Dealing with the Normative Dimension in Clinical Ethics Consultation

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Introduction: Controversial Ideas about the Roles of the Clinical Ethics Consultant

Clinical ethics consultation (CEC) not only interprets moral issues at the bedside and is not restricted to giving support for the ''technical'' handling of these moral issues, but it has to substantively address moral values, norms, and conflicts in the process of discussing cases and problems. We call this the *normative dimension* and use *normative* in the sense of embracing moral values and convictions of persons and groups, norms, and relevant professional and ethical guidelines as well as legal frameworks.[1] The roles and activities of the consultant as a person and the quality of CEC as a process are discussed in the American Society of Bioethics and Humanities' (ASBH) *Core Competences for Healthcare Ethics Consultation*.[2]

Some of the ASBH Task Force's recommendations resemble earlier discussions of the roles of another healthcare specialty with a complex profile, namely, psychotherapy, especially regarding the connection between the psychotherapist's role as a professional ''helper'' and as a specialist working professionally with values and norms. The title of Maurice North's book, *The Secular Priests: Psychotherapists in Contemporary Society*[3] anticipated a wording that is being used similarly to refer to clinical ethicists some 30 years later.[4] Previously, in 1970, Paul Halmos had published the results of his investigation of psychotherapists and social workers under the title *Faith of the Counselors*.[5] It is notable that, despite its popularity, the phrase *secular priest*, is, if taken literally, an oxymoron expressing a humorous or ironic contradiction in itself. Even so, it may have some validity in capturing some important aspects of the ethics consultant's role that oscillate between traditional and modern professional roles. How can we understand this designation in the context of clinical ethics consultation?

In many European countries, for example, France, Germany, or Switzerland, there is considerable emphasis on the separation of church and state—thus on the religious neutrality of the political system. This emphasis implies that the widely accepted conception of the role of a priest should be distinct from that of an ethics consultant; the latter should be independent from religion and open, instead, to

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pluralism. This understanding seems to be accepted by the numerous Catholic and Protestant hospitals in Germany, which have been very active in adopting and adapting ethics projects within their organizations.[6] Yet, among the disciplines and backgrounds of clinical ethics consultants, there are theology and pastoral care; how can these disciplinary commitments have a legitimate place in CEC?

The contribution of a priest involved in CEC *as a priest* will specifically focus on the spiritual dimension and, perhaps, on pastoral care; she or he can also address issues of theological ethics relevant to the case. Whether and how a theologian can act *as an ethics consultant* without acting as a member of a church is a different issue. In discussions within multidisciplinary training courses for ethics consultants, we hold, as a preliminary rule of thumb, that priests will transparently articulate which "hat" they are wearing each time—that of a clergyman or that of an ethics consultant—and thereby distinguish the two roles.

Another metonym is used to characterize the ethics consultant's role, namely, as that of a *judge*.[7] This designation also reflects the idea that CEC is concerned with values and norms, but with completely secular ones. Whereas a judge at court occupies a traditional and highly professional role within the legal system, one may also act like a "judge" outside the forensic sphere. To say that an ethics consultant can be a *judge* implies that the consultant is competent in deciding what is right or wrong and making an authoritative normative judgment. In fact, clinical ethics consultants do not regard ethics consultation as a judicial procedure at all, but, instead, try to reassure those who fear that ethics consultation is a tribunal by assuring them it is not. Whether, and in which way, CEC should reach normative (moral) decisions is a matter not only of practical but also metaethical concern and is a topic ripe for further investigation and open for debate.

The role of a consultant is also linked with the method of or approach to CEC.[8] Should the consultant intervene as a *negotiator*, *mediator*, or *arbitrator* in the task of conflict resolution?[9] These three options have different implications about partiality and adherence to standards. They also differ regarding normative activities and even their underlying understanding of *normativity*. Do they represent mutually exclusive approaches as the literature suggests? And does the consultant need to rely on specific moral values to perform each of these roles accordingly? Does the consultant need to introduce these values explicitly? Or do consultants in these roles impose moral judgments? A *negotiator*, for example, may have just one "technical" value or outcome criterion for CEC, namely, to achieve a stable agreement or decision and behave neutrally regarding (normative) content. A *mediator* may want more than that, for example, to achieve conflict resolution or reconciliation among the parties, and may have to insist on minimal moral standards for the agreement.[10] An *arbitrator*, like a judge, may need to rely on *criteria* to decide what is right or wrong from an independent ethical perspective. Thus, even if one believes that CEC should avoid moralizing, we have to admit that the phrase *ethics consultation as a moral engagement* has some validity.[11]

