respect for the dignity of each individual. But [it] must also protect the web of intersubjective relations of mutual recognition by which these individuals survive as members of a community. To these two complementary aspects correspond the principles of justice and equal rights for the individual, whereas the second postulates empathy and concern for the well-being of one's neighbor (p. 200).

Without individual respect and concern for the common good working in tandem as principles governing discourse, parties will not be able to reach a realistic and durable agreement.

Consensus, once disrupted, requires repair by either agreeing on a new interpretation for a norm or replacing the norm in question with another one. As Aiken (1962) suggested, "decision is king"—the goal of discourse is the resolution of a practical moral difficulty (p. 87). Reaching a decision that incorporates the interests of each person without compromising the moral integrity of the individuals or their understanding of their interests requires patience, understanding, and cooperation. Aiken described the end result of moral discourse as an exciting occasion capable of motivating the will.

Habermas (1990) describes discourse in similar terms—as "an intersubjective process of reaching understanding" that "can give the parties the knowledge that they have collectively become convinced of something" (p. 67).

As I suggested in Chapter Four, empathy requires not only respect and concern, but also mutual recognition of vulnerability. Without sincere respect for the individual and concern for the common good, discourse can be a dangerous activity and make the parties vulnerable to domination, coercion, or manipulation. For Habermas, such vulnerability is an essential feature of human morality—one that discourse ethics is designed to safeguard. As he argues, "linguistically mediated interaction...is both the reason for the vulnerability of socialized individuals and the key resource they possess to compensate for that vulnerability" (Habermas, 1990, p. 201). For Habermas, successful discourse requires empathy, respect for the individual, and concern for the common good—all of which are designed to allow individuals to cooperate and avoid the dangers inherent in misusing power to manipulate the vulnerability of others. As Habermas suggests, "it is in our power to counteract the extreme vulnerability of others by being thoughtful and considerate" (p. 199). The inability or unwillingness to view others with equal respect and to keep concern for the common good of all engaged in discourse as first principles will doom attempts at authentic discourse.

Habermas, Consensus, and Ethics Consultation. One reason why consensus makes an attractive process and/or product for ethics consultation is because it affirms moral pluralism. In a society as morally diverse as North America, there may not be societal agreement about certain practices or the justifications offered for them.

Moreover, the democratic ideals of freedom operative in North America allow persons the right to pursue their own conception of the good (within certain broad ethical and legal boundaries). Nevertheless, the fact of moral pluralism also makes negotiating a common and habitable moral world a challenge. If agreement is sometimes not possible and no one moral position or view is morally authoritative, then how ought persons who disagree with one another try to reach a decision together? As the discussion of Habermas has shown, consensus represents a justifiable, content-rich, and philosophically robust ground for moral interaction and resolution. Adapting Habermas' concept of consensus to ethics consultation requires transposing the preconditions or ground rules for consensus into workable elements of the consultation process.

Respect for moral pluralism is a core feature of ethics facilitation. As in consensus, moral pluralism requires that the individuals engaging in an ethics consultation at least respect each other's diverse and divergent values and have as a common value concern for the discourse in which they are engaging. In practical terms, respect for each other and concern for the common good can be operationalized into one of two preconditions that ought to govern ethics consultation—willingness to engage in discourse and the will to keep it alive until some desired end or goal is achieved. However, as I have argued before, *Core Competencies* does not address the responsibilities of parties other than the consultant. However, for TEC, which acts as an adjunct to ethics facilitation, willingness corresponds to one of the preconditions for

consensus. Parties must be willing to see each other as second persons deserving of equal respect and concern.[61]

For Casarett and colleagues, willingness is also a prerequisite for consensus. Consensus is fragile and easily disrupted, they argue. Moreover, one "immediate obstacle to consensus is unwillingness to engage in dialogue" (Casarett, et.al., 1998, p. 9). Casarett and colleagues (1998) characterize willingness in terms of respect and concern. "Consensus building depends on participants' willingness to listen, reflect, and reconsider their own normative claims" (p. 9). Without the *ability* to overcome one's own viewpoint, as Habermas terms it, such *willingness* cannot exist. The ability to view others as second persons—as moral equals—requires that the moral interests of others be accorded the same respect and concern we have for our own. In practical terms, such respect and concern requires that we be willing and able to listen to others, respond to them with empathetic sensitivity, and understand their perspective as they see it. In essence, to paraphrase Habermas, consensus requires the cultivation of a common will to reach a shared understanding through interpersonal communicative interaction.

The question, and the challenge for TEC, is how this form of common will can be achieved in ethics consultation. In the last chapter, I suggested that the attempt to achieve a shared sense of responsibility first requires the presence of a trusting atmosphere, followed by the attempt to engender collective empathy. Casarett and colleagues suggest

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[61]The second principle, the *ability* to see others as second persons, is directly related to and prior to the *willingness* to do so. Moral judgment cannot exist without a prior moral perception. Moreover, the willingness to overcome one's own viewpoint requires the ability to see the need for overcoming it to establish concern for the common good and determine how it will be achieved.

a similar answer. Theirs depends on acknowledging the parallels between Habermas' view of consensus and ethics consultation.

According to Casarett and colleagues (1998), disruption of consensus exemplifies one reason why ethics disputes occur: "conflict breaks the thread of routine intention or unconsidered action and demands a moral discussion and evaluation" (p. 7). To further complicate matters, most disruptions of consensus that turn into ethics consultations involve the very diversity of values that a socially pluralistic democracy extols: "The participants...often arrive at the table from vastly different...moral, religious, and cultural landscapes. They bring diverse understandings of the situation and of their own roles, and they may perceive the rules of the game very differently" (Casarett, et al., 1998, p. 7). For Casarett and colleagues (1998), the only practical, efficient, and respectful way to resolve such differences is through dialogue and consensus: "we each bring our moral theories to the table, and talk to each other until we find a course of action that most supports or least violates the principles each of us holds most dearly" (p. 8). As Habermas argued, such moral argumentation must be cooperative, respectful, and oriented towards the common good of all involved parties. In the most intractable of cases, however, respect and concern cannot be generated by the parties themselves. When such consensus cannot be reached, parties call on the skills of ethics consultants to help facilitate discussion and consensus repair.

The addition of a third party to the discourse, however, requires that the consultant act as a communication facilitator, Casarett and colleagues argue. The consultant must not substantively interfere with the parties' ability and willingness to

shoulder the responsibility for the emerging discourse. In fact, it is the ethicist's job to positively reinforce the parties' ability and willingness to shoulder such joint responsibility. Thus, within this role, the consultant's chief goals are "to clarify the moral positions of others, and to arrange a safe moral space within which differences can be aired, understood and resolved" (Casarett, et al., 1998, p. 6). The ethicist's role is not characterized so much as a problem-solver, but more in terms of three elements—interpretation, communication, and consensus-building. In effect, the consultant must help establish the preconditions of respect and concern that will allow the parties to reach consensus.

TEC requires establishing the proper atmosphere and environment for the generation of collective empathy. In describing the consultant as communication facilitator Casarett and colleagues (1998) underscore the importance of this first step in ethics consultation: "When she acts as a facilitator, the ethics consultant sets the stage and arranges the props to facilitate moral argumentation" (p. 8). After establishing the tenor of the consultation as one of respect and concern by showing empathy and validating emotion, the consultant must act as the interpreter of communicative interactions so that true discourse and moral argumentation can be fostered between the parties. Casarett and colleagues describe this role as "hermeneutic, conciliatory, and directed toward the establishment of a dialogue that can lead to consensus" (p. 8). In describing the role thus, Casarett and colleagues suggest the consultant acts both as interpreter/translator and mediator.

As a translator of communicative interaction, it "would be the ethicist's role...to find common ground among conflicting views by posing questions, suggesting strategies, and helping participants to see their own positions relative to those of the other participants" (Casarett, et al., 1998, p. 9). As a mediator, consultants "must achieve a precarious and often elusive balance.... They must create an environment for honest discourse in which the core values that we all cherish remain respected, and in which future collaboration remains possible" (Casarett, et al., 1998, p. 10).

Such activities seem no different than the ones outlined in *Core Competencies*. What is substantively different between the role and responsibilities of the consultant as presented by Casarett and colleagues and the one *Core Competencies* endorses? The only major difference is that the responsibilities of the parties are more fully spelled out in adapting discourse ethics to ethics consultation. In addition to the consultant showing respect, concern, and empathy to the parties, both the second step of TEC and discourse ethics require the parties to show respect, concern, and empathy for each other and their interests and values. This small difference is not trivial, for it marks the difference between an integrated and morally authentic dialogue that is the joint responsibility of the parties, on the one hand, and mere consultant facilitation, on the other. Hence, if joint decision-making requires respect and concern for others, then the adaptation of discourse ethics to ethics consultation suggests the same conclusion as the one I asserted in Chapter Four. The empathy, intended to instill a shared sense regarding the views, interests, and values of others and how to integrate them into a resolution reached collaboratively, must be a precondition of moral dialogue and thus consensus. The remaining challenge is to

show that TEC provides one way to operationalize respect and concern in moral discourse. Again, the role of empathy cannot be underestimated in the cultivation of respect and concern.

Discourse Ethics, the Phenomenology of Empathy, and TEC. Casarett and colleagues describe the role of the consultant as a communication facilitator and suggest three elements describe this role—interpretation, communication, and consensus-building. I argue that this role and its three elements correspond to the structure of TEC as a supplement to ethics facilitation. Moreover, the correspondence between these three elements and TEC extends to the intrapersonal and the interpersonal levels where moral conflict is experienced. The fact that the sequence of empathy requires integration of these two levels helps to elucidate how to achieve operationalization of discourse ethics into TEC.

Habermas describes morality as intersubjective. Individual moral perceptions can lead to different interpretations of the same moral phenomenon, which then require coordination between the individual "worlds" that characterize each individual's moral reality. Alternatively, appeal to specific norms or interpretations of norms can cause moral conflict. Habermas focuses on the interpersonal communicative interactions that should govern the process for resolving moral conflicts of these types. However, translating moral interpretations of phenomena into communicative interaction requires integration of the interpersonal with the intrapersonal. We make moral assessments by consulting reason, conscience, and our moral feelings. The process of bringing these intrapersonal elements into the moral realm of interpersonal interaction requires the sort

of internal cycle that Callahan describes as decisions made in conscience—the simultaneous integration of our rational, intuitive, and emotional faculties of perception and judgment.

