Special Section: Coming of Age in Clinical Ethics Consultation: Time for Assessment and Evaluation

Is Consent Necessary for Ethics Consultation?

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Introduction

Is consent necessary prior to the initiation of a specific clinical ethics consultation? This is not a question that has received much attention despite the fact that the issue of consent is one of the earliest considerations associated with bioethics.[1] Perhaps this is because of how clinical ethics consultation, as a formidable clinical practice, came into being. Specifically, although the place and time of its conception is not readily identifiable, it is not unreasonable to say it was born on March 31, 1976, when the New Jersey Supreme Court stated, in its Quinlan decision, that consultation would be necessary with "the hospital 'Ethics Committee' or like body of the institution in which Karen is then hospitalized. [And i]f that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition [then her] life-support system may be withdrawn."[2]

With these words, the Quinlan Opinion placed ethics committees squarely within the nexus of decisionmaking, alongside the physician, family, and guardian, as consulting bodies empowered to render judgments about prognosis (as opined in the Quinlan decision) or to substitute their own judgments for that of incompetent patients (as some came to understand the Quinlan Opinion).[3] Whether these are correct interpretations of the role of clinical ethics consultation, or even the Quinlan Opinion, has been—and likely will continue to be—areas for ongoing debate. No longer, however, would ethics committees be as they had typically been understood up till then, that is, purely advisory.[4] More importantly, given the attention directed toward the Quinlan case at the time, in its aftermath, the issue of the legitimacy of ethics committees' "clinical" role drew the spotlight;[5] any concern for consent that may have been raised was thus easily overshadowed.

Although there was much discussion of the legitimate clinical role of "ethics consultation" in the years after Quinlan, in terms of actual practice, ethics consultation remained a fairly novel idea.[6] Matters changed when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) required all healthcare institutions to develop an "ethics mechanism" by which to address clinical ethical issues.[7] Along with the need to satisfy the JCAHO requirement, the early 1990s saw the emergence of vigorous and contentious debates regarding who ought to be allowed to perform clinical ethics consultations,[8] by what methods and formats it should be performed[9] and then evaluated,[10] and what constitutes the legitimate ends of clinical ethics.[11] In this environment, too, the issue of consent generated little interest.[12] It was not the case, however, that

Cambridge Quarterly of Healthcare Ethics (2009), **18**, 384–396. Printed in the USA.

doi:10.1017/S0963180109090586

no one raised the question about consent; a few articles did appear in the late 1980s and early 1990s addressing this question. But in these very few instances, there was virtually no *debate*, no *disagreement*, regarding the answer to the question. Rather, all agreed: When it comes to ethics consultation, consent from patients (or their representatives) is required.[13]

Moreover, all seemingly shared a key presumption. Specifically, the arguments found in these few discussions favoring that consent be obtained from patients or their families prior to the initiation of ethics consultation presume that patients have a privileged position in terms of framing what is taken to be ethically significant within these clinical contexts. In other words, *being a patient*, as opposed to the *actual moral experience* of whomever *is* the patient—let alone the moral experience of others involved in that patient's care—is taken as most significant in terms of appreciating the ethical dimensions of the specific clinical situation (this is why, after all, *patients'* consent was to be obtained prior to addressing the ethical issues via ethics consultation). This is, however, a deeply problematic presumption. In fact, there are two areas of difficulty raised.

First, a concern for ethics consultation that ignores the actual moral dynamics of the specific clinical setting in which the ethics consultation occurs raises serious questions about the legitimacy of ethics consultation as a clinical practice.[14] Second, ignoring, or making of secondary importance, moral understanding and experience of *anyone other than the patient*, even when those others are directly involved in the care of the patient, can lead to misunderstanding—if not outright missing—the ethical issues prompting the request for ethics consultation in the first place. The aim of what follows is to highlight this latter point and, in so doing, to suggest that the appropriateness of seeking consent in relation to clinical ethics consultation must be based in what is at stake and for whom in the actual practice of ethics consultation.

Focusing on the Problem: Consent, Vulnerability, Role, Experience

To gain perspective on the dimensions of the problem at hand, brief mention must be made of the discussions associated with the historic development of the concept of ''informed consent'' as a bioethical concern and, more specifically, the initial motivations that helped shift the concept of ''informed consent'' from its original legal context of the 1950s to a core matter for the emerging bioethics field of the mid- to late 1960s. As Faden and Beauchamp[15] have shown, the impetus for the emerging field of bioethics to embrace this relatively new legal concept was due to a series of interrelated phenomena. These included several well-reported public and professional revelations about clinical research, a variety of responses by governmental and professional organizations to those revelations, and the emergence of the patients' rights movement.[16] Taken together, these highlighted and brought to the fore an important point about the status of being a research subject or a patient, namely, for all their attendant differences, to be in either role is to be particularly *vulnerable* and thus greatly susceptible to exploitation. Preventing exploitation, by limiting vulnerability, is squarely an ethical matter and thus worthy of special attention.