These questions are hard to answer without a conceptual framework that allows for a sober analysis of what ethics consultants actually do and what they should do (if we were to reach a hypothetical agreement about this issue). Such a framework requires that we combine the perspective of *activities*[12] with that of *roles*.[13]

What can be learned from the previous discussion of values, goals, and roles that took place in the field of psychotherapy about 30 years ago,[14] when orthodox

authorities of the field rejected the idea that psychotherapists ought to try to reach *objectives*. A later, comparative investigation revealed that even quite different paradigms of psychotherapy shared *some* basic sets of moral values, even when they were hesitant in introducing material values directly into the process of counseling and therapy.[15] When psychoanalysis was still determined by a faith in scientism, psychoanalyst Wolfgang Loch provocatively suggested that the role of the psychoanalytic therapist as a "legislator and teacher" be considered[16] as opposed to a role steeped in the rhetoric of "value neutrality" derived from the Freudian abstinence principle, which was often sworn to like an oath or mantra. It is notable that Loch did adhere to the abstinence principle, but also tried to cleanse it from the misleading connotation (and exaggeration) that the therapist had *no* guiding role, not even toward a patient in need of orientation—an articulation that may remind us of some questions in bioethics as well.[17]

Metonyms such as "legislator and teacher" are stimulating (though, perhaps, irritating) interpretations in the context of both psychotherapy and ethics consultation. Calling the normative implications of a professional role by such provocative names raises questions. The activity of CEC may become suspicious for interfering with the individual autonomy of those involved in cases, for example, the professionals, and that needs clarification. This issue is illustrated in the rigor with which the ASBH Task Force argues against an *authoritarian approach* of CEC on the one hand yet also rates a *pure facilitation approach* as completely insufficient.

The concept of authority, however, may deserve a second look for a more constructive interpretation of its meaning in clinical ethics and decisionmaking,[18] and requires that it be distinguished from *directivity* in a consultant's attitude.[19] The stark alternative of the authoritarian and pure facilitation approaches stimulates reformulatation. Rather, we propose that the function of CEC can be characterized as involving a searching attitude that necessarily oscillates between too much or too little (acknowledgment or incorporation of) normativity. To find a way out, the ASBH Task Force suggested the label *Ethics Facilitation Approach*, which we understand as a kind of Solomonic solution. This may terminologically satisfy wishes for a compromise and a third category, but it leaves unresolved what the normative character of the consultant's behavior legitimately involves.

To decide whether there is such a third category—Ethics Facilitation—that is different in substance from the "Pure Facilitation" and the "Authoritarian" approaches,[20] we offer an interpretative framework and a conceptual model. For the sake of clarity, we will analyze a clinical case example with the help of the model to elaborate, more explicitly, the normative implications of CEC.

An Inventory and an Escalating Model of Dealing with the Normative Dimension in CEC

In CEC, the consultant engages in a variety of activities that are mostly linguistic in nature ("speech acts") but not limited to them. For a better understanding of the "doing" of a consultant, we need some agreement on the essential components of the consultant's activities. Contributions of other participants in a CEC are, of course, also part of this picture; they can be complementary, work in the same line, or even replace certain activities otherwise typical of an ethics consultant's role. The left side of Figure 1 shows an approach toward operationalizing the different activities and their gradually increasing normativity; references to some conceptual

