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Target Article

Four Roles of Ethical Theory in Clinical Ethics Consultation

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When clinical ethics committee members discuss a complex ethical dilemma, what use do they have for normative ethical theories? Members without training in ethical theory may still contribute to a pointed and nuanced analysis. Nonetheless, the knowledge and use of ethical theories can play four important roles: aiding in the initial awareness and identification of the moral challenges, assisting in the analysis and argumentation, contributing to a sound process and dialogue, and inspiring an attitude of reflexivity. These four roles of ethical theory in clinical ethics consultation are described and their significance highlighted, while an example case is used as an illustration throughout.

Keywords: bioethics, clinical ethics, education, ethical theory, ethics committees/consultation

A primary task of clinical ethics committees (CECs) is the analysis of clinical-ethical cases or dilemmas. One goal may be to give advice on the most ethically appropriate courses of action if such advice has been requested. However, another important goal is to clarify the medical and ethical premises involved, shedding light on the case from several angles, thus increasing stakeholders' and participants' insight into the dilemma. After a successful CEC deliberation, everyone involved may have acquired a deeper understanding that could make a difference in future challenging clinical situations.

An important but perplexing question is what use there is for normative ethical theories in such case deliberations. Many CEC members tell of a chasm experienced between the textbook presentation of the classical ethical theories (such as deontology, consequentialism, and virtue ethics) and the ethical deliberation that takes place within the committee (Clouser 1989; Tunzi 1999; Callahan 2003). CEC members without training in ethical theory may yet have an excellent grasp of the dilemma at hand, and might contribute to a pointed and nuanced analysis of the case. Correspondingly, a CEC having members well versed in ethical theory does not guarantee that the analyses will be of high quality; neither does having a philosopher as an ethics consultant. Although knowledge of ethics is perceived by many to be helpful, such knowledge does not seem to be a *sine qua non*, and its precise contribution is hard to pin down.

This initial perplexity—with the perceived importance of the question—has led us to examine the topic in some

detail. When surveying the literature we noted that more recent work on the role and status of ethical theories has been done in the related fields of empirical ethics (Davies, Ives, and Dunn 2015; Salloch et al. 2015) and ethical expertise (e.g., Steinkamp, Gordijn, and ten Have 2008) than in clinical ethics. The experience on which we draw in our analysis is from our work with research on, and development and supervision of, the Norwegian CECs (Pedersen, Akre, and Førde 2009; Førde and Pedersen 2011; Førde and Pedersen 2012a; Førde and Pedersen 2012b), from ourselves having been CEC members, and from our knowledge of CECs' organization and methods in other countries. Our reflections on this experience, including on CEC cases we have been involved in, have led us to propose four core functions of ethical theories in CEC deliberations.

By normative ethical theory, we mean a practice-oriented account of the good, the right, and the reasons for action. Here we apply the definition somewhat loosely, so as to include theories more occupied with process than with actions and conclusions, such as narrative ethics and discourse ethics.

Ethical theories are not the only sources of normativity available in ethics consultation. In particular, law, clinical practice guidelines, hospital policies, and professional standards are normative frameworks that are invoked in CEC deliberations. Our focus is exclusively on ethical theories, and we do not address the wider question of the relative importance that different sources of normativity should have in clinical ethics deliberations. However, an upshot of our argument is that ethical theories contribute to making

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the normative content of the other sources of normativity more explicit, and thereby remind us that this content could have been different. Ethical theories thus contribute to critical perspectives on law, guidelines, and policies.

As early as three decades ago, it was common for clinical ethicists to criticize a certain paradigm of “applied ethics,” in which clinical ethics would consist of a deductive “application” of one or more preferred ethical theories (especially, perhaps, “high moral theories” such as deontology, consequentialism, or natural law) to a clinical-ethical problem. In regard to this view, sometimes derisively labeled “engineering ethics” (Caplan 1980), an adequate resolution of the moral dilemma would result from a careful application of properly specified moral principles to the case in the way dictated by the theory. Nevertheless, this paradigm has numerous problems (Arras 2010), in particular the following four: (1) Which theory or theories should be applied? A theoretical framework appropriate for a work in academic applied ethics (say, preference utilitarianism) may be challenged as unjustifiably narrow in a clinical context. In the face of the lack of knock-down arguments and consensus among philosophers, and the fact of societal pluralism, a CEC arguably would not be justified in relying on one or a couple of moral perspectives to the exclusion of all others. (2) The ethical theories may lack specificity. In the process of specifying the general and abstract theorems into concrete moral verdicts, sensitive judgement and further premises that the theories themselves cannot supply are needed. (3) Using the theories in the prescribed way may be very demanding for a CEC, and the deep justification of moral verdicts promised by the theories may be unnecessary for the CECs’ more modest purposes. (4) The “engineering ethics” paradigm may misconstrue the nature of clinical ethics, as it gives the illusion that the “ethical work” is only commenced when moral dilemmas and morally relevant facts enter the discussion, neatly sorted and labeled (Caplan 1989; Agich 2001). Furthermore, it also downplays the moral importance of context, interpretations, and the interaction among the CEC members, among stakeholders, and between stakeholders and the CEC.

