Realistic Goals and Expectations for Clinical Ethics Consultations: We Should Not Overstate What We Can Deliver

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Realistic Goals and Expectations for Clinical Ethics Consultations: We Should Not Overstate What We Can Deliver

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The article by Professor Fiester (2015) expresses concern about the long-term moral distress or negative moral emotions, both aspects of moral residue, that linger in some stakeholders’ experiences because of unresolved issues encountered in health care delivery. She suggests that this happens when ethics consultants do not perform clinical ethics consultations (CECs) in a manner that reaches “closure,” and particularly in consultations that provide recommendations without engaging the parties in meaningful dialogue. Drawing primarily from the nursing literature to clarify the goals of closure, she says that CECs “need to prioritize assisted conversation between different stakeholders” (29) so as to promote a sense of bringing them to a harmonious completion or comforting or satisfying sense of finality achieved when one finds peace of mind. In short, for the subset of CECs where involved parties are dealing with “moral distress or feelings of guilt, anger, resentment and indignation,” part of the moral mandate of CEC should be to help reach stakeholder closure, thus adding a new skill to our understanding of CECs. We reject the claim, even if ideal support is provided in CEC, that closure should be a standard by which effective intervention is judged. Instead, we argue that closure should be an aspirational CEC goal at best, and show why it is important not to overstate what clinical ethics consultants can deliver.

First, Professor Fiester apparently only refers to instances of moral regret and negative moral residue that occur within the context of CECs. Her concerns point to a much larger problem that permeates the work of interprofessional caregiver teams throughout the health care system in all of its in- and outpatient settings. There are many cases in hospitals alone throughout the United States that involve serious conflicts including ethical conflicts that do not involve CEC intervention. In a great number of these cases, stakeholders have strong emotional reactions that may leave unresolved moral residue if not addressed properly (Epstein and Hamric 2009). Those cases for which a CEC is provided represent just a small fraction of the total cases of stakeholder conflict and moral angst (Agich 2001). Thus, it is important to put into context and perspective the extremely limited degree to which CECs are dealing with a wide-ranging problem. Clinical ethics consultants simply are unaware of the vast majority of such cases. The question of why physicians, nurses, social workers, case managers, pastoral care staff, and others do not always see CEC as a valuable resource in the institutional setting when these cases arise is an important one that deserves more scholarly attention and research (DuVal et al. 2001).

It is also crucial to keep in mind that depending on whether the stakeholder is a health caregiver or a patient or a family member, the nature of moral distress and emotions in cases of value-laden conflict presents really different topics of concern that call for different types of aided discussion. Each has its own potential type of emotional residue, requiring different types of assistance, and possibly different understandings or uses of closure. For a health care provider, dealing with tragic outcomes can be emotionally draining. But this is the challenge of being a...
good nurse or good doctor or other caregiver, or a good ethics consultant, and demands an ongoing process of seeking insight and growth in one’s professional obligations. There are always a few cases that leave emotional scars and maybe some that even haunt us (Ford and Dudzinski 2008). In particular cases, it is important to process the experience of a tragic outcome and reach whatever closure is possible as dedicated professionals. Sadly, in our experience, physicians, nurses, and other caregivers do not talk enough about such experiences to one another. Closure for health care stakeholders in such very troublesome cases seems likely to be a continuing process of professional development, rather than a single moment of finality. For patients, closure might be accepting the reality of impending death following a decision to forgo dialysis, or dealing with a permanent disability or loss of function. For families, the challenge may be the grief of losing a loved one and the responsibility one feels for participating in the decision to discontinue treatment or life support. What is closure in such cases for patients and family members and what are the time frame and intervention necessary for achieving it? The guidance and support for these encounters in CEC are meant for the individuals to adjust and reach closure in their own individual ways within the time frame required. Thus, closure for each of these stakeholders necessitates a different type of facilitation, and a different type of individual undertaking.

It is clearly true that in a subgroup—maybe most—of CEC cases, consultants must interact with grieving individual stakeholders making and responding to difficult moral decisions, requiring emotional support through skilled communication. Almost all of these CEC encounters with stakeholders are with patients and family members (Swetz et al. 2007). And because many conflicts center on very sick or dying patients, several are with extended families. Typically, clinical ethics consultants have short-term, task-oriented meetings with involved parties in cases of conflict directed toward reaching a consensus so that important goals of care can be achieved. Clearly, a recommendation alone cannot accomplish such an outcome, as Fiester rightly says. As consultants work toward consensus through time-limited interaction with stakeholders, they must be sensitive to and address their emotional reactions, often of an ethical nature (Fletcher and Siegler 1996). But how far into these areas consultants who perform CECs can go remains very much an open question.