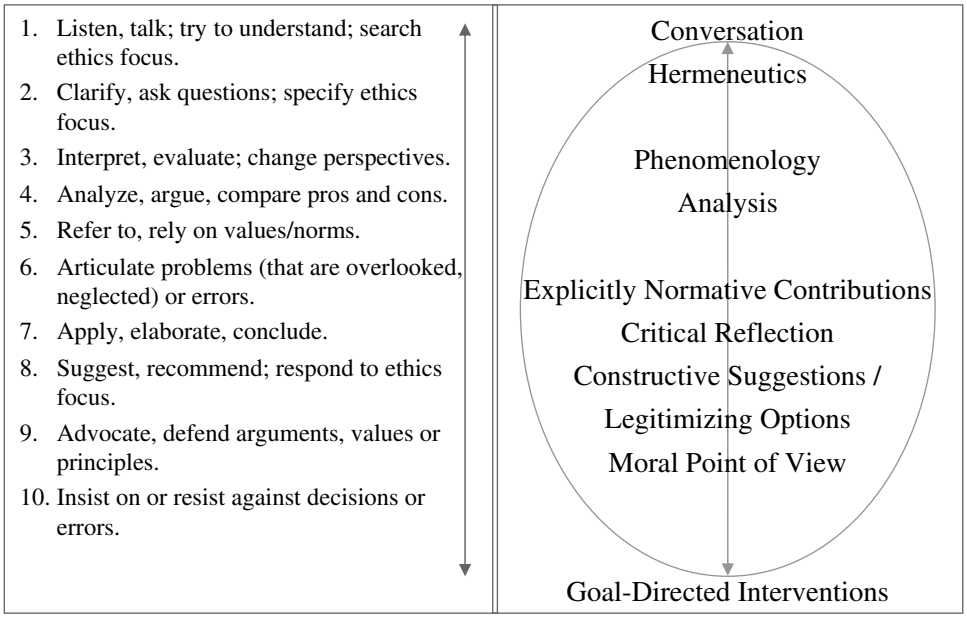

Figure 1. Inventory and escalating model of dealing with the normative dimension.

frameworks by which these activities/levels are understood are made on the right side.

The levels described in the model are gradually inclusive, with subsequent levels building on prior ones. We hereby assume that before going forward to the next level, the previous activities will often have been carried out or tried. The inventory gives indications about what we could do or actually do.[21] The *doing* embraces activities that generally characterize conversation, such as listening and talking, and using arguments or making suggestions as well as a number of CEC-specific actions, such as the identification and specification of an *ethics focus*, that is, asking the question(s) that will be worked through with the aim to find answers (Levels 1 and 2). These questions often have to be selected among a variety of problems presented by the clinical staff at the beginning of CEC. Not all of them may be ethical questions, and some may be impossible to solve in the setting, requiring different approaches. The (re)construction and formulation of an ethics focus that all accept to work on in the CEC session is important in ensuring efficiency and transparency in our approach.[22]

Level 3 deals with the understanding of the problem, and Level 4 leads to moral reasoning and explicitly addresses normative issues. Activities at Levels 1, 2, and 3 may have some normative quality as well, but in a less evident way, for example, by asking questions (think of the *normative power* of asking questions in the Socratic Dialogue). The normative *meaning* of such implications is attained by proceeding through content carrying connotations. The intensity of normativity increases as explicit reference is made to suggest or support particular values or principles (Level 5). Referring directly to normative texts may in some way introduce ''authority'' to consultation. Yet, this kind of authority is based on external sources, such as guidelines, not on the consultant's person or by behaving in an

"authoritarian" demeanor (see the warning of the ASBH Task Force).[23] References made to external sources also pay tribute to reality, that is, to the world where factual norms and conventions actually limit the range of individual moral decisions and choices. A very specific activity of the consultant that regards the epistemic quality of the consultative process is the articulation of errors of knowledge. Such errors occur when, for instance, a relevant ethics guideline is ignored; errors of judgment are made when fallacies occur or inconsistent conclusions are drawn (Level 6). This topic (of errors) has not received much attention so far, but has been addressed by Sulmasy and Sugarman[24] in the context of medical ethics and by Bernal[25] and Reitemeir[26] regarding ethics consultation.

The activities of Levels 7 and 8 deal with linking general values and norms to the specific case and its related questions in order to formulate suggestions and recommendations. In a constructive and productive CEC meeting as we understand it, suggestions and recommendations are formulated and refined through a process shared by the participants. Based on agreement, the decisions are written down and documented (in the minutes or on the patient chart). These decisions, however, are often not yet ready to be applied in practice. Instead, the decisions include additional efforts planned for persuading a patient whose informed consent is not certain or they suggest how a patient will be approached; also, further communication with a patient's relative who is not present may be determined to be a necessary step in building consensus.