If ethical theories are important for CEC deliberations, then arguably it is not because theories can be readily applied as per the “engineering ethics” model. In our view, ethical theories play four more modest, yet constructive and important, roles (see the following list). Arguably, no single ethical theory fulfils all these roles fully adequately. In the remainder of the article, we describe the four roles. To help illustrate some aspects of these roles, we employ an example case outlined next.¹

1. The case is fictional, but is based on a composite of a number of real patient stories. The examples given of the contributions of ethical theory to the CEC’s deliberation stem partly from actual CEC deliberations in similar cases, and partly from the authors’ own experiences with case deliberation and reflection on the case and the role of ethical theory.

Four roles for ethical theory in CEC deliberations:

1. Awareness and identification of moral challenges.
2. Analysis of, and argumentation about, moral challenges.
3. Shaping the deliberation process and moral dialogue.
4. Spurring reflexivity and interpretation.

The Case of the Uncooperative Dialysis Patient

A middle-aged man developed terminal renal failure. He was found to be medically unsuited for a renal transplant, and was started on hemodialysis. However, the patient’s behavior quickly became an immense test for the health professionals. The patient was often extremely uncooperative. Although he had been informed about the extra costs and inconveniences for others, the biggest problem was that he frequently missed dialysis appointments, sometimes showing up in the middle of the night in need of life-saving acute dialysis and intensive care, a combination that was much more costly than planned dialysis. When he was in need of intensive care unit treatment, other patients often had to be displaced from the unit in order to make room. The patient was deemed competent, and repeated psychiatric assessments did not reveal any treatable condition.

Nurses and physicians in the dialysis department turned to the CEC for advice on what needed to be done. The situation was perceived to be untenable. Hence, was it legitimate to stop providing dialysis, even though this would likely lead to the patient’s death?

Awareness and Identification

The “engineering ethics” paradigm criticised above may be taken to imply that we already know what “the” (singular) moral problem is. However, the “ethical work” often commences at a prior stage. In practice, becoming aware of and identifying and defining the moral issues at stake may be difficult, and may require discernment, close attention, and a knowledge of ethics, health sciences, and health care services. The ability to perceive moral issues is crucial, and such “moral sensitivity” can be trained, for example, by gaining insight in ethical theories. Often, clinicians present a situation perceived to be difficult and challenging, and then require the CEC’s help in putting the core moral problem(s) into words with a precise ethical vocabulary. In one case much like the dialysis case (described above), the clinicians’ initial question was whether treatment had to be continued at any cost or whether one could say that the patient has had enough chances to comply. With the CEC’s help this question was sharpened into “whether it would be morally and legally acceptable to forego dialysis.” This was then taken to be the primary moral problem guiding the subsequent discussion.

In addition, there was a related moral problem that was not immediately apparent to the CEC and the presenting clinicians and that knowledge of ethical theory helped identify. If the hospital declares that the patient is no

longer entitled to dialysis because of the frequent breaches of requirements of conduct, then a different team of clinicians will be required to deny the patient lifesaving dialysis if and when he is admitted in a life-threatening condition. Among ethical theories, care ethics (relational ethics, ethics of proximity) approaches are particularly suited to elicit the serious moral conflict the clinicians may experience in this case. In short, care ethics emphasizes that moral demands primarily arise from encounters with others; for health professionals, a strong clinical-moral imperative of beneficence arises from the encounter with the suffering and needy patient. When this imperative is set aside, and a patient who could be saved is not, this goes against the grain of clinical-moral intuitions and may be experienced as extremely morally distressing. Here, the care ethics approach helps identify and detail an additional ethical problem that was not part of the initial request to the CEC.

Ethical theories supply us with numerous concepts that make it easier to perceive and articulate moral challenges and the values at stake, and to acknowledge different perspectives and interests. The clinician or CEC member who grasps the meaning of, for example, the “rule of rescue,” moral complicity, moral distress, respect for patient autonomy, and bedside rationing is better equipped to recognize moral challenges in clinical situations.

Ethical theories also help us single out the specifically moral aspects of situations perceived to be challenging. Dilemmas in health care may have medical, moral, juridical, practical, organizational, economic, and other components. When are we facing an ethical dilemma suitable for the CEC, and when is it a case, for example, for hospital quality assurance systems or health authorities? Such a “sorting” of cases is a crucial part of the initial work for the CEC. Knowledge of ethical theory is helpful here because ethical theories delineate what belongs inside and outside the domain of the moral. When sorting through the myriads of facts and information, ethical theories help us describe what is of moral import—and how, why, and how much (Brody 1989). Our own experience indicates that CECs without members trained in ethics find such a discernment to be more difficult, or jump too quickly to a fixed and sometimes biased problem description. In several cases, including a case resembling our dialysis case, some clinicians and CEC members appeared to reduce the question of the patient’s competence to a question of whether psychosis or dementia were present; when ruled out, they deemed the patient competent in a clinical and moral sense. Another, general observation is that from the perspective of ethicists, clinicians often speak of moral problems as if they were fully medical/technical problems.