The vulnerability of patients is an extremely complex phenomenon. First, in the most immediate sense, patients are vulnerable because illness or injury disrupts the status quo of their lives, including that which is typically the most taken for granted, that is, their bodies.[17] Less immediately but equally powerfully, patients are vulnerable to the physicians, nurses, and other healthcare providers whom they seek for help and with whom they then interact, because these healthcare providers, in virtue of their roles, knowledge, expertise, and discipline, have a socially sanctioned power over patients. Moreover, given the institutional nature of healthcare delivery, such providers are *needed* by those in need of healthcare.[18] In a related way, patients are also vulnerable to the institutions themselves in which they must seek healthcare as well as to the financial mechanisms by which healthcare services will be paid for and, further, the social and cultural influences that shape how they will (or will not) be reintegrated into health and into their communities. To become a patient is thus to become vulnerable in a complex variety of ways.[19]

Acknowledgment of patient vulnerability historically provided an unexamined foundation for those few attempts to argue that consent must be obtained from patients or their surrogates prior to the commencement of ethics consultation. More specifically, it was argued that engaging in ethics consultation without consent exposed patients to information disclosure that increases their vulnerability.[20] It was also argued that failure to obtain consent runs counter to fundamental due process requirements; more specifically, to engage in clinical ethics consultation without patients' consent mutes, if not outright negates, patients' voices and thereby ignores the importance of including patients in decisionmaking about their own care.[21]

For present purposes, there is no need to assess whether these two rationales have merit.[22] Rather, the appeal to patient vulnerability that forms the crucial basis for requiring patient consent to ethics consultation implies that, whatever else is ethically at stake in a clinical circumstance such that ethics consultation may be warranted, the patient's stake, as epitomized by the patient's vulnerability, is of *primary* importance. This is why, as already mentioned, the *patient's* consent is necessary—as opposed to obtaining consent from any other of the various individuals with whom ethics consultants may interact.

There can be little disagreement that, as a conceptual starting point, patient vulnerability is an ethically significant dimension of the clinical context. However, clinical contexts are inherently complex environments that need to be unpacked in an ethically nuanced fashion. Some of the factors contributing to this complexity concern the nature of illness and injury itself.[23] Some concern the ways in which medicine, nursing, and the other disciplines associated with patient care not only function in practice, but also how they are conceptually understood by their practitioners.[24] An additional factor is that patient care almost always occurs within the context of complex and dynamic human relationships.[25] Each of these factors reflects diverse ethical perspectives and considerations such that all clinical contexts are inherently ethically rich.

Within this rich and dynamic clinical context, any number of considerations may turn out to be at the crux of ethical concern. For instance, "what matters ethically" within a specific clinical circumstance may be reflective of social, political, or cultural assumptions that underlie the relational dynamics of those involved in that circumstance.[26] This can hold for the relationships between medical and nursing staff, among members of either staff, as well as between and among others independent of the patient as much as between healthcare provider and patient (the usual locus of attention).[27] More significantly, such ethical concerns may reflect and highlight a different set of vulnerabilities from those of the patient all together. These vulnerabilities are associated with the practices and role of being a nurse, a physician, or some other healthcare provider who takes care of patients.[28] And what is at stake in *those* vulnerabilities may practically have little to do with, and impose little effect upon, a given patient's vulnerability.

For instance, whether prompted by a nonconsequential error in judgment or skill,[29] the stress of having too many patients to care for in the time allotted,[30] or the emotionality of taking care of critically ill people,[31] physicians may begin to doubt their skills or question their worthiness to be in a position of offering help in the first place. Having such doubt and engaging in such questioning, however, are not often taken as appropriate activities in which physicians are to engage,[32] which can further fuel a sense of what in the nursing literature has been recognized as an endemic feature to nursing practice: "moral distress."[33] The stakes raised by the experience of this kind of distress, however, go beyond considerations associated with the practical dimensions of providing care for specific patients.

In the experience of such moral distress, not only are matters fundamental to what it means to act in the role of "physician" or "nurse" raised for the individuals acting in those roles, but the daily encounters with the frailties and limitations of human bodies also bring to the fore more elemental considerations associated with what it is to be human itself.[34] Accordingly, the injured or ill bodies toward which these healthcare providers routinely direct their actions also make available for their attention concerns about power and powerlessness, individuality and dependence, integrity and dissolution, and other matters of human existential meaning (even if not explicitly acknowledged); and these features have even less traction within professional discourse.[35] At stake for the healthcare provider while in the midst of a clinical encounter with a patient, therefore, are considerations both practical (e.g., "What action should be taken to help this patient?") and profound (e.g., "What does it mean, and who am I, to provide such help?") It is especially the latter of these that highlights the point that what is at stake in healthcare providers' vulnerabilities may differ substantially from that of patients' and may, moreover, have little immediate applicability to the vulnerability of a given patient. "Vulnerability," then, as relevant to clinical ethics practice, should not be framed merely by considerations associated with being a "patient." This is in keeping with paying attention to what is actually occurring within specific clinical circumstances—a crucial hallmark of clinical ethics work—as opposed to taking for granted the meanings and values presumed to be typically involved.[36] If vulnerability is to be addressed by a clinical ethics consultant, it must be addressed as it is uniquely presented, and the consultant must be ready and able to respond accordingly.