Such a procedure characterizes the intrapersonal component of discourse—the preliminary step necessary to engender interpersonal communicative interaction. Habermas describes discourse as a dialectic between self, other, and the world. Interpretation requires an internal and external dialectic designed to integrate our intrapersonal emotional and cognitive faculties of moral perception and judgment so that we can understand our own moral interests and be able to communicate them to others. In this way, interpretation functions much as the first step of TEC does—the purpose is to harmonize intrapersonal perceptual and evaluative faculties so that we have the *ability* to communicate with others. We may be willing to do so, but without this preliminary step, we will not know what our own interests are. Without this knowledge, it is not possible to reconcile or merge the interests of others with ours.

The second element, communication, requires the building of empathy between persons by bridging the intersubjective chasm between persons, values, language, and meaning. Reciprocation of empathy from others with whom we intend to make a joint decision is also required. Hermeneutics is the attempt to establish such a relationship between individuals, and, as Habermas reinforces, it requires collaboration, collective will, and empathy. Although Habermas focuses on interpersonal interaction, the necessity of intrapersonal attunement to reason, intuition, moral feeling, and vulnerability is implicit in his discussion of discourse ethics. The focus, however, cannot remain with the

solitary individual, as in Kant's morality, for without reciprocity, collaboration, and mutual good will, true moral dialogue cannot take place. The preconditions necessary for such dialogue correspond to the second step of TEC.

The third element, consensus-building, exemplifies the second stage of ethics facilitation—moral dialogue designed to restore consensus. And without first ensuring the presence of the other two elements, consensus-building cannot truly take place. Interpretation and communication describe the two steps of TEC, which supplement the first stage of ethics facilitation. It is not that interpretation and communication are not important or emphasized in ethics facilitation. For instance, it is the job of the consultant to interpret and infuse the discussion of options with norms from bioethics, health law, institutional policy, and moral theories. Moreover, in order to "negotiate between competing moral views," the consultant must "elicit the moral views of involved parties" and "represent" them to others (ASBH, 1998, p. 14). In the most intractable of cases consensus is not possible.[62] Parties may not be able or willing to overcome their viewpoints. Or taking the perspective of others may threaten deeply held and cherished values. Consensus is fragile, easily disrupted, and difficult to achieve. When consensus is either not possible to achieve or unravels, what recourse remains to achieve a resolution to a shared moral difficulty? *Core Competencies* suggests that when ethics facilitation has failed to achieve consensus, mediation or other dispute resolution mechanisms may help

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[62]Perhaps it is in such cases that the more consultant-based responsibilities posited in *Core Competencies* should be utilized. If the parties are having trouble establishing the preconditions necessary to reach consensus—failure to overcome one's own viewpoint, lack of respect or concern for each other due to overpowering emotions or proximity to the case or norms in question—then it would be appropriate for consultants to take over primary responsibility for identifying and analyzing the conflict or uncertainty.

to reach a resolution. In the next section, I examine the connection between mediation and ethics consultation to determine whether mediation processes and techniques can help ethics consultants establish what is missing when consensus fails—a collective sense of moral responsibility for discourse intended to resolve a shared difficulty.

Part III: Mediation, Empathy, and the Second Step in TEC

Casarett and colleagues are not the only authors to characterize the role of the consultant as communication facilitator and mediator. Although not based on the discourse ethics of Jürgen Habermas, philosopher Margaret Urban Walker's discussion upholds a similar understanding of morality as requiring communicative interaction. Unlike Casarett and colleagues, Walker argues that morality is organized around the elements of storytelling or narrative. The sharing of stories between persons in search of a common and habitable moral world requires many of the same elements as Habermas' discourse ethics. Thus, Walker's account not only provides a connection to Habermas, but also to mediation as a way of operationalizing such preconditions in ethics consultation in general and TEC in particular. Again, it is necessary to provide a brief overview of Walker's account before fully elucidating these connections.

Walker, the Elements of Narrative, and Morality. Walker argues that narrative offers structure for moral thinking. Within particular episodes of moral discourse, narrative describes how information pertinent to the discourse should be organized. Her account stresses the fact that a story or history represents the most basic form of relating a moral problem. A story or a history provides background information about the who,

what, when, where, and why—"who the parties are, how they understand themselves and each other, what terms of relationship have brought them to this morally problematic point, and perhaps what social or institutional frames shape or circumscribe their options" (Walker, 1993, p. 35).

Narrative also describes the integrative nature of moral discourse. As Habermas characterizes morality in terms of agreement, consensus disruption, moral argumentation, and consensus repair, so narrative "reminds us that 'moral problems' are points in continuing histories of attempted moral adjustments and understandings among people" (Walker, 1993, p. 35). In discourse ethics, moral conflict, which punctuates periods of moral consensus, is a necessary part of the moral life. Without it, morality would be stagnant and staid. Walker depicts morality in terms similar to Habermas—morality requires constant interpersonal negotiation, interpretation of norms, and collaborative problem-solving. Consensus can only be achieved when all parties agree to the interpretation of a given norm or consent to a replacement norm for the one in question. Thus, the authenticity of each party is important. Narrative resolutions of moral conflict "will be more or less acceptable depending on how they sustain or alter the integrity of the parties, the terms of their relationships, and even the meaning of moral or institutional values that are at stake" (Walker, 1993, p. 35).

Given this view of how narrative functions in moral discourse, an interesting comparison can be made between discourse ethics and narrative. Consensus represents the endpoint of moral discourse as well as a process for reaching that endpoint. Narrative represents the *substratum* or *vehicle* for consensus as both product and process. Evidence

that this comparison is valid can be sought by examining Walker's discussion of what is necessary for parties to exchange narratives and reach narrative resolutions. Discourse ethics and narrative share several important elements. Both suggest the parties must have a shared sense of responsibility or mutual accountability in order to reach resolution. Both suggest that overcoming one's own viewpoint is crucial to truly understand another's perspective and engage in collaborative problem-solving. Both require respect for the individual, concern for the common good, and authentic integration of reason and feeling. Finally, both emphasize the need to acknowledge vulnerabilities to avoid foreclosing certain voices in the dialogue.

Narrative and Discourse Ethics. The role of moral pluralism in exchanging narratives is similar to the one Habermas describes in discourse ethics. Walker argues that "specific values and commitments (personal, religious, professional, or cultural) may matter crucially to individuals' maintaining integrity and coherent moral self-understanding over time" (p. 35). The pluralism of values at stake and at play in individual moral conflicts implies a duty that the parties ought to determine what moral responsibilities will hold among them. Such a determination, Walker avers, must involve "a grasp of the history of trust, expectation, and agreement" between the parties "that gives particular relationships distinct moral consequences" (p. 35). By understanding what elements of relationship have brought the parties together and what consequences will result from consideration of various options, crafting a resolution becomes a possibility.

Like consensus, resolution is possible only in terms of the specific histories of the persons seeking it. What, then, facilitates the building of momentum to reach resolution? Walker discusses a case of a brother and sister to illustrate that several conditions must be satisfied—respect and concern, overcoming one's viewpoint, and acknowledgment of vulnerabilities. Carlos is Consuela's HIV positive brother. Carlos does not want to inform Consuela of his HIV status for fear that she and their father will learn of his homosexual orientation. Consuela is willing to be her brother's caregiver in the home, but she remains ignorant of Carlos' HIV infection and thus the risks to her. Carlos' physician is confronted with the ethical dilemma of whether the duty to warn Consuela overrides the duty of protecting Carlos' confidentiality.

Rather than analyzing the case in terms of the abstract principles that would justify the doctor's duty to take one course of action or another, Walker suggests a different analysis based on the relationship that holds between Carlos and Consuela. Walker argues that Carlos and Consuela are "moral actors whose history and future of moral responsibilities are intertwined in specific ways;" thus, they "need to respond to each *as such*, within a larger web of family relations and societal pressures" (Walker, 1993, p. 36). Consuela's willingness to provide care for Carlos allows Medicaid to abdicate financial responsibility for providing a home care nurse. However, asks Walker, wouldn't a home care nurse be informed of Carlos' HIV status? And, therefore, doesn't Consuela morally deserve the same respect and concern as any other caregiver?

Walker sums up the obligations that ought to hold between the brother and sister. Carlos must overcome his own worries and treat his sister with respect and concern as a

caregiver; he must be "willing to assume some responsibilities and risk some trust if he expects her to do so" (Walker, 1993, p. 36). If Carlos cannot overcome his own egocentrism and disclose his HIV status to Consuela, which might help strengthen her concern for him and have positive benefits for their continuing relationship, then Carlos must do without her care, Walker concludes.

Perspective or frame of reference is important in narrative. The way individual moral actors frame the problem, its elements, their own needs and interests, or potential resolutions are central to finding a mutually agreeable resolution. The duties at stake—between respecting Carlos' confidentiality and a duty to warn Consuela—are evident from the physician's point of view. But, Walker inquires, is the case really about the physician and his ethical quandary? The problem is squarely between Carlos and Consuela, and, as discourse ethics suggests, agreement must be forged collaboratively between them.

In order to reach an agreement, recognition of the perspective of the other is required. As Walker (1993) suggests, use of narrative encourages mutual accountability and recognition of the second-personhood of our fellow moral agents: "By accounting to each other through a moral medium, parties to a common life (or the hopes of one) recognize each other as agents of value, capable of considered choices, responsive to value, and so, responsible for themselves and to others for the moral sense and impact of what they do" (p. 37).

Hence, authenticity—moral ownership of the problem and the means of resolving it—is required. Like consensual agreements, moral narratives should be "authored and

judged by those whose moral stories they are: those *by* whom, *to* whom, and *about* whom the moral accounts are given" (Walker, 1993, p. 37). To substitute the moral authority of a third party is to usurp the authenticity and autonomy of the authors of the narratives. Moreover, for one party to be unwilling or unable to overcome his or her own viewpoint and be responsive to others as agents of value jeopardizes the possibility of reaching resolution. As Walker argues: "If moral accounts must make sense to those by whom, to whom, and about whom they are given, the integrity of these accounts is compromised when some parties to a moral situation are not heard or represented" (p. 37). The outcomes of such instances can have disastrous consequences for individuals and the moral communities of which they are a member: "alternative narratives go unexplored, and some members are in practice disqualified as agents of value" (Walker, 1993, p. 37). As Habermas suggested, the ability and willingness to communicate is both a source of and salvation for such vulnerability.