In consultations in which the consultative group has agreed on the preferred action that is considered ethically (the best) justified, this agreement serves as a normatively valid basis (at least from a procedural perspective) for deciding about clinical care and putting the decisions into action. But in case the group members do not agree, the case can proceed to Level 9 and members can exchange explicit arguments for and against certain options, that is, on content matters of ethics. Here, we assume that it is preferable for the consultant to engage in Level 9 activities only if the repertoire of previous levels does not lead to an agreement on an ethically justified solution. The ethics consultant—or any other participant—may go further. In case no consensus is reached and the necessity to move further in the escalating model is felt in order to argue in favor of a specific standpoint or to advocate a minority perspective, it is possible to insist on or resist certain decisions or errors (that otherwise would persist) as a kind of last resort option (Level 10). Levels 9 and especially 10 show most clearly how far the normativity of actions can go for all participants of a CEC. This normative activity is not uniquely reserved for the ethics consultant. However, what differentiates the (professional) ethics consultant from the other participants is that the former (by her or his professional task and identity) has to develop a reflective attitude toward his or her role and interventions, whereas the latter may claim to speak on their own behalf or take sides spontaneously. Regarding this requirement of systematic self-reflection (of normativity), the ethics consultant's role is specific[27] based on reasons and experience.

From Level 5 onward, normative contributions are part of ethics consultation and belong to the expected "normal" repertoire. Again, this is not restricted to the ethics consultant, as all participants who engage in the case discussion will make normative statements or references alike—maybe even more so and with less reflection. Compared to the ethics consultants, they may claim to be entitled to advocate interests, not only the patient's but also their own, whereas the ethics

consultant is obligated to serve as a nonpartisan colleague who is certainly not entitled to introduce his or her own (personal) interests, but is expected to introduce more general ethical considerations into the discourse.

Our model is not directly parallel to the ASBH classification, but we can hypothesize a correlation between the ''Pure Facilitation Approach'' and Levels 1 and 2 in their emphasis on conversation and hermeneutic efforts to improve the understanding, perhaps even complemented by some activities from Levels 3, 4, or 5 without having to deal explicitly or methodologically (reflectively) with normative content. Importantly, the ''Authoritarian Approach'' cannot be localized at one point of the inventory. We consider an approach to be *directive or authoritarian* if its methodology fails to support or encourage the competence of those involved to contribute to shared and appropriate views and conclusions and, instead, monopolizes the activities of the ethics consultant despite opportunities for a more participative process.

In Figure 1 we also suggest connections between the inventory of activities on the left side and various conceptual frameworks on the right side; both sides illustrate the idea of gradual ways to deal with normativity. The two-sided vertical arrows serve to localize the given activities or the normative intensity. Conversation serves as the basis of every consultation. For a certain part, CEC can be described as working in a mode of ''hermeneutic ethics'' dedicated to (better) understanding the problem and its focus; this can be complemented by a phenomenological perspective followed by analysis of ethical and practical content issues. The emphasis on the effort to understand, rather than on making moral judgments, may stimulate sympathy; but taking the edict ''don't be normative!'' too literally may take us too close to the Pure Facilitation Approach. A purely *analytic* attitude could restrict CEC to somewhat sterile formalism lacking the constructional elements of conjectures and designs—a vital component of practical ethics. We preliminarily state that more is required than the activities included in Levels 1 to 4 to make a meeting serve as a helpful CEC. Looking at the following steps of Levels 5 to 8 shows that neither is necessarily connected with any ''authoritarian'' or ''directive'' attitude or with moral paternalism. It will depend on *how* the statements or references of normative content are presented in the discourse, that is, on the general attitude and procedure of the consultant, the trust she or he has gained, the respect for the others shown, and the adequacy of his or her suggestions or whether an input is welcomed or perceived as a dictate or ukase—which may also happen erroneously or by projection.

The inventory explicitly lists various activities; these need to be reflected upon and evaluated in light of the particular circumstances or situation of the case in order to decide what steps are appropriate. But at the same time, it implicitly conveys some suggestions about what we should or should *not* do in CEC. The following considerations apply not only to the role of the ethicist, but to other professionals as well. Let us focus first on the ''don'ts'' as they are suggested in the model.