The Problem of Role and Prioritization Clarified

Congruent with the complexity and specificity associated with any particular clinical situation, there are many ways to characterize that situation. One manner is in terms of the various roles individuals occupy therein: "patient," "physician," "family member," "nurse," and so on, including "ethics consultant."[37] All such roles serve as the gateway through which every individual involved in a specific patient care situation comes to be part of that situation. The role that each occupies shapes how choices, decisions, experiences, and other forms of engagement and interaction within that circumstance are understood and valued.[38]

At the same time, in a specific clinical circumstance, whatever prompts a request for ethics consultation is not fully contained or defined by the particular healthcare role of the individual who makes the request. This point may be seen even when no details about the specific clinical circumstance are provided. For instance, consider a situation in which an attending physician requests ethics consultation in relation to one of her hospitalized patients. Without knowing any of the details regarding the patient care situation associated with this request, or without knowing any details about this physician, including why she's making this request, at least this much is clear: It is at least partially due to this physician's being "the physician" for this patient that she faces the concerns she does. That being said, it is also very easy to imagine that, had some other physician been "the physician" for this patient, this second physician might not have had the concerns of the requesting physician. The reason is that a physician who requests ethics consultation is not acting merely as *a physician*. The physician is also acting as one who has a defined institutional position with a unique relationship to existing community standards (or biases) associated with healthcare practices, the meanings of illness, economic and cultural forces, and so on.[39] In addition, there are the other "personal" facets of this physician's identity such as religious beliefs, emotional disposition, and so forth that influence the decision to request an ethical consultation.

Stated slightly differently, "what matters" for any given individual within a specific clinical circumstance is not wholly determined by the particular role that an individual occupies within that circumstance, even if that role serves to bring "what matters" to that individual's attention or to the attention of others participating in other roles within that circumstance. Instead, "what matters" reflects a combination of considerations and values associated more fully with who that individual *is* in the midst of occupying that role—which includes considerations and values associated with the role, but not only so.

This becomes more readily apparent when details are provided to the above one-sentence example of an attending physician requesting ethics consultation in relation to one of her patients. Consider, for instance, this much more fleshed-out rendering of the example:[40]

> A cardiologist is the attending physician for an elderly gentleman for whom she has provided care for well over a decade and who has now been in the hospital for several weeks. This hospitalization is the fifth in the past 18 months, his cardiac disease (and the various comorbidities) having progressively gotten worse. During these past months, the cardiologist has spoken with this gentleman on several occasions regarding his preferences should he find himself in a situation where the prognosis was bleak. In each conversation, he had been fairly clear that he did not want to end up long term in a nursing home, debilitated and unable to care for himself.
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> Several weeks into this current hospitalization, this gentleman has suffered a series of significant setbacks, including pulmonary failure requiring mechanical ventilation, acute renal failure, which was being managed by medication (the cardiologist had already decided she would not initiate dialysis), a variety of infections, and a prolonged altered

> mental status (complications of being in the ICU). The patient's family had come into town (his son and daughter both live out of state, and both have come, along with their respective spouses), and the cardiologist has had several long talks with them about the likely course, including the signs that things were improving, signs that things were worsening, and what she and the patient had discussed over the year concerning his preferences. His children, too, had discussed with him these matters (starting several years prior after their mother, the patient's wife, died) and reported to the cardiologist that he did not want to end up debilitated and in a nursing home.
>
> It is now clear to this patient's family that their father is undergoing the very kind of interventions that he would not want, that he was not improving, and that any possibility of improvement would require continuing the interventions even longer as well as moving him to a nursing facility. Accordingly, they have requested that his life support be withdrawn and that he be allowed to die. At that point, the cardiologist requested ethics consultation.
>
> Her request, however, was not for the sake of reviewing the situation in order to make sure that the family's request is consistent, or at least compatible, with this gentleman's long-held values and preferences, for she knows they are. Neither is she in need of advice regarding the hospital's policy on DNR orders or terminal weans or clarification regarding standards of practice or established norms for end-of-life care. Rather, as she stated as part of her request, she is looking for assistance in talking through her own experience of managing this gentleman's care and whether now is the "right" time to stop. Indeed, she is torn between her patient's stated preferences and her own uncertainty about whether, if she could get him through this current hospitalization, he would, indeed, be as debilitated as the family and patient fear.
>
> This cardiologist's request for ethics consultation thus presents (at least) two parallel, and intertwined, concerns: to help identify and clarify the relevant ethical values and goals with which she now finds herself confronted and to *help ensure for herself* that her judgment is ethically reasonable.

This more fully articulated example of a request for ethics consultation reveals several important points. First, although there may be elements such as professional standards, practice guidelines, institutional policies, and other matters explicitly and directly linked to her acting within the role of "physician," these are only relevant for her, in that moment, because it is *she*, who occupies the role "physician" for this patient, who must act. Thus, besides role-based considerations, there are a whole host of deeper existential and personal concerns.