Given the vast differences in power, education, and training between patients, surrogates, and health care providers, what role is proper for the ethics consultant? How can consultants act as third party surrogates for fostering exchange of narratives without usurping the authenticity, authority, and autonomy of the parties? Like Casarett and colleagues, Walker argues that the ethicist's role is oriented towards process, atmosphere, and translation/communication. She stresses elements that also characterize discourse ethics—emphasis on the particular, integration of moral feeling with reason, social situation, and the need for collaboration. Moreover, resolution is determined by how

much the solution makes sense to the parties in terms of their value framework. Thus, respect, concern, and a shared sense of moral responsibility are required.

Narrative, Ethics Consultation, and the Role of the Consultant. Walker's understanding of morality as requiring the exchange of stories shifts morality away from the traditional concern with applying theories to cases to thinking of morality as a live medium for growth, adjustment, and acknowledgment among persons in search of a shared and livable moral world. Traditional morality abstracts away many of the features that a narrative approach brings clearly into focus—one's social setting and the relationships that characterize that setting, the constructive and collaborative nature of moral histories and resolutions, and concern with particular moments of moral conflict. Moral competence, Walker (1993) asserts, echoing feminist thinkers like Virginia Warren, must consist of more than mere "intellectual mastery of codelike theories and lawlike principles;" it must also involve "skills of attention and appreciation," "the wisdom of rich and broad life experience," and "the role of feelings in guiding or tempering one's views" (p. 34).

When it comes to ethics consulting, Walker argues that all participants—the consultant as well as the parties who are experiencing conflict or uncertainty—must have these traits of moral competence. Thinking and feeling must act in concert, and thoughts and feelings must be communicated in such a way as to promote collaboration and mutual understanding. Rather than focusing merely on the consultant as the source of moral authority and competence, Walker acknowledges that the ethicist "is neither a virtuoso of moral theory nor a moral virtuoso, but is one among other participants in a

process" (p. 38). All must be concerned with making decisions responsibly and with respect for others involved in the collaboration. As such, the goal of ethics consulting involves "clarifying the responsibility and accountability of patients, proxies, and professionals, not preempting, erasing, or diluting it" (Walker, 1993, p. 38). Thus, it is not so much "what the ethicist knows" but rather "what the ethicist does or enables" (Walker, 1993, p. 33).

In order to guard against the dangers of exploiting or co-opting responsibility and authority, Walker suggests a metaphor for the role of the consultant. Using language reminiscent of the role posited by Moreno and Casarett and colleagues, Walker (1993) suggests that the ethicist "has special responsibility to enliven a process in which...common moral concerns stay in focus while differences are recognized and, ideally, mediated" (pp. 38-39). The ethicist accomplishes this task by fostering critical, reflective, and collaborative moral thinking. Elements of atmosphere are important, for without the moral space and freedom to enliven such a process, moral discourse cannot take place safely and authentically. Walker (1993) characterizes the first job of the ethicist as that of a moral architect, the person responsible for creating and sustaining the moral space and structuring it such that "an integrated and inclusive process of moral negotiation within the constraints of a particular institution" can flourish (p. 40). Within the moral space structured and nurtured by the ethicist, the parties and their stories take center stage. The role of the ethicist is to help sustain, or as philosopher Árnason suggests, midwife, the moral dialogue. The primary interest of the ethicist is not to supply

ready answers to moral dilemmas but to participate in the situation "with a primary commitment to a fruitful process of resolution" (Walker, 1993, p. 40).

Walker does not precisely specify what a "good" resolution would involve. Rather, because narratives are open-ended and their resolutions should not be engineered, the ethicist should concentrate on upholding the integrity of the narrative process. As an architect of moral space and a mediator of moral discourse with that space, the ethicist's primary function is to act as a surrogate for fostering the second personhood that the parties may not be able to generate through their own efforts. The ethicist can encourage critical self-reflection in a manner that respects the individual values and interests of the parties while helping to coordinate their diverse moral experiences into a cohesive moral passage within their evolving moral histories. Keeping the parties focused on the task at hand and in the proper relationship to each other characterizes how a mediator of moral dialogue acts as a midwife—guiding but not controlling the process until an agreement is birthed with which all parties are satisfied.

The mediator role seems nebulous without specifying particular techniques and processes to achieve the goal of midwifing moral resolutions. How ought respect, concern, collaboration, and sharing of narratives be operationalized in ethics consultation? In the next section, I attempt to connect Walker's discussion of the consultant's role as mediator to techniques that mediators have found useful for encouraging shared moral problem-solving and collaborative decision-making. As such, the techniques to be discussed will help achieve the expansion of empathy into a

collective form of communicative interaction that is central to the second stage of TEC—[63]

The Mediation Process. Before embarking on an in-depth examination of the features of mediation and how they can help in operationalizing Walker's discussion of the role of narrative in moral discourse, the mediation process itself must be explained. The separation of its stages helps to see the logic behind the separation of steps in TEC.

Although there is great diversity among individual mediators and mediation models, most incarnations of the process share several features: the impartiality or neutrality of the mediator, confidentiality of the proceedings (often protected statutorily, depending on individual state laws), an opportunity for parties to voice their concerns without interruption, and mediator-guided problem-solving, option generation, and option assessment. The goal is a feasible, joint agreement balancing the concerns that originally brought the parties to mediation.

How the stages or steps of the mediation process are structured also belies great diversity. Most traditional configurations of the mediation process follow a sequence similar to the two stages of ethics facilitation. However, before identifying and analyzing the conflict or uncertainty that has brought the parties to mediation, mediators explain the mediation process and its ground rules. Some ethics consultants also have an introduction

[63]The question of how Walker's approach differs from ethics facilitation is a valid question. Again, the answer concerns the fact that, like Habermas and Casarett and colleagues, Walker is clear that the sharing of stories is the responsibility of the parties. Unlike ethics facilitation where the consultant has primary responsibility for much of the sharing of stories, interpretation of values, and interjection of moral expertise, the mediator's role is peripheral compared to the parties. The mediator sets the atmosphere, ensures the parties remain respectful of one another, and keeps the process on track.

where they introduce themselves, discuss their role in facilitating the interaction, but such an introduction is not an explicit requirement of ethics facilitation.

Since mediation is a communication process designed to engage the parties directly in resolving a shared conflict or uncertainty, mediators focus their introductory remarks on discussing the importance of several ground rules. The mediators make it clear that their role is impartial—they will not decide the outcome for the parties, but will help them to clarify the issues and possible solutions in terms of their expressed values and interests. Mediators generally ask that the parties be honest. Each party should respect the other and not interrupt speakers but rather concentrate on listening. Mediators also explain that discussions should be kept confidential. These three ground rules are thought to help in creating an atmosphere of trust, not only in the mediators, but in the mediation process itself so that the parties can feel free to discuss their interests and values in a respectful atmosphere.

After explaining the mediation process and its ground rules, the second stage of mediation—often called the storytelling or fact sharing and gathering stage—commences. Mediators listen attentively to each parties' perception of the conflict or uncertainty and employ a variety of communication techniques to acknowledge emotions often underlying interpersonal conflicts. Mary Beth West and Joan McIver Gibson (1992) describe several of these techniques. One such technique, active listening, involves acknowledging feelings by mirroring the statements of one party in a nonjudgmental fashion. Having a third party mediator interpret and match a feeling to the statements of one party helps that party understand his or her own feelings and allows integration of

feeling with previously expressed values and interests. More important, it helps others establish an emotional connection to a party's expressed vulnerabilities. Use of active listening and other reframing and clarifying communication techniques in this stage of mediation allows the building of rapport and empathy, first between the mediators and the parties, then, hopefully, between the parties themselves. If such empathetic understanding is not evident in parties' overcoming their own positions and shifting moral orientation to one of respect for the fellow problem-solvers, mediators sometimes take separate sessions with each party.

Achieving a second-person orientation is necessary for the third stage of mediation, where problems are identified, interests and values matched to these problems, and options explored to resolve the problems. If unable to establish a shared sense of empathetic understanding, most mediations will fail, and either the parties will halt the process or the mediators will terminate it in order to protect the vulnerabilities of one party. However, most skilled mediators are able to help the parties identify common interests by posing a problem statement—one single statement that combines both the dilemma being experienced by the parties and the values underlying it. Such a statement can help keep parties focused on resolving the problem—which requires an orientation to the future—rather than dwelling on the issues from the past that have separated the parties and kept them from reaching a resolution.

Once all parties agree upon a problem statement, they begin to suggest options to resolve it. Often, mediators ask the parties to be creative and brainstorm options without first exploring their acceptability or feasibility. After each party has identified several

options, the mediator begins to explore each option in succession to determine whether and how it correlates with the interests and values of the parties. This part of the process is similar to what Habermas refers to as moral argumentation—reasons are summoned to justify the options, and when the parties agree to an option, consensus is reached. In terms of bioethics mediation, the mediator helps the process along by introducing concepts, principles, theories, policy statements, and other bioethical "data" to help justify particular options.

The fourth and final stage of mediation attempts to bring closure to the session, determine the responsibilities of the various parties in terms of specific actions, how such actions will be carried out, and what follow-up is necessary by the mediator to ensure the that the actions agreed upon are fulfilled.

Bioethics Mediation and Empathy. Nancy Dubler and Leonard Marcus (1994) adapt the generic, four-stage mediation model to the clinical setting in their book *Mediating Bioethical Disputes: A Practical Guide*. The fast-paced nature of clinical medicine and the frequent urgency for a resolution often short-circuits traditionally and formally structured mediation sessions. Dubler and Marcus' more informal application of mediation might utilize all the steps of traditional mediation, but not have the same ordered structure of a formal mediation session, where the role of the mediator and the mediation process can be adequately explained. In such cases, Dubler and Marcus emphasize how mediation techniques and skills can assist in the resolution of ethical dilemmas.

According to Dubler and Marcus, empathy is such a skill. First cultivated by the mediators to show respect towards the feelings and vulnerabilities of the parties, they argue that empathy, if cultivated among the parties themselves towards each other, has the force to transform the stance parties have towards the views and interests of others. This process and its goal is similar to what Habermas describes as overcoming one's own view and understanding the interests of others and what is described in empathy theory as achieving the respect and concern for others through second-personhood. Both are alternative ways of achieving the moral orientation that the second step of TEC requires.