Taking the inventory as a starting point, we should not overstretch the competence of ethics consultation. This implies articulating limits of knowledge or skills and the duty to collaborate with other services, for example, clinical or legal specialists. The ethics consultant should not fail to articulate which questions need to be addressed; this may require going beyond or reformulating the original proposals of the staff. Ethical implications, for example, those of the questions the

consultant asks, should not be kept implicit, but made transparent. Introducing moral values, ethical principles, or guidelines should not happen in an apodictic way, but with an *open mind* toward discourse and skeptical questioning. Errors that persist in the discussions should not be tolerated or silenced, but corrected (as far as possible). Articulating problems or errors is an important epistemic function but may be a sensitive issue for participants and should not be expressed judgmentally or as personal criticism. Also, academic excursions (monologues) or sophisticated subtleties may (in most cases) not be helpful; rather, conclusions and recommendations should be focused on the case and practically relevant. Ethics consultants who feel they should prevent an approach that is preferred by the rest of the group should not fail to have civil courage yet maintain an open mind, abstaining from an ideological or dogmatic attitude. The role of an ethics consultant, above all, should never be colored by moral proactivism[28] or therapeutic (moral) furor, but should be performed in a reflective manner. Furthermore, it would be most unfortunate, and maybe even represent a kind of malpractice, if the ethics consultant did not try to integrate divergent perspectives, deal with the resulting ambiguity as well as the emotions (fear, shame) of those involved in a competent and supportive way. CEC should follow a strong orientation toward solving the problem that was agreed as being the *ethics focus*. In the effort to help those who ask for support, the ethicist should maintain attentiveness to patient rights and needs and try to balance the perspectives from a moral point of view.

A Case Example from Obstetrics: Should We Set Limits to a Patient's Preferences?

Our case is an acute CEC in a Women's University Hospital. Present are the clinical leadership, interdisciplinary clinical staff, and one ethics consultant. Ms. Lucky[29] is a married woman in her late 30s with an intercultural background and academic education. She has a high-risk twin pregnancy after fertility treatment carried out in the United States. Treatment with an egg donation is illegal in the European country where the couple lives and where the woman is currently receiving medical care. The patient is hospitalized at 22 + 1 weeks of gestation (wg) because of cervical insufficiency and an acute risk of preterm delivery. Treatment includes an emergency cerclage, bed rest, and antibiotics stabilizing the situation, but the risk for preterm delivery is still remaining at 22 + 5 wg. Both fetuses have a high risk of death or severe handicap correlated with the imminent premature birth: The earlier they will be delivered, the higher the risk.

Ms. Lucky refuses a potentially life-saving intra-uterine lung treatment[30] for her unborn children although it is strongly recommended by the hospital staff. Her view can be summarized by the following literal quote: ''If pregnancy ends prematurely and I cannot have a healthy child, I want the child to be dead. I do not want a treatment that helps a child to survive with handicap.''

Documentation of the fertility treatment indicates that Ms. and Mr. Lucky have made considerable efforts to become parents. The mother-to-be carries a genetic deviation correlated with her infertility that somewhat modifies her appearance, but does not prevent her from leading an independent life. Staff gave her detailed information about the medical situation, the risks of preterm birth, the suggested treatment option, and its significance for the chances of survival and health of the

Table 1. Escalating Model: What Do We Do in Clinical Ethics Consultation?

A. Inventory of activities	B. Material, access, and medium	C. Case: Questions and steps
1. Listen, talk; try to understand; search ethics focus	Problems, questions, statements containing normative elements	a. Collect the positions. b. Shall the patient's refusal for intra-uterine treatment be accepted?
2. Clarify, ask questions; specify ethics focus	Various opinions; things that are unclear or ambiguous	a. Who shall make the decision? b. Is the patient's information sufficient for decision making? It is assumed that she is drawing misleading conclusions from her internet searches.
3. Interpret, evaluate; change of perspectives	Observations and assumptions about the case and those involved	a. Can her motivation of opposing the medical recommendation be understood and supported? b. What would it mean to the staff to follow the patient's preferences?
4. Analyze, argue, compare pros and cons	Approaches, options	a. What options are possible? b. What else may be acceptable for the patient?
5. Refer to, rely on values and norms.	Values, norms, principles; normative texts; guidelines	a. Make the ethical dimension of the options explicit (e.g., protection of the fetuses' lives; respect for autonomy of the patient).
6. Articulate problems (that are overlooked, neglected) or errors	The consultant's own observations and insights referring to those involved	a. Staff seems to feel morally challenged by the expected outcome if they follow the patient's preference. Staff seems to be caught in a dilemma.
7. Apply, elaborate, conclude	The preliminary results of the discussion; values, norms, guidelines to the case	a. Elaborate the best option(s) in concrete terms. b. How could/should the staff proceed? What are the central ethical arguments for this plan?
8. Suggest, recommend; respond to ethics focus	Specific proposals to be decided upon and documented	a. The ethics consultant repeated questions regarding the values of the staff members, the concept of the hospital and mother-and-child program for more thorough clarification in the light of the ethics focus. b. Staff was encouraged to reflect how far they would go in respecting the patient's preferences that were contradictory to their professional and ethical values. c. A counseling strategy was agreed upon that should be carried out by an experienced consultant (obstetrics or psychosomatics) with the patient.