Second, although it is conceptually possible to distinguish what is at stake for a particular individual in a specific clinical circumstance and what is at stake for that individual in the particular role that individual occupies within the circumstance, such a distinction often does not reflect what is *experienced* by that individual while in the midst of that actual clinical situation and acting within that particular role. The cardiologist in the example may or may not delineate aspects of her concerns as "physician-based" and "personal-based" when she finds herself challenged in such a way that her response is to request an ethics consultation. Given this possibility, when the request is received, how should the ethics consultant respond to this cardiologist and *to whom* should the response be directed: the individual as if divorced from her role of physician, the individual as if intimately coupled to that role, or the role as if independent of the individual who fulfills it in this particular circumstance?

And what of the patient's son and daughter, their spouses, the many nurses who have been caring for this gentleman over many weeks of his hospitalization, or the other care providers, family members, friends, and others who may be participating in, and have influence over, the decisionmaking for this patient—and thus may have a stake in what is decided? These individuals simultaneously occupy multiple roles, that is, some wholly based in the healthcare context, such as "nurse," "consulting physician," "respiratory therapist," and others based in the broader sociocultural sphere such as "daughter," "daughter-in-law," "best friend," and so forth.[41] With what focus, then, should any of them be addressed, especially if the request for ethics consultation originated with one of them?

Asserting that consent must be obtained first from a patient (or the patient's legal representative) before ethics consultation may proceed presumes an answer to these questions, namely, that it is role that matters most. But not just *any* role, for priority is given to the specific role of "patient." And this is so *by definition*, which is to say, without regard to what the requester may be experiencing as morally at stake, such that he or she believes ethics consultation is warranted—and hence independent of what may be discoverable by first directing attention toward what is going on *with the requester*. When put this way, and keeping in mind that any of the individuals involved in a patient's care—in addition to the patient—may be experiencing doubts, questions, and concerns rooted in deeper worries about their own basic commitments, beliefs, and values, it is difficult to imagine what might legitimate granting the patient the power to decide, whether or not those worries are addressed—especially when the requester is asking for them to be. Indeed, to argue that patients (or their representatives) must give initial consent before ethics consultation commences raises serious questions regarding the meaning of responsibility in ethics consultation—a topic that, like consent, has received scant attention within the clinical ethics literature—as such a position seems to show little concern for what is actually going on in the situation.

Responsibility, Vulnerability, and Consent

To pay attention to what is going on in a specific clinical ethics consultation, differences between the function that ethics consultation fulfills within an institution and the implications of the specific activities of ethics consultants must be recognized as well as the fact that these differences raise crucial questions about responsibility *in* ethics consultation.[42] Whatever else may be said about these differences, this much is at least clear: Ethics consultation and the practitioners who pursue it serve as a focal point for talking about "clinical" matters, that is, matters arising within and as a result of clinical interactions, in a manner not typical of such clinical interactions. Moreover, such conversations occur with and among people who are, for the most part, strangers to one another.[43] Coupled with the inherent uncertainties found within clinical contexts, the "moral space"[44] constructed by the ethics consultation process is fraught with risk. By design, it represents a potential for individuals to explicitly and directly encounter issues and concerns that may be transformative insofar as deeply held values, commitments, and convictions become raised for inspection.[45] In other words, the possibility for *creating* or *exacerbating* vulnerability is as much endemic to clinical ethics consultation as is the possibility for ameliorating or alleviating vulnerability. Whether either potential is realized, of course, will at least depend on what, in fact, *is* going on in the specific situation for which ethics consultation has been requested. In this light, ethics consultation might be said to function at the intersection and overlap of various personally, professionally, and institutionally mitigated articulations of values, commitments, and beliefs in which vulnerability, as associated with illness, decisionmaking, curative efforts, and care, may itself also come to be articulated—via the actions in which participants in that situation engage, if not via the outright words they speak. To be responsible in clinical ethics practice, then, is to be, at the minimum, ready and able to be responsive to such articulations.[46]

When the physicians, nurses, and other healthcare providers with whom ethics consultants regularly interact become vulnerable within a specific clinical circumstance, the risk associated with such matters may be lessened by the fact that, as colleagues within the institution, ethics consultants and those others are likely to have opportunities for ongoing interaction beyond the moments defining the specific ethics consultation. Following up with ''colleagues,'' in other words, beyond the typically understood ''end'' of a specific consultation, may help ensure that vulnerabilities that are possibly uncovered or encountered within the consultation process are adequately addressed, or at least identified, so that the possibility for limiting potential harms of the ethics consultation itself may be addressed. The same, however, cannot be said for patients, their families, and others within a patient's circle of intimates. Unlike those who occupy roles primarily linked to the institution, these other individuals enter and then exit the confines of the institution. Once outside of the institutional bounds, not only may there be little practical possibility for following up and checking to see if the undergoing of the ethics consultation process has unleashed or provoked further moral entanglements, but there may be little warrant for doing so: In short, responsibility and privilege within the frame of ethics consultation is bound by the confines of the institution within which such ethics consultation functions.