Dubler and Marcus (1994) describe the purpose of mediation as reframing "the tenor of negotiation" from a "positional…negotiation posture" to "an interest-based, integrative process" (p. 21). Positional negotiation refers to the "rigid stance" parties adopt to a conflict when they perceive other parties as their adversaries (Dubler & Marcus, 1994, p. 21). Dubler and Marcus contrast positional negotiation with a more integrative, cooperative, and collaborative stance, interest-based negotiation. Interest-based negotiation emphasizes the unique needs, objectives, and concerns of both sides. Its tenor resembles Walker's narrative approach: "Its purpose is to discern the range of interests of each party and to construct a solution that best addresses the range of legitimate issues" (Dubler & Marcus, 1994, p. 21).

The first step in attempting to move parties from their positional stance to an interest-based stance involves allowing "the parties to let off steam" by venting "their anger and frustration with one another" (Dubler & Marcus, 1994, p. 23). Much like the first step of TEC, the objective of venting emotions is to help the parties "to buy into the

process" by building "a trusting relationship with the mediator" (Dubler & Marcus, 1994, p. 25). Dubler and Marcus (1994) identify empathy as the activity that allows the parties to extend trust in the mediator to trust in each other: "[Developing] that relationship with the [mediator] is antecedent to…developing a more trusting relationship with the other parties to the dispute. Key to this process is confidence that their concerns are acknowledged and understood by others at the mediation table" (p. 25). Active listening and mirroring describe activities designed to establish empathy first between the mediator and the parties. Through active listening, the mediator can "offer tangible assurance to the parties, voicing and demonstrating his or her own concern and understanding for the feelings and emotions experienced by the parties" (Dubler & Marcus, 1994, p. 25). Establishing such respect and concern at moments when emotion runs high can help keep the process on track, Dubler and Marcus argue. In addition, such activity models the sort of respect and concern with which the parties should regard each other. One effective technique for fostering second personhood involves role reversal—the mediator asks the parties to overcome their own viewpoint by actually reversing the roles, values, and interests of the parties. By taking on the interests and values of other parties, the vulnerabilities of each party can be laid bare and empathetic concern established.

The change in stance from positional to interest-based negotiation characterizes the second step of TEC. Such a change facilitates movement to the final stage of ethics facilitation, where options must be generated, evaluated, and consensus reached. As David Casarett, Frona Daskal, and John Lantos argue (1998), often an "immediate obstacle to consensus is unwillingness to engage in dialogue" (p. 9). For Dubler and

Marcus, empathy bridges that gap. Active listening and mirroring allow empathic understanding to be transferred from the ethics consultants to the parties themselves. As the parties begin to understand that they share common interests in resolving their conflict, the setting is ripe for ethics facilitation. The question, in terms of a practical situation like Jamie's case, which prompted this investigation, is whether the parties are ready to move on to the second stage of ethics facilitation.

Part IV: The Conclusion of Jamie's Case and Use of Transformative Ethics Consultation

"Okay, let's summarize what's transpired so far," ethics consultant Dennis McCullough said. "Everyone here wants to make sure that Jamie is provided the best possible care. Mrs. Jackson has said that for her that care would involve taking Jamie home with her. Rev. Williams has collected enough money to provide care for Jamie for six months. He will continue to raise money in an effort to continue providing care for Jamie. One reason Mrs. Jackson and Rev. Williams feel so strongly about caring for Jamie at home is their faith in God. Now, Mrs. Jackson and Rev. Williams realize that there is no way to treat Jamie's pneumonia. It will get progressively worse. Mrs. Jackson says that she will agree to a DNR order so that Jamie will not be transported back to the hospital should he have a cardiopulmonary arrest. Have I got all that right?"

"Yes," Mrs. Jackson responded.

"Now the medical team also wants to make sure Jamie is provided the best possible care. For them, that care can either be here in the hospital or at home. If it is here

in the hospital, the medical team cannot in good conscience continue to provide food and water for Jamie. They have offered to give Jamie small sips of water to quench his thirst, to use glycerin swabs to keep his mouth and lips moist, and give him ice chips. They have even offered to have you and Rev. Williams take part in providing this care to Jamie. If you take Jamie home, the medical team understands your right as his mother to provide him food and water. To facilitate that option, should it be the one everyone agrees on, the team has agreed to provide medications to help Jamie's bowels pass the food and water. Jamie is not stable enough for a surgery to correct his bowel obstruction."

"Right," Dr. Cassidy agreed.

"So," Dennis concluded, "everyone wants the best possible care for Jamie. There's just disagreement as to how and by whom that care should be delivered."

What has transpired, in terms of process and substance, to enable the ethics consultants to reach the point of generating options to resolve the case? First, all the parties agreed that some decision had to be reached. They could not delay coming to some sort of agreement, even if everyone did not agree with every detail of the agreement. After securing agreement on that first point, the ethics consultants focused attention on the emotions of moral distress present among the parties.

The ethics consultants asked Mrs. Jackson to explain how she felt about the care Jamie had received. She described her gradual decline in trust as Jamie was bounced from facility to facility.

"There's just no trust left. Not now, after all Jamie's been through. Hearing that you wanted to give up, just to throw up your hands and give up, on Jamie in his time of need was all I could take. I know that his lungs are bad and that there's nothing you can do to stop that. But, not to give him food and water—that's just abandoning him. And I won't let that happen."

"So you don't trust these doctors?" ethics consultant Kendra Davidson asked.

"I don't trust any doctor who wants to give up on my Jamie!"

Nurse Doris Evans reached over and held Mrs. Jackson's hand. "I have seen you take care of Jamie for three years. I was here, you remember, when Jamie first had his accident."

Mrs. Jackson smiled briefly and nodded her head.

"You've had to be Jamie's rock, when it seemed that everyone was just giving up," Doris continued. "That's a tough job. I'm a mom, too, and I don't know that I could have done what you've had to do, especially given all that's happened to your family in the past few years. What would it take to show you that we don't want to give up on Jamie?"

Mrs. Jackson looked into Doris' eyes. "Letting me take him home."

The turning point, however, occurred when Mrs. Jackson asked to see Jamie's X-rays, CT scans, EEGs, and other test results. Dr. Cassidy offered to sit down with Mrs. Jackson and Rev. Williams and have one of the neurosurgeons who operated on Jamie three years ago review the results and explain them. That meeting had taken place yesterday. No one had even sat down with Mrs. Jackson or Rev. Williams and explained

the overwhelming evidence of Jamie's decline. After that meeting, Mrs. Jackson had agreed to a DNR order, but on the condition that Jamie continue to be fed and hydrated until either she took him home or the conclusion of the ethics consultation. The medical team agreed.

Securing these preliminary agreements may have seemed like stop-gap measures, but for these parties, it helped establish the trust, respect, and concern in the ethics consultants to guide the process fairly. After seeing that agreement was possible and that each party was willing to hear and understand the interests and values of the other, a shift in moral orientation occurred—not to fully overcoming one's own perspective and understanding the interests of the other, but shifting from a positional stance to a collaborative stance. The parties had unconsciously determined that a collaborative solution was possible as long as it incorporated their individual interpretation of their cherished values. In a sense, the parties reached a consensus that the norm *care* would guide their collaborative efforts. Care means different things to each party, but the use of the norm was mutually agreed upon. Care was a norm that helped integrate the individual values and interests into one moral construct. Use of this norm enabled the mediators to develop a problem statement upon which the parties could focus their problem-solving efforts—"How best to care for Jamie?"

After the parties agreed on the problem statement, the task of the consultants was to forge options that respected both interpretations of the norm "to care for Jamie." For Mrs. Jackson and Rev. Williams, caring meant taking him home and feeding him until either Jamie died or Medicaid took over his care and he could be placed in a long term

care facility. For the team, caring meant that the value of professional integrity and nonmaleficence could not compromised—they would not offer surgery to repair Jamie's bowel obstruction nor provide him food and water because it might cause him (and them) suffering and was a medically ineffective therapy given Jamie's goals of treatment and poor prognosis.

Left with these options, the consultants needed to encourage the parties to agree to certain measures that would facilitate their implementation. In the former case, if Jamie were to be taken home, the team would have to agree to provide medications to allow Jamie's bowels to move. The effort might prove futile, but if offered with a full disclosure of its likely effects (or lack thereof), it would show that the team respected Mrs. Jackson's choice as an agent of value. In addition, Mrs. Jackson would have to agree to a DNR order for Jamie so that he would not be transported back to the hospital should he arrest.[64] The option proposed had the support of all parties, for it contained the individual interpretations of what it meant to care for Jamie. Although it may have seemed like a compromise, it was not. A compromise would have asked the parties to concede not only to particular actions, but also to the values underlying those actions—with which they may have fervently disagreed. Rather, the parties reached consensus—in the senses intended in ethics facilitation, TEC, and discourse ethics.

One question remains to be answered. If TEC relies so heavily on techniques and processes from mediation, why not just substitute a mediation process for such cases

[64]The state in which Jamie's case occurred had laws ensuring that paramedics and other first responders did not resuscitate and/or transport patients in cardiac arrest who had valid "EMS-DNR" orders. Protocols were established so that pain medications could be administered to ease suffering, but persons who had valid EMS-DNR orders were not to be hospitalized.

when ethics facilitation fails? Such a sentiment is endorsed by the authors of *Core Competencies* (ASBH, 1998, p. 8). As I will show in the next chapter, TEC is not equivalent to mediation despite the fact that it relies on many of the techniques and processes of that conflict resolution model. In fact, the use of TEC represents a superior option for ethics consultants when conflict seems intractable, for it does not require the substitution of persons who tried to facilitate a resolution with impartial, third party mediators. Such a substitution would require that the parties must re-hash the elements of the case and re-establish trust in new people. Nevertheless in some cases, it must be acknowledged such a course of action might help (such as when parties are angry with the consultants and will refuse to engage in ethics consultation).

particular. The strongest criticisms concern the supposed neutral or impartial stance mediators must take to the conflicts in which they intervene. Such impartiality is either not appropriate for ethics consultation or it is impossible to achieve, opponents of bioethics mediation argue. In this chapter, however, I will differentiate between TEC and mediation by suggesting a new understanding of impartiality for ethics consultation that comports with the approach posited in *Core Competencies*. If impartiality only extends to the parties and their values, not to the norms used to reach the outcome, TEC is liberated from such criticisms, although it might be open to others.