		d. This strategy was supposed to clarify the errors of the patient and put forward the intra-uterine treatment as the best—standard—option to avoid severe damage. e. It shall be articulated that the woman relies on erroneous assumptions regarding the prognosis (no treatment will lead to dead children, treatment will lead to handicapped children). f. A plan B was voiced so that the counselor would have "something in her back" to rely on in case the patient was not convinced, namely, the message that the staff was not willing to accept the role as bystanders to the withholding of treatment. Part of the counseling should also be: g. to acknowledge the efforts the couple has made to become parents, the engagement of the mother-to-be to find out what the "right" solution could be h. to reassure the patient that no treatment would be given without her informed consent, but also communicating that staff feels that withholding treatment means neglecting the fetuses and putting them at avoidable risk. i. The motivation of staff to give good care for mother *and* unborn children should be made explicit as well as the values of the clinic.
9. Advocate, defend arguments, values, or options	The consultant's own observations and insights referring to those involved	a. The consultant was able to rely on the moral reasoning of the staff involved in the consultation responding to the questions and suggestions (see 8). b. In case the staff had not been articulate about the values and conflicts, the consultant would have stimulated more reflection and demonstrated how the values conflict. c. It is possible that the consultant would have gone as far as asking for an extended round to assess the consequences of violating the principle of nonmaleficence.
10. Insist on or resist decisions or errors	The consultant's own observations and insights referring to those involved	No activity

children. The patient engages in searching medical information on her own on the Internet during obligatory bed rest. Mr. Lucky is devoted to his wife and supports her preferences, staying rather silently in the background.

The staff explains that they do not see any possibility to carry out treatment for the unborn children without the informed consent of the mother, but they struggle heavily with feeling forced to tolerate Ms. Lucky's refusal and, at the end of the day, to become bystanders in neglecting the children and putting them at an unnecessary and avoidable risk.

Are there any ethical limits (to set) for the choice or self-determination of Ms. Lucky at this stage of her pregnancy? Let us keep this question as a preliminary ethics focus for the CEC.

Practical Application of the Model to the Case

How can we integrate the activities of a consultant according to the inventory (column A in Table 1) with concrete aspects of material (content), the access or the medium (how you address an issue) used in CEC (column B) in relation to specific steps during the consultation process (column C)? Table 1 delineates these elements across columns A, B, and C, and proceeds through the levels of the inventory 1 to 10. The right column (C) relates to the case specifically.

In Table 1, we show how the actual CEC proceeded. Due to limited space we do not discuss the consultation process any further here. The case came to a happy end, as the patient agreed to fetal treatment in a timely manner and was delivered of two healthy newborns by cesarean section at 28 wg.

Discussion

The proposed inventory and escalating model serve to reconstruct case consultations and especially the activities of ethics consultants. With this model, we put to discussion a principle of *minimal effective intensity of normativity*, that is, performing as many normative activities as are necessary in order to reach an ethically acceptable result. In the primarily introspective approach of the author, the model seems to capture cases and processes with the different components and their normative implications. The model and its assumptions were tested by presenting it to several audiences with a particular interest in finding out whether the principle of *minimal effective intensity of normativity*, that is, proceeding stepwise in the escalating model, would prove convincing.