But even when patients and their families are within the confines of the institution, the ethics consultant's responsibility to them is not the same as that to colleagues. Patients and families do not ''belong to'' the institution as do the physicians, nurses, and so on who care for them. Moreover, most patients and their families have little familiarity with the clinical processes and personnel of ethics consultation.[47] Indeed, despite Joint Commission requirements that they be informed of their rights to access ethics consultation mechanisms, there is evidence that most hospital ethics mechanisms are infrequently utilized.[48] This further highlights that patients and their families are likely to have significantly different understandings of the function of ethics consultation—and may well be more likely to misinterpret the activities of ethics consultants than the ethics consultant's colleagues—because of its unfamiliarity. As such, it may well be that—akin to the conclusions in those few articles addressing the need for patient consent in the context of ethics consultation—the participation of patients and families in ethics consultation might exacerbate vulnerability. This is so because the disruptions brought on by illness or injury potentially give way to challenges of confronting deeply held values, commitments, and beliefs due to a process—ethics consultation—of which patients and families likely know little. Accordingly, those who provide ethics consultation must be attentive to the possible appearance of such vulnerability, and, in some cases, it may be warranted to allow patients and their loved ones to have pause, that is, to temporarily "opt out" of conversations and decisionmaking in the effort to minimize, or at least not exacerbate, their vulnerability.

In some circumstances, however, there may be warrant for more than merely allowing patients and their families to opt out temporarily, and instead for fully determining whether or not they wish to participate in ethics consultation. Such circumstances are those in which their potential participation bears only the potential for risk for them. For instance, consider once again the brief scenario mentioned above, in which the cardiologist requests ethics consultation in order to help her identify and clarify the relevant ethical values and goals that may help ensure that her judgment is ethically reasonable. In this circumstance, the patient has long been on record as stating his preferences should he find himself in the kind of medical condition he is currently in, and his children are not only familiar with these wishes, but agree and support them.

Without going into any more detail about the situation and the challenges this cardiologist believes herself to be facing, the pertinent question is this: Should this family have a choice about whether to participate in any of the discussions that may unfold as the ethics consultant sets out to find a way to help this cardiologist? The aim of the consultation is to help this physician. It may well be that she would like to have this patient's children meet with her and again talk through their father's beliefs about end-of-life care and the decision he has made for himself. But for whose sake would such a conversation be held? It is not the children's; it is the physician's. Moreover, it is easy enough to imagine that the family, even as they accept their father's wishes and pledge to support them, are facing for themselves deeper and unsettling questions about how to understand this moment in their family's life. In such a circumstance, offering them the choice to participate in further conversations regarding their father and his decisionmaking process, why he made those decisions, what he himself believed to be at stake, and so on is clearly justified. But so too is their turning down the offer, especially if to delve further into those issues holds out for them, from within their own perspective, little prospect but that of exacerbated grief. To force them to participate, and thus to deny them the opportunity to refuse, cannot be justified because engaging in such discussion is not for the sake of changing the decision or clarifying it or even *helping them*. Rather, as stated above, the concern is explicitly and directly about the physician's own understanding.

Here, then, is at least one kind of situation in which it not only makes sense to allow patients and families to decide whether to participate in the process of ethics consultation, but which further highlights that, even if they refuse, it makes little sense to deny others involved in the circumstance—for example, healthcare staff—the opportunity to engage in the process. There may be others as well, which is why paying close attention to the actual details of the specific circumstance in which ethics consultation is requested—including the reason for the request itself—is crucial for ethics consultation practice. More important, though, is the fact that, whether patients or their loved ones are granted a pause and momentary remove from the consultative process or they explicitly choose not to participate at all, the consultation must still be able to continue with all those others involved in that circumstance for whom ethics consultation holds out the prospect of being of help. For whatever else ethics consultants are responsible, then, they must be attentive to the potential vulnerabilities fostered by their own practices in order to most reasonably ensure that those others with whom they interact are not left worse off as a result of participating in ethics consultation.

Conclusion

In many ways, the notion that any one individual involved in a patient's situation may be given the ability to deny another to seek assistance to address that other's own ethical concerns flies in the face of now 30-plus years of recognition that clinical ethical matters are not the sole domain of any one group. Indeed, allowing role or professional discipline to subjugate the moral experience of others, who are acting within the legitimate bounds of their own roles, only serves to exacerbate already present vulnerabilities inherent to clinical contexts generally. Obtaining consent from patients or families for ethics consultation may at times make sense, for instance, when the risks associated with ethics consultation are clearly borne by them but without likely benefit. More important, however, is to recognize that at the beginning of a specific consultation, when there is still much to discover about what is going on in the circumstance that necessitated the request of the consultation in the first place, to require such consent is not warranted. This is especially so when the issue at hand involves ethical considerations highlighting the vulnerabilities of healthcare providers, and it may be the moral reassurance of these providers that is being sought in the consultation.