Part I: Critiques of Bioethics Mediation

Many sources in the bioethics literature on ethics consultation reference the role that the mediation process, mediation skills and techniques, or mediators play in resolving bioethical problems (Spielman, n.d.; Moreno, 1991b; Frader, 1992; Wagener, 1992; West, 1992; West & Gibson, 1992; Scofield, 1993; Walker, 1993; Baylis, 1994; Dubler & Marcus, 1994; Gibson, 1994; Hoffmann, 1994a; Hoffmann, 1994b; Lynch, 1994; Reynolds, 1994; Rubin & Zoloth-Dorfman, 1994; American Hospital Association & CPR Institute for Dispute Resolution, 1995; Craig, 1996; Glidewell, 1996; Waldman, 1997a; Waldman, 1997b; SHHV & SBC, 1997; ASBH, 1998; Casarett et al., 1998; Dubler, 1998; Welie, 1998; Gibson, 1999).

Despite its prevalence in the ethics consultation literature, few sources argue that mediation can serve as a stand-alone consultation modality. Nancy Dubler and Leonard Marcus (1994) outline such a model in their book *Mediating Bioethical Disputes: A*

Practical Guide. Like traditional configurations of the mediation process, Dubler and Marcus argue that a bioethics mediator must be impartial. The goal behind bioethics mediation is to help transform parties' initial positional stances to a conflict or uncertainty into shared opportunities for dialogue and resolution. Dubler and Marcus argue that impartiality—where the mediator does not favor any particular parties' position—facilitates this transformation. The goal of bioethics mediation should be a consensus solution, generated in light of common interests and in comportment with established and recognized ethical and legal standards.

Other bioethics mediation supporters, like Yvonne Craig (1996), tout that mediation enhances patient autonomy. Again, the reason concerns the impartial stance the mediator takes to disputes. Impartiality, Craig argues, empowers parties and encourages moral ownership of the problem. The claim of impartiality, however, has received significant criticism. Opponents argue that bioethics mediation is an inappropriate method for resolving particular clinical problems because the neutral or impartial role of the mediator is either not appropriate for ethics consultation or impossible to achieve. Exploration of criticisms provides a segue to consider central differences between bioethics mediation and TEC in the second part of this chapter.

Professionalization and the Façade of Mediator Neutrality and Impartiality. Of the four generic mediation stages I introduced in Chapter Seven, the second focuses on narrative. Mediation parties relate their perspective of the situation in their own words and without interruption. The mediators acknowledge any emotive content in such narratives and use communication techniques like active listening or mirroring to

represent the substance of the narrative to other parties. The goal is to ensure that all parties have a similar understanding of the situation, that all parties have a comprehensive account of "the facts" as each of them understands them, and that the mediator has made the parties comfortable expressing their views and concerns.

In Chapter Seven I presented Walker's account of morality as narrative in nature and introduced the role of the ethicist as a mediator of divergent narratives and an architect of the moral space for such mediation. Stories provide robust descriptions of our moral experiences, blending emotion, rationality, perception, and judgment into one corpus. Walker's idea of ethics as narrative and ethics consultation as architecture and mediation is not without its critics. Giles Scofield (1993) attacks Walker on both points. Scofield argues that ethics consultation should not be considered a profession, and thus efforts at professionalization should not be attempted. His rationale for this claim concerns an inability of ethicists to articulate, teach, test, and certify what amounts to ethical expertise. In addition, Scofield believes that ethics consultation, because it assumes that its practitioners somehow have the market on moral expertise, represents the antithesis to the democratic understanding of morality—that all persons are moral equals.

Scofield cites Walker as a scholar who seems to share his criticism regarding the inappropriateness of ethical expertise. Instead of suggesting that ethicists are experts or ethical engineers who master code-like theories and use this knowledge to solve moral problems for their owners, Walker proposes the idea that ethics consultants should be regarded as architects or mediators. Their role is not to solve moral difficulties for the parties experiencing them, but rather to create the moral space where conversations can

occur. Such a role should uphold and operationalize a commitment to moral pluralism—that all persons are moral equals. Moreover, it would emphasize the role of narrative dialogue and conversation above any expertise in moral theory the ethicist brings to the consultation. Although Scofield does not object to keeping moral space open and conversation free-flowing, he articulates two concerns with the roles for which Walker argues. Both concern professionalization.

The first criticism focuses on the architect metaphor. For Scofield, architecture, like engineering, is a profession, whose members possess a kind of knowledge that distinguishes them from others. Thus, Scofield argues that Walker begs the very question she charges traditional ethics of emphasizing—that ethics consultants have some sort of ethical expertise that others do not. Moreover, Scofield takes Walker's metaphor—that like architects, ethicists create moral space—and turns it on its head. He argues that:

> architects do not create space; they create enclosures. The space is less open after the architect has fenced it in. If ethics consultants are architects, how do they separate what is inside from what is outside our supposedly open moral space? Does the wall they create keep certain types of knowledge outside? What sort of enclosure can be open to all yet closed to some at the same time? Instead of keeping the moral domain open, aren't ethics consultants fencing it in (Scofield, 1993, p. 20)?

For Scofield, the inversion of Walker's architect metaphor exemplifies his concerns regarding the professionalization of ethics consultation. According to Scofield, ethics consultants are carving out this corner of morality and attempting to make it their own by suggesting that only they possess the unique set of skills and knowledge to facilitate ethical conversations. If so, then all the well-intended notions about increasing patient autonomy or protecting patient interests that has characterized much of ethics

consultation must be secondary to the concerns of marketshare. Professionalization of ethics consultation will, according to Scofield, take the democratic process for resolving disputes out of the hands of the disputing parties and place them in the hands of a qualified moral expert.

Scofield also criticizes Walker's mediator role. He argues that the consultant's role as a mediator seems objective and impartial, but it is not. The mere involvement of the consultant violates this notion of objective neutrality: "It is impossible to mediate a discussion without affecting, even influencing, it. ...[W]e should not delude ourselves into thinking that they [ethicists] do not, cannot or will not influence how others discuss and deliberate ethical dilemmas" (Scofield, 1993, p. 20). In essence, Scofield objects to the implicit moral superiority inherent in casting ethics consultants as architects or mediators. Both still presuppose some sort of ethical or conversational expertise, he argues, which "is hardly a benign claim. If consent is the essence of democracy, and conversation is the essence of consent, then the ethics consultant's claim is that some individuals know better than others what needs to be said and how conversations ought to proceed" (Scofield 1993, p. 20).

It might seem that Scofield has leveled significant criticism against the role of the ethics consultant as a mediator. However, casting the role of a bioethics mediator or a bioethicist using mediation techniques less in terms of neutrality and more in terms a midwife of authentic dialogue might salvage bioethics mediation from Scofield's two criticisms. As I have suggested in Chapter Five, TEC accords with Árnason's midwife metaphor. The midwife metaphor allows the parties problem ownership while supplying

what Scofield criticizes as "ethical expertise" in such a way that does not violate the democracy of the process. The expertise is used not to usurp the authenticity of the parties, but rather to enhance it by guiding a process to integrate, on both the intrapersonal and interpersonal levels, emotion and reason within the process of perception and judgment.

However, author Diane Hoffmann takes Scofield's criticism one step further and suggests that the supposed neutrality or impartiality of the mediator poses a paradox for its use in ethics consultation. Not only is impartiality impossible to achieve, it is not appropriate for ethics consultation. Examination of her evidence for this claim, in tandem with Scofield's criticisms, provides an opportunity to clarify the appropriate use of norms in ethics consultation and how the use of bioethics mediation in TEC can be salvaged from the criticisms of these two strong mediation opponents.

The Paradox of Neutrality or Impartiality. Hoffmann argues directly against authors, like Craig, who suggest that mediation enhances patient autonomy. Like Scofield, Hoffmann contends that the supposed impartiality of the mediator is a façade. If mediation enhances autonomy, Hoffmann reasons, then the parties should be the primary decision-makers. The mediator should both refrain from inputting values into the debate and not force the parties to use particular norms to reach agreement. Since mediators cannot help but shape the discussion with their own values, and bioethics mediation, in particular, must use relevant norms from ethics, policy, and the law (Scofield, 1993;

Dubler & Marcus, 1994; Hoffmann, 1994b; Waldman, 1997a; Waldman, 1997b), then the argument that mediation enhances autonomy does not hold.[66]

Traditional mediation, Hoffmann argues, attempts to place the decision-making onus on the parties by eschewing reliance on outside norms and by ensuring the neutrality of the mediator. The principles and rules of justice governing legal and civil interaction between persons are suspended in mediation and the parties are free to create their understandings of such principles and rules. Neither are appropriate for ethics consultation, however. *Core Competencies* suggests that a pure facilitation (or a pure mediation) approach might yield a consensus that falls outside of culturally enshrined and societally acknowledged ethical and legal limits. But even if neutrality can be achieved, Hoffmann continues, mediators cannot guarantee the fairness of the proceedings because their supposed neutrality makes it inappropriate to enter the fray of the conflict to prevent power imbalances. The impartial role of the mediator, Hoffmann argues, seems at odds with the ability to ensure balance of power. Since mediators may not interfere with the substance of the resulting agreement, they lack an effective means to ensure the fairness of the outcome. To fully state the paradox, not only is impartiality a façade, but that same impartiality, intended to ensure a balance of power between the parties, prevents the mediator from ensuring the fairness of agreements.

[66]Hoffmann's criticism parallels my own regarding the amount of consultant-driven moral work that ethics facilitation presupposes. The challenge is to strike a balance between guiding the process while allowing the intrapersonal and interpersonal authenticity of the parties to take center stage. Thus, applications of mediation, like TEC, may not enhance the autonomy of the decision-makers, it does enhance their authenticity.

The paradox seems to doom mediation from playing any appropriate role in ethics consultation and thus TEC. Ethics facilitation and, by implication, TEC clearly mandate that ethics consultants not impose their own values on the parties. In essence, the ethics consultants must be "impartial" towards the parties and the use of their own values and preferences. However, ethics facilitation requires partiality towards the outcome—the decisions reached must accord with (or at least not violate) socially, ethically, and legally recognized standards. Thus, the ethics consultants cannot be impartial to the outcome or to the use of norms used to reach that outcome. These distinctions, if they are valid, between impartiality—towards parties, towards outcome, and towards norms—indicates that Hoffmann and Scofield may have conflated the notion of impartiality in their analyses. Although the paradox of impartiality might apply to traditionally structured mediation, the paradox lacks applicability to bioethics mediation and the use of mediation processes and skills in TEC, as I will show in the next section.