From an external perspective, the escalating model seems to possess validity and turned out to be useful and applicable with several audiences where it was tried. It was presented by the author and discussed at a one-day workshop in Maastricht, the Netherlands, in May 2006, within the European Clinical Ethics Consultation Network (ECEN), a group of approximately 25 European colleagues active in ethics consultation. As a first step, three authentic clinical cases (including the case presented here) were given as illustrations of the model. Second, several network members presented their own cases with the task to show which steps of the escalating model they considered appropriate for their case consultation. Summarizing, all members were able to use the inventory, its major components, and the gradual inclusiveness of the escalating model. They also adopted the proposed principle of *minimal effective intensity of normativity*, focusing on the effort to take

advantage of the prior levels before escalating. At a case-based discussion, 2 (out of 25) colleagues preferred to go straight to activities at Levels 9 and 10 in the role of an ethics consultant in order to reach the preferred and—in their eyes—ethically legitimate actions rather than focusing more intensely on previous levels or a more participatory and inclusive strategy (1 of the 2 colleagues was a guest from outside Europe). This difference shows that the model is sensitive to differences of roles, approaches, and concepts of normative intensity. It also distinguishes between more procedural and more goal-directed attitudes. Another debate is triggered by the model, that is, whether ethics consultants act in a prescriptive manner, whether they *should* do so, and, if yes, how this should be practiced.

The model allows us to reflect not only on the normative intensity of the activities of the ethics consultant, but also on activities of other participants or on certain steps in the process. Bringing the steps and the conceptual frameworks together, the model highlights where the strengths of certain approaches lie. It may be that proponents of ''hermeneutic ethics'' or ''phenomenologists'' would frame the activities and their normative implications differently. A discussion between different schools of ethics consultation is invited about whether the proposed model could serve as a *joint model* for orientation in regard to the *dosage* of normativity or how it could be further developed.[31]

One limitation is that the model has been tested and approved so far only qualitatively by two dozen highly competent European colleagues, with three classes of the European Master in Bioethics/the Erasmus program[32] and approximately 120 trainees of CEC from German-speaking countries; therefore, it is supported only by qualitative validation. More research is required to validate this model and on clinical ethics consultation generally, both conceptually and empirically.[33] It seems that the escalating model corresponds with several recent focuses of research as published in a thematic issue on clinical ethics of *Medicine, Health Care and Philosophy*, for example, the empirical evidence of errors of judgment about ethical issues at the bedside. A recent study by Beck, van de Loo, and Reiter-Theil has shown that German intensive care physicians have difficulties in distinguishing between permissible and prohibited options of treatment limitation.[34] An American study has dealt with fear of retaliation as a response to requesting an ethics consultation.[35] A Norwegian team has found out that physicians have concerns about clinical ethics committees and perceive the procedures of reporting as a kind of tribunal.[36] These studies show that normative aspects are ubiquitous and pose challenges to ethics consultation in different settings. Further research is suggested that should be designed to study intersubjective judgment in order to better understand the connections between normative intensity, process, and outcome qualities of CEC. If ethics consultation is to be evaluated regarding outcome and procedure, it will be necessary to define criteria about which way of handling the normative intensity shall be esteemed.[37] The proposed model may serve as a tool for evaluating ethics consultation, especially the normative dimension and within a pluralistic and comparative framework.

Notes

1. The article focuses on the moral norms and on norms formulated in texts such as (ethics) guidelines, rather than on legal norms.

2. American Society for Bioethics and Humanities (ASBH). *Core Competences for Health Care Ethics Consultation*. Glenview, IL: ASBH; 1998; reprinted in: Auliso MP, Arnold RM, Youngner SJ, eds. *Ethics Consultation. From Theory to Practice*. Baltimore, MD: Johns Hopkins University Press; 2003: 165–209.
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19. See note 17, Reiter-Theil 1998.
20. See note 2, American Society for Bioethics and Humanities 1998.
21. To avoid misunderstanding, this inventory is not meant to guide the process of CEC as a stepwise ''method''; rather, it should help in understanding the complex process of CEC and facilitating comparative discussion.
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23. See note 2, American Society for Bioethics and Humanities 1998.
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31. A relatively large audience of multidisciplinary healthcare professionals from German-speaking countries was familiarized with the model during case discussions in the context of training courses (of approximately 40 participants each) and small group work. Interestingly, they responded to the model because they found it particularly intuitive and applicable for the reflection on one's behavior and attitude in the context of learning ethics consultation (Distant Teaching Program "Clinical Ethics Consultation" Fernlehrgang Ethikberater/in im Gesundheitswesen, classes of 2006, 2007 and 2008).
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