Over the past 25 years, many models and methodologies for the clinical practice of ethics consultation have been proposed. Despite many differences among these, all share an acknowledgment of the need to be attentive to what is actually going on within the clinical circumstance for which ethics consultation has been requested. Accordingly, having appreciation of the various roles individuals occupy in such circumstances, and the various embedded values linked to them, is one important practical dimension of "doing" clinical ethics. Another is recognizing that associated with these many roles are any number of vulnerabilities, some reflective of the roles per se, others more highly associated with the specific circumstance in which those occupying those roles now interact. As such, what any individual experiences in the midst of that specific circumstance may set up possibilities for encountering deeply held ethical commitments, convictions, beliefs, values, and so on, which may further exacerbate vulnerability. In this sense, all requests for ethics consultation might be thought of as originating in some sort of moral distress, as Dudzinski has put forth.[49] At the very beginning of an ethics consultation, when a request has been received and action is called for, and when the question of consent might have some practical force, however, the details about all of these considerations are, at best, speculative.

The question of consent in the context of clinical ethics consultation, like the practice of clinical ethics consultation itself, must therefore be approached with full attentiveness to the actual and ongoing complexities of the specific circumstances in which such consultation is practiced. To do anything less is to misunderstand the import of *clinical* in "clinical ethics." Although the answer to the question, then, of whether or not consent must be sought prior to initiation of clinical ethics consultation is clearly "no," the answer to the question of whether consent will be needed in what subsequently unfolds is a resounding, "maybe, maybe not."

Notes

1. Jonsen AR. *A Short History of Medical Ethics.* New York: Oxford University Press, 2000.
2. *In the matter of Karen Quinlan*, 70 NJ 10, 355 A(2d) 647 (1976):272.
3. Sargeant KJ. Withholding treatment from defective newborns: Substituted judgment, informed consent, and the Quinlan decision. *Gonzaga Law Review* 1978;13(3):781–811; Savage D. After Quinlan and Saikewicz: Death, life, and God committees. *Critical Care Medicine* 1980;8(2):87–93.
4. There were ethics committees before the Quinlan Opinion made reference to them, as Teel noted in her article, "The Physician's Dilemma: A Doctor's View: What the Law Should Be," which appeared on pages 6–9 of the same issue of *The Baylor Law Review* cited in footnote 8 of the Quinlan Opinion in reference to the legitimate roles of ethics committees [1975;27(1)]. There, Teel explicitly notes that "the authority . . . and their official status is more that of an advisory body than of an enforcing body" (p. 9).
5. Oberdiek H. Who is to judge? *Ethics* 1976; 87(1):75–86; Cantor NL. Quinlan, privacy, and the handling of incompetent dying patients. *Rutgers Law Review* 1977;30(2):243–66; Veatch RM. Hospital ethics committees: Is there a role? *The Hastings Center Report* 1977;7(3):22–5; Levine C. Hospital ethics committees: A guarded prognosis. *The Hastings Center Report* 1977;7(3):25–7; Shannon TA. What guidance from the guidelines? *The Hastings Center Report* 1977;7(3):28–30; Ramsey P, Veatch RM. Stopping treatment: Who decides? *The Hastings Center Report* 1978;8(1):43; Annas GJ. Reconciling Quinlan and Saikewicz: Decision making for the terminally ill incompetent. *American Journal of Law and Medicine* 1979;4(4):367–96; Annas GJ. The Quinlan case: Death decision by committee. *The New Physician* 1979;28(2):53–4, 56; Buchanan A. Medical paternalism or legal imperialism: Not the only alternatives for handling Saikewicz-type cases. *American Journal of Law and Medicine* 1979;5(2):97–117; Annas GJ. Refusing treatment for incompetent patients; why Quinlan and Saikewicz cases agree on roles of guardians, physicians, judges, and ethics committees. *New York State Journal of Medicine* 1980;80(5):816–21.
6. Randal J. Are ethics committees alive and well? *The Hastings Center Report* 1983;13(6):10–2; Capron AM. Twenty questions about ethics committees. *Ethics Committee Newsletter* 1984;1(4):2–10; Rosner F. Hospital medical ethics committees: A review of their development. *JAMA* 1985;253(18):2693–7; Paris JJ, Reardon FE. Ethics committees in critical care. *Critical Care Clinics* 1986;2(1):111–21.
7. Heitman E. A proactive role for the ethics committee or ethics consultant: Meeting the JCAHO standards on patient rights. *Trends in Health Care, Law and Ethics* 1993;8(4):11–6.
8. Mitchell SM, Swartz MS. Is there a place for lawyers on ethics committees? A view from the inside. *The Hastings Center Report* 1990;20(2):32–3; LaPuma J, Schiedermayer DL. Ethics consultation: Skills, roles, training. *Annals of Internal Medicine* 1991;114(2):155–60; Moreno JD. Call me doctor? Confessions of a hospital philosopher. *Journal of Medical Humanities* 1991;12(4):183–96; Thomasma DC. Why philosophers should offer ethics consultations. *Theoretical Medicine* 1991;12(2):129–40; Marsh FH. Why philosophers should not do ethics consults. *Theoretical Medicine* 1992;13(3):285–92; Murphy PA. A nurse–ethicist model of ethics consultation. *Trends in Health Care, Law and Ethics* 1993;8(4):23–4.
9. O'Connell LJ, Yeide H. The many styles of clinical ethics. *The Journal of Clinical Ethics* 1990;1(1):82–4; Moreno JD. Ethics consultation as moral engagement. *Bioethics* 1991;5(1):44–56; Jonsen AR. Casuistry as methodology in clinical ethics. *Theoretical Medicine* 1991;12(4):295–307; Barnard D. Reflections of a reluctant clinical ethicist: Ethics consultation and the collapse of critical distance. *Theoretical Medicine* 1992;13(1):15–22; Zaner RM. Voices and time: The venture of clinical ethics. *Journal of Medicine and Philosophy* 1993;18(1):9–31; Walker MU. Keeping moral spaces open: New images of ethics consulting. *The Hastings Center Report* 1993;23(2):33–40.
10. Perkins HS, Saathoff BS. Impact of medical ethics consultation on physicians: An exploratory study. *American Journal of Medicine* 1988;85(12):761–5; Siegler M. Defining the goals of ethics consultations: A necessary step for improving quality. *Quality Review Bulletin* 1992;18(1):15–6; Orr RD, Moon E. Effectiveness of an ethics consultation service. *Journal of Family Practice* 1993;36(1):49–53; Fry-Revere S. Some suggestions for holding bioethics committees and consultants accountable. *Cambridge Quarterly of Healthcare Ethics* 1993;2(4):449–55; Fletcher JC, Siegler M. What are the goals of ethics consultation? A consensus statement. *The Journal of Clinical Ethics* 1994;7(2):122–6; Fox E, Arnold RM. Evaluating outcomes in ethics consultation research. *The Journal of Clinical Ethics* 1994;4(4):127–38.
11. Schiedermayer DL, LaPuma J, Miles SH. Ethics consultations masking economic dilemmas in patient care. *Archives of Internal Medicine* 1989;149(6):1303–5; Agich GJ. Clinical ethics: A role