Part II: The Use of Norms in Ethics Consultation: Why TEC and Bioethics Mediation are Not Equivalent

Three Types of Norm-Based Mediation. On the basis of her critique of using mediation to resolve certain ethical conflicts, Hoffmann asks about the appropriate place of norms in mediation. Mediation, traditionally structured and practiced, presupposes that parties will generate the norms that will constrain the options and solutions to resolve a case. Ellen Waldman (1997a; 1997b) terms such traditional mediation norm-generation. She contrasts norm-generation with two other norm-based approaches to mediation:

norm-education and norm-advocation, both of which apply to mediation, bioethics mediation, and, by implication, to TEC. These three types of norm-based mediation help to distinguish several subtypes of impartiality, one of which comports with the ethics facilitation approach promulgated in *Core Competencies*.

Waldman argues that norm-generation has its place in mediation and in bioethics. Some bioethical conflicts or uncertainties involve cases where no norm has been societally agreed upon to guide resolution. Waldman points to futility disputes as an example. In contrast, norm-education involves educating the parties regarding the legal and ethical norms at stake, but allows the parties to judge how to apply or interpret such norms. Waldman argues that rarely is norm-education useful for mediating bioethical disputes. It would be inappropriate to educate the parties regarding a consensus norm in bioethics, but then tell them to feel free to interpret it how they want or to discard it altogether. Finally, norm-advocation involves educating the parties regarding the relevant legal, social, and ethical norms, but the mediator urges the inclusion of particular norms in the resolution.

Norm-advocation seems to mirror the stance in *Core Competencies* that consensus should not be accepted if it does not fall within a socially accepted range of ethical options. Moreover, norm-advocation seems to involve constraining the "substance" of agreements to ensure not only the fairness of the outcome (Hoffmann's worry) but also accomplishes it in such a way that does not violate the autonomy of the parties or the democracy of the process (Scofield's worry). Thus, while norm-advocation might be

appropriate for bioethics mediation, norm-education is certainly not, and norm-generation, the traditional structuring of mediation, has limited utility.

The Use of Norms in Bioethics Mediation and a Parallel in Ethics Consultation. Hoffmann argues that end-of-life disputes in particular ought not be resolved by traditional applications of mediation. First, mediation presupposes that the parties are all competent to negotiate. In end-of-life disputes, often the party whose interests are the subject of the mediation is incapacitated or incompetent and cannot participate. Thus, Hoffmann worries that no one in mediation will be properly able to represent the values of the patient and negotiate in good faith on his or her behalf.[67] Mediation may not be able to ensure the adequate protection of the patient's rights, she argues.

Hoffmann's worry regarding the use of norms in mediation has a correlate in ethics consultation. The bioethics literature has debated several questions related to the appropriate use of norms in ethics consultation. Should ethics consultants be patient advocates and ensure the protection of the patients? Should ethics consultants make recommendations or merely provide moral advice? If ethics consultants make recommendations, should they stem from well articulated and supported personal positions or should they represent consensus opinions from the bioethics literature?

Core Competencies clearly argues that ethics consultants should not advocate for any one party. Such a role clearly violates the consultant's facilitative role. However, the process and interpersonal skills suggest that the appropriate role of the ethics facilitator is

[67]Hoffmann's worry about the lack of patient protection prompts an example of how norm-advocation can ameliorate her concern. Ethics consultants can educate the parties to an end-of-life dispute (one in which the patient is not a participant) regarding the legally and ethically appropriate standards for surrogate decision-making and ensure that the decisions that emerge accord with those standards.

to empower the parties to communicate and ensure that a proper balance of power exists during the consultation. Thus, to answer the first question posed above, the ethics consultants should not be patient advocates in the formal sense of the term, but rather strive to ensure the equal protection of all parties' rights by balancing the power, ensuring effective communication, and facilitating divergent moral views. TEC takes it one step further by attempting to generate empathetic understanding between the parties and so align them as allies in solving a mutual difficulty.

That ethics consultants should not advocate for any party suggests ethics facilitation requires a type of impartiality towards the parties and their values. Impartiality, in this sense, operationalizes an explicit respect for moral pluralism by not privileging any one set of values. Construing impartiality as limited to the parties and their values and preferences provides an answer to the question above regarding recommendations. According to *Core Competencies*, ethics consultants can and should provide recommendations, but in two very different senses. The result of the first stage of ethics facilitation should yield several ethically justifiable options. These are, in effect, the options that ethics consultants could recommend. However, ethics consultants do not have to recommend that specific options be implemented. The only admonition *Core Competencies* provides is that ethics consultants should make it known when they are recommending particular options, especially when such recommendations incorporate the consultants' personal moral views. Disclosure will lessen the tendency such recommendations have to impose the consultant's values on the parties and so usurp their decision-making authority and responsibility.

Core Competencies does not use the language of impartiality or neutrality to describe the role of norms in ethics facilitation. Nevertheless, its warning that ethics consultants be conscious of the influence of their personal moral views on the consultation outcome, coupled with its focus on individual decision-making ownership, suggests that ethics facilitation implicitly utilizes a form of norm-advocation. If consultants do indeed recommend particular options, already determined to be ethically justifiable, they are advocating that particular norms determine the consultation outcome. The only proviso is that *how* such norms are advocated be made explicitly clear—consensus norms from the bioethics literature or personal moral views. Imposing one's own values seems in direct violation of the facilitative role *Core Competencies* outlines. However, norm-advocation does not impose one's personal values but rather socially and ethically accepted values. A clear example concerns situations where the options generated are not ones the consultant would have generated or chosen, but they accord with acknowledged ethical and legal standards.

The challenge for consultants, then, becomes how to avoid imposing their values or seeming to do so by advocating for particular norms to decide the consultation. Strict impartiality is inappropriate for ethics consultation, but how does norm-advocation uphold the sort of impartiality to the parties and their values required by a commitment to moral pluralism? An answer to this question can be found by turning to one of the first publications to articulate the use of bioethics mediation, Dubler and Marcus' *Mediating Bioethics Disputes*. These authors unknowingly affirm norm-advocation as the goal of bioethics mediation.

Dubler and Marcus (1994) argue that the goal of bioethics mediation is a "principled solution"—a solution generated through application of the mediation process that both respects the interests of the parties but also accords with consensus ethical and legal standards (p. 34). A principled solution is Dubler and Marcus' answer to the problem of pure facilitation discussed in *Core Competencies*. In order to protect against facilitated or mediated agreements falling outside of certain socially determined legal and ethical boundaries, agreements using bioethics mediation must not be reached by pure norm-generating mediation. Ethical and legal consensus, where they exist, should guide the resolution in such a way that the ethical and legal norms match the expressed and articulated values of the parties. Where such norms do not exist, perhaps applications of norm-generation bioethics mediation may be appropriate, as Waldman suggests.

Overcoming the Problem of Impartiality. Both Scofield and Hoffman argue that mediator impartiality is a façade. The use of norm-advocation, which seems most appropriate for bioethics mediation, violates the strict impartiality of the mediator. Like Scofield claims, in order to guarantee the integrity of the outcome, the mediator must advocate that certain values or norms take precedence in the consultation. Thus, while the mediator might appear impartial or be impartial in one regard, advocating that certain values should help decide the matter not only usurps the democratic ideals behind traditionally structured norm-generating mediation but also makes the mediator's supposed impartiality disingenuous.

Rather, I argue that we need to reconceive impartiality. Scofield and Hoffman seem to contend that a mediator must be impartial or neutral to *both* the parties *and* the

values or norms used to resolve the dispute. Ethics facilitation requires that consultants be impartial to the former, but not the latter. Thus, impartiality towards the parties—not favoring or advocating for one particular party—supplies an appropriate context for a form of impartiality consistent with ethics facilitation.

Ethics facilitation clearly mandates that ethics consultants not impose their own values on the parties. In essence, a commitment to moral pluralism requires that the ethics consultants be impartial towards the parties, their values and preferences, and even the options generated, so long as they comport with established ethical and legal norms. However, ethics facilitation requires partiality towards the outcome—the decisions reached must accord with (or at least not violate) socially, ethically, and legally recognized standards. Thus, the ethics consultants cannot be impartial to the outcome or to the norms used to reach that outcome. These distinctions between three subtypes of impartiality—towards parties, towards outcome, and towards norms—indicate that Hoffmann and Scofield may have conflated the notion of impartiality in their analyses.

Although the paradox of impartiality might apply to traditionally structured mediation, the paradox lacks applicability to norm-advocation bioethics mediation and the use of mediation processes and skills in ethics consultation. Ethics facilitation requires that no one person's moral values or interests be accorded privileged status. The attempt to reach consensus in ethics facilitation represents a blending designed to uphold impartiality towards the parties and their values but also comportment with recognized ethical, legal, and clinical standards. Mediation modalities that incorporate norm-

advocation, but eschew impartiality towards outcome and norms, comport with ethics facilitation and thus could serve as adjuncts to the ethics facilitation process.

Impartiality towards the parties—not favoring or advocating for one particular party—supplies a proper context for the acceptance of a kind of impartiality in bioethics mediation in general and ethics consultation and TEC in particular. Framed in terms of Árnason's existential notion of authentic interaction, ethics consultants, as midwives of the ethical discourse, can more effectively help the parties reach agreement. By focusing on the procedural aspects of the consensus process, and using norm-advocation to interject moral discourse with bioethical knowledge, consultants empower the parties to overcome their viewpoints and reach substantive agreement on contentious issues.

As I argued in Chapter Seven, the ability of parties to overcome their own viewpoint requires several steps. Impartiality is especially important in validating emotion and showing empathy in TEC. Ethics consultants can be impartial towards the parties yet interject and advocate for specific ethical and legal norms that should be used to decide the case through educational efforts. However, to distinguish such a role from both norm-advocation and impartiality, I characterize the role as one of midwife of authentic interaction. Not only does this characterization help to distinguish bioethics mediation from TEC, but it also frees the process and interpersonal techniques that bioethics mediators use from Scofield's and Hoffmann's criticisms. Thus, these process and interpersonal techniques can be utilized in TEC, which advocates the same kind of impartiality towards the parties that the ethics facilitation approach does. Such impartiality implies that ethics consultants be midwives to the discourse, helping it along

with various communicative techniques and processes (some from bioethics mediation), but leaving the real moral labor to the parties. Most important, however, structuring the sort of impartiality towards the parties in terms of norm-advocation distinguishes TEC from traditional mediation and its particular criticisms.