Second, it is far from clear that most clinical ethics consultants are trained in even the basic applied communication and interpersonal skills as articulated in the American Society for Bioethics and Humanities (ASBH) Core Competencies for Healthcare Ethics Consultation (American Society for Bioethics and Humanities Update Task Force 2011). The kind of interactions between a health care professional and stakeholders necessary to obviate moral regret and negative residual emotions and find closure would involve a level of skill in interacting with individuals that goes well beyond the boundaries of facilitation and mediation as they are currently used in CEC. We seriously doubt whether the typical well-trained consultant who performs CECs has such enhanced skills. Moreover, the relatively short duration of CEC encounters is an inherent constraint on the possibility for full emotional closure. Given the depths of feelings and reactions that many individuals experience in tragic situations, the time required for meaningful closure could certainly be quite lengthy, even weeks, months, and years, and sometimes never. Rather than set as an objective the often unobtainable goal of true closure, we think it is more important for clinical ethics consultants to work collaboratively with the health care team to provide effective support for individual patients and family members as long as they require assistance in the setting in which the CEC occurs, and to help assure that they receive other additional services in their communities. With appropriate training it may be possible for CEC consultants to assist other interprofessional team members to create a basis for further progress toward closure that would continue over time. This too is a topic that merits continued reflection and scholarly investigation (White et al. 1993).

In sum, one goal of CEC, whether based on facilitation or mediation, should be to foster positive adjustment in individual stakeholders, with the aspiration to reach emotional closure as much as possible in a difficult situation. But it is an overstatement to claim that closure should be a quality standard in CEC. We have seen little evidence that full closure results. Clinical ethics consultants often begin their involvement in a case well after an ethical conflict has evolved and festered, which means they often enter at the height of emotional intensity about a conflict that has reached an impasse. This is a venue where the immediate goal of the CEC is to reach a civil compromise that will get the case back on track. It is usually seen as a mark of success if strong emotional, value-laden reactions become malleable to continued discussion and interaction so as to reach a negotiated outcome. Of course, follow-up support for stakeholders should continue for a reasonable period of time if feasible. But when is the CEC really over? Just as we are never sure how and when an ethical or value-intense conflict began, we are often not sure when an ethics consultation does—or should—end. Even with skilled and intentional involvement, it is a judgment call to know when the time has come for a CEC to conclude. And once that judgment has been made it seems likely that the major stakeholders will continue to face the challenge of dealing with the after-effects, even if optimal support had been provided.

REFERENCES


Closure is indeed a neglected end of many clinical ethics consultations. And Dialogue-Focused Models do offer “the best hope for closure” in a clinical ethics conflict (Fiester 2015, 34). By involving patients, family members, and health care providers more directly in the process through which difficult decisions are made, such models greatly increase the likelihood that all stakeholders will understand why a specific treatment plan is recommended. And since “exploring moral convictions, religious beliefs, emotions and interests are the very stuff of the model’s charge,” such approaches are also more likely to result in “a satisfying ending that all parties accept” (33). Yet bioethics mediation is not the only dialogue-based approach clinical ethics consultants might use to resolve cases involving serious moral disagreement. And in cases where philosophical conflicts render shared understanding impossible, bioethics mediation may not be the best.

Philosophical counseling is another dialogue-based approach, and though it is more frequently practiced with individual clients, philosophical counselors also work with groups. Like bioethics mediators, philosophical counselors aim to respect and promote autonomous and informed decision making by their clients. And like bioethics mediators, philosophical counselors avoid diagnosing their clients’ problems and strive to remain neutral while helping clients explore competing points of view. The aim of a philosophical counseling relationship, like the aim of a bioethics mediation, is to help clients reach decisions the clients themselves can fully endorse. Still, the lens of philosophical counseling is subtly different from the lens of bioethics mediation: where mediators focus primarily on the values, interests, and concerns that are shared across several persons, philosophical counselors look more closely at the specific concepts and patterns of reasoning that shape any given individual’s unique perspective.

A growing body of literature documents the ability of philosophical counseling to help clients manage a variety of problems in both personal and professional life, including conflicts that arise in clinical ethics (Epright 2003), nurse management (Fitz-Gibbon and Russell 2009), rehabilitative medicine (Levi 2011), and xenotransplantation and genetic counseling (Littig 2010). Moreover, looking at the problem of “closure” through the lens of philosophical counseling helps to explain why bioethics mediation may not be able to avoid moral residue in every type of case. (Since Fiester’s own argument is “not that there is only one path to closure” [35], what follows should be read less as a criticism of bioethics mediation than as a friendly addition to her overall view.)

Perhaps the most distinctive form of expertise a philosophical counselor offers to a client is skill in identifying “presuppositions—cultural, professional, moral, and philosophical—which are commonly left both unexplored and unexplored,” and that frequently turn out to be inconsistent with the clients’ goals or wider worldview (Epright 2003, 19; cf. Lahav 1996). Hence one worry a philosophical counselor might have is that a mediator’s emphasis on “shared decision making” runs the risk of conflating the ethical course of action with any action “that all parties accept” (Feister 2015, 33). In fairness, the literature is clear that bioethics mediators always wear “two hats”: a “mediator hat” that encourages them to remain neutral values, interests, and concerns that are shared across several persons, philosophical counselors look more closely at the specific concepts and patterns of reasoning that shape any given individual’s unique perspective.

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