theoretic look. *Social Science and Medicine* 1990;30(4):389–99; Fletcher JC. Needed: A broader view of ethics consultation. *Quality Review Bulletin* 1992;18(1):12–4; Youngner SJ. Clinical ethics and cost containment: Promises and pitfalls. *The Cleveland Clinics Journal of Medicine* 1992;59(6):649–50; Forrow L, Arnold RM, Parker LS. Preventive ethics: Expanding the horizons of clinical ethics. *The Journal of Clinical Ethics* 1993;4(4):287–94.

12. Veatch RM. Ethics consultation: Permission from patients and other problems of methods. *American Journal of Bioethics* 2001;1(4):43–5.
13. Veatch RM. Advice and consent. *The Hastings Center Report* 1989;19(1):20–2; Wolf SM. Ethics committees and due process: Nesting rights in a community of caring. *Maryland Law Review* 1991;50:798–858; Fletcher JC. Ethics committees and due process. *Law, Medicine and Health Care* 1992;20(4):291–3; Arnold RM. Should competent patients or their families be notified before HECs review the patients' cases? Yes. *HEC Forum* 1994;6(4):257–9; Roberts LW, McCarty T, Thaler GB. Should competent patients or their families be able to refuse to allow an HEC case review? Yes. *HEC Forum* 1995;7(1):549–50.
14. Bliton MJ, Finder SG. Strange, but not stranger: The peculiar visage of philosophy in clinical ethics consultation. *Human Studies* 1999;22(1):69–97; Finder SG, Bliton MJ. Responsibility in actual practice: Consent and participation in clinical ethics consultation. In: Hestor M, ed. *Ethics by Committee: A Textbook on Consultation, Organization, and Education.* Lantham, MD: Rowman & Littlefield; 2007: 79–106.
15. Faden RR, Beauchamp TL. *A History and Theory of Informed Consent*. New York: Oxford University Press; 1986.
16. See note 15, Faden, Beauchamp 1986: Part II (ch. 3–6).
17. Toombs KS. *The Meaning of Illness: The Phenomenological Account of the Different Perspectives of Physician and Patient* (Philosophy and Medicine Series, Vol. 42). Dordrecht, the Netherlands: Kluwer Academic Publishers; 1992.
18. Cassell EJ. *The Nature of Suffering and the Goals of Medicine.* New York: Oxford University Press; 1991.
19. Zaner RM. Power and hope in the clinical encounter: A meditation on vulnerability. *Medicine, Health Care and Philosophy* 2000;3(3):265–73.
20. See note 13, Veatch 1969:21; Arnold 1994:258; Roberts et al. 1995:549.
21. See note 13, Wolf 1991:803; Fletcher 1992:292; Roberts et al. 1995:548.
22. It should be noted that the merit of the two most common arguments favoring the need for consent prior to proceeding with ethics consultation, that is, concerns about information disclosure and due process, were not accepted by all; see, for instance, Agich GJ, Youngner SJ. For experts only? Access to hospital ethics committees. *The Hastings Center Report* 1991;21(5):17–25; Finder SG. Should competent patients or their families be able to refuse to allow HEC case review? No. *HEC Forum* 1995;7(1):51–3.
23. See note 18, Cassell 1991: ch. 7 and 8.
24. Zaner RM. Phenomenology and the clinical event. In: Daniel M, Embree L, eds. *Phenomenology of the Cultural Disciplines.* Dordrecht, the Netherlands: Kluwer Academic Publishers; 1994:39–66.
25. Zaner RM. *Ethics and the Clinical Encounter.* Engelwood Cliffs, NJ: Prentice-Hall; 1988.
26. See note 14, Bliton, Finder 1999:73.
27. See note 8, Moreno, 1991:195.
28. Vailland G, Sorzorwales N, Macarthur C. Psychological vulnerabilities of physicians. *New England Journal of Medicine* 1972;287:372–7; McCue JD. The effects of stress on physicians and their medical practice. *New England Journal of Medicine* 1982;306:458–63; Rushton CH. Care-giver suffering in critical care nursing. *Heart & Lung* 1992;21(5):303–6; Miller MN, McGowen KR. The painful truth: Physicians are not invincible. *Southern Medical Journal* 2000;93(10):966–73; McLeod ME. The caring physician: A journey in self-exploration and self-care. *American Journal of Gastroenterology* 2003; 98(10):2135–8; Malterud K, Hollnagel H. The doctor who cried: A qualitative study about the doctor's vulnerability. *Annals of Family Medicine* 2005;3(4):348–52; Murphy JF. The vulnerability of doctors. *Irish Medical Journal* 2005;98(7):196; Sulmasy DP. Dignity, vulnerability, and medical error. *Health Progress* 2006;87(1):12–4; Rushton CH. Defining and addressing moral distress: Tools for critical care nursing leaders. *AACN Advanced Critical Care* 2006;17(2):161–8; Sporrong SK, Hoglund AT, Arnetz B. Measuring moral distress in pharmacy and clinical practice. *Nursing Ethic* 2006;13(4):416–27; McCaffree D. Moral distress and the intensive care unit. *Critical Care Medicine* 2006;34(12):3049–50; Zuzelo PR. Exploring the moral distress of registered nurses. *Nursing Ethic* 2007;14(3):344–59.
29. See footnote 28, Sulmasy 2006.
30. See footnote 28, Murphy 2005.