Conclusion

Transformative Ethics Consultation, its Shortcomings, and Ways to Overcome Them

> "The inability to 'let go' may express an inability to complete relationships as much as love for a dying family member. In any case, love requires us to let go, as Simone Weil somewhere reminds us: 'in loving, we need to learn only how to let go; holding comes naturally.'"
>
> —John Hardwig, 2000, p. 29.

Conclusion

As Jamie's case illustrated, the inability to "let go" can cause value conflict between health care providers and surrogates. As I have tried to show in this dissertation, the ability to "let go" involves a complex process of overcoming one's own perspective. Perceiving the needs of a dying loved one and judging them as more important than our own needs involves a dynamic, integrative process of perception, judgment, and action that combines emotional and cognitive faculties. In Jamie's case, emotional, religious, and interpersonal factors prevented Mrs. Jackson and Rev. Williams from achieving the proper orientation in order to "let go." But, as the case resolution depicted in light of TEC suggested, ethics consultants can help parties experiencing an inability to "let go" (an example of an intrapersonal moral difficulty that can cause impasse to ethics facilitation) achieve the proper moral orientation.

The ability of ethics consultants to recognize the need for TEC is one matter. The ability of TEC to address the inability of parties to "let go" (of their loved one, their values, and their viewpoints) depends on the willingness and ability of parties to view others as moral equals, deserving of moral respect and concern. As I argued, sometimes

ethics consultations are not the most appropriate venue for TEC. As an adjunct to the ethics facilitation process, TEC can help address lack of empathy between patients, surrogates, and clinicians. Moreover, TEC has educational uses beyond resolving conflicts. TEC and the skills that comprise it can be taught to health professions students in order to help them recognize situations that call for empathetic attunement. But, the question remains whether TEC has shortcomings of its own, unique to its own goals, procedures, and skills. In the following paragraphs I consider some of TEC's shortcomings and either posit avenues of future research that will hopefully answer.

TEC and the Shortcomings of Ethics Facilitation. As an adjunct to ethics facilitation, TEC may be open to the criticisms of that method, which have been quite extensive. A special issue of the *Journal of Clinical Ethics* has been devoted to discussion of ethics facilitation. One article in particular presents three shortcomings of ethics facilitation that help to distinguish TEC from ethics facilitation. Edmund Howe (1999) charges ethics facilitation with three flawed presuppositions. All concern power and trust and help crystallize my own criticisms of ethics facilitation and its emphasis on consultant-directed responsibilities.

Howe argues that the first stage of ethics facilitation, in which the consultant helps generate options, may be flawed because it assumes that the consultant can simultaneously exert decision-making authority and maintain the trust of the parties. TEC clearly recognizes this fundamental flaw and addresses it squarely by triggering an initial trust-building stage before options are explored. This initial trust-building stage, followed by less consultant-led option generation, enhances the authenticity of the parties. The

consultant does not exert decision-making authority over the options. By placing less decision-making authority on the consultant and transferring that authority to the parties, the consultant can concentrate on establishing trust and infusing the discussion of options with knowledge from moral theory and bioethics in a way that is not destructive to trust-building.

Howe's second criticism concerns the ability of the consultant to forge consensus and maintain trust at the same time. Again, by placing the responsibility for reaching consensus on the shoulders of the parties, who, with the help of the consultant, must expand their own viewpoint, TEC is not as susceptible to this criticism as ethics facilitation. Ethics facilitation places the onus on the consultant to reach consensus for one of the options. It is up to the consultant to interpret the discourse and to determine which option has the best chance of meeting the values and goals of the parties. TEC reverses this moral responsibility. Using TEC, the consultant can concentrate on helping the parties to maintain the proper moral stance to one another and keeping the discourse on track while not worrying about foisting his or her own interpretation of consensus for one particular option on the parties.

Howe, a psychiatrist by training, suggests that many ethics consultation parties may act irrationally and may not be able to separate their feelings towards the consultants regarding the two shortcomings. Parties may feel distrustful of a consultant who tries to make decisions for them or they may fear that the consultant is more interested in reaching agreement than in truly understanding their concerns. A quote from Howe regarding these points illustrates the essential rationale behind TEC. Consultants might

not be aware of parties' unconscious feelings of anger towards them, Howe argues. Hence, "ethics consultants may not recognize that patients may be acting out unconscious feelings, rather than expressing what they genuinely want. ...[Thus,] ethics consultants may err by seeking an ethical solution when an emotional intervention is needed" (p. 20, including text from an accompanying footnote). TEC is, in essence, such an emotional intervention—one designed to acknowledge whatever feelings the parties may be experiencing. One such feeling could be fear or distrust of the consultants. By acknowledging such feelings, the consultants can show they are concerned about what the parties feel. Clearly delineating the boundaries of the consultants—who will only facilitate, and not make, the actual decision—can help the parties better understand the consultant's role. Ensuring parties' trust in the process is antecedent to building trust with the consultants.

Nevertheless, if such "irrational" concerns persist after the attempt to qualify the role of the consultants and engender trust in the process, no process may be able to help the parties facilitate consensus. Such is the case with the problem of false belief. For instance, if Rev. Williams had persisted in his belief that withdrawing food and water would starve Jamie to death after exploration, expression, and acknowledgment by others of his anger and distrust, the consultation could not proceed. What other mechanisms could be triggered after the consultation depends on individual health facility policies about dispute resolution—administrative review, involvement of counselors, ombudspersons, or other advocates, going to court, or a third-party mediation by an

outside, unaffiliated community member. At heart, however, while TEC is certainly amenable to the problem of false belief, so is every other consultation modality.

TEC and its Reliance on Bioethics Mediation. As a process that depends greatly on mediation skills and processes, TEC could be said to be open to the criticisms of bioethics mediation. However, as I suggested in Chapter Eight, criticisms related to the undesirability of bioethics mediation in ethics consultation can be effectively countered by positing a new understanding of impartiality in ethics consultation.

The challenge from critics of bioethics mediation concerns the supposed impartiality of the mediator. On the one hand, if the mediator is supposed to be truly impartial, he or she must refrain from interjecting the mediation with values or norms. The values and norms must be created by and agreed upon by the parties. If adapted to ethics consultation, such a model may allow certain agreements to be reached that would be considered unethical or that would override important values or norms that should have primacy in the consultation. On the other hand, impartiality requires that the mediator not intervene to engineer the outcome or to prevent agreements, even unethical ones, from being reached. Thus, bioethics mediation critics argue, the impartiality of the mediator creates an untenable, undesirable, and paradoxical set of process constraints. The mediator cannot infuse the discussion with values or norms, nor can he or she prevent the parties from eventually agreeing to unethical outcomes.

Such a depiction of the role of mediation in ethics consultation, I argue, is a caricature. Strict impartiality is not imputed in the sources that suggest a role for mediation in ethics consultation. For example, Dubler and Marcus suggest that the

outcome to consultations should be a principled solution—a consensus between the parties that accords with ethical and legal societal standards. TEC suggests the very same outcome. Even examination of the ethics facilitation process suggests a form of impartiality that is appropriate to ethics consultation. Respect for autonomy presumes a type of impartiality towards the values and norms that the parties bring to the table. That same impartiality, however, does not extend to the outcome of the consultation. The consultant must be able to ensure that the agreements reached are ethically and legally appropriate to the context of the situation at hand. Bioethics mediation critics suggest that impartiality extends to all three—the values and norms agreed upon during the consultation, the interpretation of values and norms by the parties, and the agreements reached at the resolution. Such an all-encompassing notion of impartiality conflates these three elements into one. Rather, I suggest that impartiality need only extend to the values and norms and how the parties interpret them, not to the outcome reached. This understanding of impartiality helps to distinguish TEC from this criticism of bioethics mediation.

TEC: Where's the Beef? As a communication process designed to address and integrate the emotional concerns of the parties with cognitive processing, is TEC really an *ethics* consultation method? In essence, this criticism demands to know "Where's the ethics?" in TEC. Such a criticism also seems to be concerned with labeling the interpersonal resolution of health care disputes "ethics consultation." Such disputes may involve social issues, strong emotions, and other elements, but where is the ethical issue or value conflict, which is the domain of so-called ethics consultants? A skilled social

worker, without a background in moral theory, should be able to resolve disputes of this nature, claims *Core Competencies* author Charles Bosk (2000, personal communication).

Susan Rubin and Laurie Zoloth-Dorfman (1994) address this question in their article "First-Person Plural: Community and Method in Ethics Consultation." My response to Bosk's criticism resembles the answer Rubin and Zoloth-Dorfman offer in their article. The answer squarely depends on how one defines a moral or ethical problem or conflict. For Rubin and Zoloth-Dorfman (1994), ethics consultations are necessary and not reducible to "instances of psychological dysfunction, communication problems, or personality conflicts" because "there is no broad consensus about what is right and good in each and every case, and there is no simple formulaic question that will uncover the inherent truth or answer to each conflict" (p. 52).

My response differs in one regard to that of Rubin and Zoloth-Dorfman's. I define a moral or ethical problem or conflict differently. By basing my account of what is moral or ethical on the phenomenological account of how we perceive others and what communicative preconditions must exist to relate to one another, my definition is somewhat broad. The definition would be narrower if the account were solely based on Habermas' notion of consensus repair, for a norm or its interpretation would have to be in question. On my account, all that needs to be present for an occasion to be considered moral is the presence of two or more persons who must reach a decision jointly. In order to do this authentically, the persons must be able to relate morally or ethically to one another as subjects of respect and concern. Once again, the words of phenomenologist

Levinas provide a vivid metaphor—the face of the other presents itself to me such that I have an ethical responsibility to that other.

So, while Bosk's criticism may in fact be correct—a skilled social worker without training in moral theory could resolve the sorts of cases that incite charged emotional difficulties—the *moral* task before the consultants and the parties does not diminish. The consultant must be able to help the parties to achieve the preconditions necessary so that they can relate ethically or morally to one another. And, yes, while a skilled social worker can help achieve this goal, reaching the goal represents a moral achievement, and the TEC process used to reach the goal in certain cases represents a distinctly *moral* way for persons to communicate and resolve a joint difficulty. As Vetlesen argues, without establishing an emotional and empathetic bond with others, true moral understanding cannot occur—one moral subject will fail to address the other in a manner that respects the unique personhood of that other.

Consensus about Consensus? As a process that has consensus as its goal, TEC may suffer from the same criticisms as other consultation modalities that include this goal as the outcome for moral intervention. The criticisms range from whether consensus is even an appropriate goal of morality to whether there is consensus as to what consensus is and what it would look like in ethics consultation. While these topics could be dissertations in themselves, it is necessary to survey some of the criticisms and respond to them at least briefly.