31. See footnote 28, McLeod, 2003.
32. See footnote 28, Malterud, Hollnagel 2005.
33. See footnote 28, Rushton 2006.
34. MacIntyre A. *Dependent Rational Animals.* Chicago: Open Court; 1999; Rendtorff JD. Basic ethical principles in European bioethics and biolaw: Autonomy, dignity, integrity and vulnerability—Towards a foundation of bioethics and biolaw. *Medicine, Health Care and Philosophy* 2002;5(3):235–44; Kottow MH. The vulnerable and the susceptible. *Bioethics* 2003;17(5–6):460–71; Kottow MH. Vulnerability: What kind of principle is it? *Medicine, Health Care and Philosophy* 2004;7(3):281–7; Dodds S. Depending on care: Recognition of vulnerability and the social contribution of care provision. *Bioethics* 2007;21(9):500–10.
35. Levine C. The concept of vulnerability in disaster research. *Journal of Traumatic Stress* 2004;17(5):395–402; Hoffmaster B. What does vulnerability mean? *The Hastings Center Report* 2006;36(2):38–45; Perry J, Lynam MJ, Anderson JM. Resisting vulnerability: The experiences of families who have kin in hospital—A feminist ethnography. *International Journal of Nursing Studies* 2006;43(2):173–84.
36. Zaner RM. Interpretation and dialogue: Medicine as a moral discipline. In: Crowell SG, ed. *The Prism of the Self: Philosophical Essays in Honor of Maurice Natanson.* Dordrecht, the Netherlands: Kluwer Academic Publishers; 1995:147–68.
37. See note 25, Zaner 1988:30–6.
38. Bliton MJ, Finder SG. Traversing boundaries: Clinical ethics, moral experience, and the withdrawal of life supports. *Theoretical Medicine* 2002;23(3):233–58.
39. See note 25, Zaner 1988:30–2.
40. This brief example is based on an actual clinical ethics consultation. Although the details have been changed in order to protect the confidentiality of all participants, the core issue regarding why ethics consultation was requested is an accurate report from the physician requester.
41. Reiter-Theil S, Mertz M, Meyer-Zehnder B. The complex roles of relatives in end-of-life decision-making: An ethical analysis. *HEC Forum* 2007;19(4):338–61.
42. See note 14, Bliton, Finder 1999:72–5.
43. See note 25, Zaner 1988:69–71, 105.
44. See note 9, Walker 1993.
45. See note 19, Zaner 2000:271.
46. Zaner RM. Listening or telling? Thoughts on responsibility in clinical ethics consultation. *Theoretical Medicine* 1996;17(3):255–77.
47. Reiter-Theil S. Balancing the perspectives: The patient's role in clinical ethics consultation. *Medicine, Health Care and Philosophy* 2003;6(3):247–54.
48. Fox E, Myers S, Pearlman RA. Ethics consultation in United States hospitals: A national survey. *American Journal of Bioethics* 2007;7(2):13–25.
49. Dudzinski DM. The practice of a clinical ethics consultant. *Public Affairs Quarterly* 2003;17(2): 121–39.