Core Competencies defines consensus as "agreement by all parties" (ASBH, 1998, p. 7). Perhaps it is this type of definition that is problematic for consensus. For

instance, while Habermas' discussion of consensus concerns the same endpoint for consensus, several preconditions are necessary to reach the goal, and the discourse to achieve consensus has two constraints. Individuals must have respect for each other as moral equals (which pragmatically translates to veto power over the inclusion of certain norms or interpretation of norms) and concern for the common good (which pragmatically translates to the ability to overcome one's own viewpoint and achieve empathetic attunement with the interests of others). While not without criticisms of its own, the consensus process Habermas endorses may enjoy more justifcatory status than ethics facilitation's due to the inclusion of these constraints and the amount of time Habermas spends in justifying consensus as an appropriate ground for morality. In essence, Habermas devotes much discussion and analysis to provide consensus independent moral authority, where *Core Competencies* does not.

On another level, the contrast between Habermas' discourse ethics and ethics facilitation helps delineate several distinctions between types of consensus found in the literature on the subject. Is consensus a product, a process, or both? And is consensus descriptive or prescriptive? Perhaps one objection to consensus as defined by *Core Competencies* is its emphasis on outcome—agreement by all parties. Habermas viewed consensus as both process and product, and since TEC views it similarly, the consensus reached is less likely to result in hasty or unstable consensus. These distinctions are discussed in great detail in Jonathan Moreno's book on consensus, *Deciding Together: Bioethics and Moral Consensus.*

Although Moreno spends time distinguishing between whether consensus is product or process and descriptive or proscriptive in nature, he eventually finds these distinctions do not help elucidate the essential features of consensus. Rather than dichotomizing consensus into these categories, Moreno finds a phenomenological notion of consensus—one that parallels Habermas' understanding of the concept—more satisfactory. The phenomenological motifs emerge in examining the difference between consensus and compromise. According to Moreno, despite the fact that in common parlance, the two terms are used interchangeably, there is a crucial difference between consensus and compromise. In fact, he suggests that "consensus involves reaching agreement on one of a number of theoretically available compromises" (Moreno, 1995, p. 45). The process of reaching a compromise presumes that the parties values or views are fixed, and all that is required is agreement on a course of action. In contrast, consensus relies more on the phenomenological notion of changing one's perception regarding possible viewpoints. As Moreno (1995) states, consensus "suggests an openness to unanticipated possibilities and points of view. At a deeper level, it holds out the prospect that individuals will themselves change as a result of the process, that they will achieve perspectives that had not been available to them before" (p. 45). Much like the goal of TEC, Moreno (1995) suggests that when consensus is construed as openness to possibilities and to overcoming one's own viewpoint, consensus can be a transformative force for the parties engaging in the dialogue to reach the goal: "whatever its failings, consensus at least suggests the possibility that particularistic self-concern may be transformed into a sense of what persons value in common" (p. 39).

The concept endorsed in *Core Competencies* does not concern individual transformation. Rather, consensus in ethics facilitation seems more akin to what Moreno describes as compromise: "Usually a situation in which the realistic goal is compromise offers at best the prospect of a modus vivendi, an arrangement that makes living feasible in spite of continuing difficulties, whereas a situation in which one may reasonably aspire to consensus can, for well or ill, involve a true…transformation" (p. 46). Thus, to parallel Moreno's language, whatever its failings, the concept of consensus underlying TEC best approximates the nuanced understanding as process *and* product rather than reducing consensus to the only legitimate outcome for ethics consultation as ethics facilitation does.

Another potential problem with consensus concerns not how it is defined, but its appropriateness in moral decision-making. The fact that consensus seems ubiquitous in moral decision-making does not negate the fact that many authors have observed a multitude of problems with consensus. Bruce Jennings (1991) notes that consensus may reinforce established patterns of dominance and power by avoiding or neutralizing conflict, by smoothing over rough patches of moral disagreement, and by diluting responsibility among groups charged with decision-making. In his now classic article on consensus, Bernard Lo notes that some ethics committees may reach consensus without soliciting the input of all parties. A strong chairperson or other member of the committee may deem a certain position or decision consensual when in fact, true consensus, agreement by all parties, may not be present. Lo labels such "consensus" an instance of

groupthink, after George Orwell's Newspeak from *1984*. TEC attempts to protect against these dangers associated with consensus by encouraging authenticity in the parties.

Specifically related to ethics facilitation, *Core Competencies* authors Mark Aulisio and Robert Arnold (1991) argue that there may not consensus about consensus. Despite the fact that several methods of ethics consulting—clinical pragmatism, ethics facilitation, and mediation—appear to share the same consensus method of reaching resolution, Aulisio and Arnold warn that more is needed to determine the presence of a consensus regarding the use of consensus in ethics consultation. Aulisio and Arnold are responding to author Patricia Martin, who endorses a consensus method for ethics consulting on the basis of these three complementary methods. Aulisio and Arnold believe that Martin sees a consensus about methodology, when, in fact, there may not be one.

While the particular concerns regarding consensus posited by Aulisio and Arnold do not affect TEC, the shortcomings they identify with Martin's consensus method have applicability. Aulisio and Arnold argue that Martin's method is best suited for consultations done by individuals or a small team of consultants. The same claim could be made against TEC. There is no consensus regarding the most appropriate way to conduct consultations—by committee, by individuals, or by teams of individuals. TEC, however, is best used by a team of individuals whose backgrounds and training can

complement one another.[68] TEC skills, however, could be utilized by committees when they conduct consultations.

The second shortcoming Aulisio and Arnold identify with Martin's consensus process is that it requires a formal meeting. Sometimes, they argue, a formal meeting is not required or wanted. TEC maintains the same position. Its adaptability—as an adjunct to formal ethics facilitations or as a stand-alone methodology to address emotional concerns—is a virtue in this respect. As Aulisio and Arnold (1999) suggest, "the need for many ethics consults stems more from factual, psychological, or interpersonal issues than it does from underlying value differences" (p. 328). Such a claim represents the essential reasoning behind positing the TEC process.

The third shortcoming stems from the second. Formal meetings can sometimes impede communication. As Aulisio and Arnold (1999) note, "certain people may find it very difficult to express their views in the context of a formal meeting" (p. 328). Again, the adaptability of TEC lends itself to such concerns. TEC can begin as a formal consultation meeting, change to individual sessions where parties may feel more comfortable expressing their views, then reconvene with a formal meeting. Or, TEC can begin as an individual session and then turn into a formal group session after the parties

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[68]Jeffrey Spike and Jane Greenlaw argue that in acute-care settings, ethics consultation by committee has several drawbacks. The quick evolution and nature of acute-care ethical difficulties makes convening a 10-15 person committee unwieldy. The appointment of members based on job description rather than interest and training in ethics makes consultation by committee less effective than by teams of highly trained consultants. Groupthink is a third danger: "One member, such as the most politically powerful person (a member of the hospital administration or the hospital attorney), can easily and sometimes inadvertently dominate the decision-making process" (Spike & Greenlaw, 2000, p. 55). The most compelling reason consultations by teams of consultants, however, is the fact that the private opportunity of parties to tell their perspective of the case becomes "impersonal at best" or "inquisitions at worst" before committees (Spike & Greenlaw, 2000, p. 55). TEC has the flexibility and adaptability for either way of conducting consultations, although it, too, is most amenable to consultation by teams.

feel comfortable expressing their views. The combinations of uses of TEC and TEC skills can be easily adapted to the particular needs of the parties.

The one problem Aulisio and Arnold identify that TEC has at present is testability. Currently, TEC is pure conjecture based on a small number of particular cases and evidence from the bioethics literature. Nevertheless, it is possible to test TEC's effectiveness by training ethics consultants in the techniques and seeing how they fare compared to colleagues without such training. Such empirical testing represents an avenue of further research.

In terms of additional further efforts, the research underlying transformative ethics consultation has benefits of its own that could be translated into training programs for ethics consultants, health professions students, and students of ethics consultation. The skills could be offered as a certificate program in advanced interpersonal skills development as recommended in *Core Competencies* or as a supplement to already existing courses in ethics consultation. The empathy theories underlying the process can help inform work in health care education. Programs specifically designed for physicians, such as Balint groups, can help physicians in training learn how to be more empathetic towards colleagues and patients. Nurses and allied health professionals can explore the concept of moral distress and forums can be designed to help empower them to overcome feelings of powerlessness due to the high level of personal responsibility they take as hands-on patient advocates, but who often have little authority to oversee the decisions that are made.

As one nurse in the case involving Mr. Sullivan from Chapter Six remarked at the end of the consultation, "Doctors write orders, and nurses follow them." Her remark served not only to vent her personal frustration with the case, but summed up the fact that although the underlying clinical issue had been resolved, an important opportunity for moral dialogue between the doctors and nurses, and thus exploration of their emotions, was lost. Using transformative ethics consultation supplies the skills and procedures needed to ensure that the often overlooked, but crucial emotional element in ethics consultations are adequately addressed.

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Vita

David Perlman was born in Atlanta, Georgia on October 13, 1970. A proud product of the public school system, David attended Emory University as an undergraduate major in Philosophy/Classics and Biology. After becoming involved in Student Pugwash, the student affiliate of Nobel-prize winning ethics and technology organization Pugwash, David decided to combine his interests in philosophy, ethics, and biology in a career in bioethics. He enrolled in the Philosophy Masters program at Georgia State University in 1992, soon after his graduation from Emory and his engagement to Kristine Biggie, a pediatric nurse practitioner. After publishing his Master's thesis on feminist approaches to genetic engineering, David attended the University of Tennessee in Knoxville. He remained there from 1993 to 1997, studying philosophy, bioethics, and conflict resolution. These interdisciplinary disciplines serve as the focus for his dissertation on the role of empathy and mediation in ethics consultation.

In 1998, David was selected to participate in clinical fellowship program at the Medical University of South Carolina in historic Charleston. In addition to clinical rotations, David participated on the Ethics Consultation Service, which prompted further research on the role of empathy and mediation in ethics consultation. David conducted research on these topics in 1998 and 1999 as Coordinator for the very fellowship he had finished and as Adjunct Faculty member at the College of Charleston. David currently lives in Philadelphia, Pennsylvania with Kristine and works as the coordinator for an Institutional Review Board at Chestnut Hill Hospital.