In addition to providing relevant systems of thoughts, knowledge, and terminology to make different and implicit moral problems more explicit, some ethics theories, such as virtue ethics, ethics of care, and narrative

ethics, underscore the significance of moral perception and discernment, thereby highlighting that the initial awareness and identification should not be taken for granted.

In sum, ethical theories aid the participants in the CEC deliberation to become aware of and identify moral challenges.

Analysis and Argumentation

Perhaps the most obvious use of ethical theories is to enrich the moral deliberation with precise concepts, distinctions, and perspectives to analyze arguments. When the “engineering ethics” paradigm is rejected, a natural alternative is instead to welcome every relevant moral consideration into the deliberation, regardless of which ethical theory the moral consideration may have originated from. The greater the CEC member’s familiarity with ethical theories, the greater is the repertoire of morally relevant viewpoints from which to draw. Every ethical theory may be thought to supply a unique perspective on the moral arguments at stake. From each theoretical vantage point, something of relevance that may not be apparent from the other perspectives may be pointed out (Tunzi 1999; Freeman 2006; Brody and Clark 2014). Table 1 illustrates this insight in sketching some morally relevant considerations brought forth by some ethical theories.

To illustrate further, we go into some detail using two distinct approaches to ethics as examples. First, casuistry would enjoin us to examine whether there have been any paradigmatic or analogous cases, to compare the current case with these previous cases, and to judge whether there is enough similarity to argue for similar solutions. In one CEC discussion, it was claimed that some medical treatments are analogous to dialysis in being resource-consuming and demanding meticulous patient compliance for success. For instance, in some centers repeated surgery is not offered for patients with peripheral arterial disease who persist in smoking. Another example is that patients who are deemed unlikely to be compliant with the complex drug regimen required after organ transplantation are denied a transplant, as the risk is deemed too high and the organ thus will be more likely to provide significant benefit to other potential recipients. Sometimes candidates for transplants are required to show signs of ability to comply with treatment regimens, for example, by abstaining from smoking, alcohol, or narcotics for a defined time period. These established practices were argued to provide some warrant in the dialysis case for demanding a certain level of compliance for treatment to be continued. However, there are also important disanalogies that arguably preclude adopting an equally strict policy in the dialysis case as in organ transplantation (in particular, dialysis capacity is not a scarce resource in the same way that organs for transplantation are).

Another and quite distinct approach to the current case could be to ask how and to what extent patient autonomy should be respected in this case. “Respect for autonomy” is an example of a principle that originated in ethical

Table 1. A selection of morally relevant considerations raised by some ethical theories in the dialysis case.

Ethical theory	Moral consideration
Deontology	The duty to save lives; respect for patient autonomy; does the patient forfeit his right to treatment through his behavior? Respect for the safety of health professionals
Consequentialism	The consequences of continued treatment, including for other patients, and for job satisfaction and safety for dialysis personnel; costs of treatment and potential benefits of alternative uses of the resources
Virtue ethics	Health professionals here display virtues of patience and self-effacement, but should not go too far. Where is the golden mean? What is it to be a “good” professional in this situation?
Casualty	How have analogous cases been handled? For example, patients who cooperate poorly are sometimes denied organ transplants and other treatments that demand meticulous compliance.
Narrative ethics	The extended narratives of the health professionals and the patient will likely uncover more detailed first-person perspectives and considerations otherwise neglected, yet useful for a creative resolution of the case.
Ethics of care	The severe moral conflict experienced by those who are to deny the patient life-saving dialysis
Principlism	Prima facie duties to respect patient autonomy and provide beneficent health care; the imperative not to harm other patients; the question of just allocation of resources
Discourse ethics	The patient himself and all health professionals involved in the patient’s care (not only the dialysis personnel) ought to participate in the moral deliberation and decision making. Viewpoints and proposed courses of action must be underpinned by reasons.

theories, but that has subsequently been refined and developed further within bioethics (Baker and McCullough 2007). Deontological and consequentialist theories give rise to different conceptions of what respect for patient autonomy involves, conceptions that contrast with the ones dominant in contemporary bioethics. In Kant, respect for autonomy involves respect for the person as self-legislator, as far as that the norms that the person gives herself are in line with the moral law (“moral autonomy”; Kant 1997). In Mill, on the other hand, autonomy has more to do with a respect for individuality (“individual autonomy”; Mill 1869). In today’s bioethics, respect for patient autonomy often means respect for a competent patient’s decisions—regardless of how the decision coheres with any external moral standard or even with what is perceived to be rational.

According to a contemporary bioethical notion of autonomy, it could be argued that since the dialysis patient was competent, was well informed, and explicitly accepted the treatment and conditions set forth by the health care professionals, it follows that the patient’s consent to treatment was valid, that the decision to submit to the treatment plan was an autonomous one, and that respect for patient autonomy enjoins that the health services should provide the treatment. However, his repeated sabotage of the treatment conditions could raise doubt as to whether he really wanted lifelong dialysis or whether his competence was fluctuating. Was his conduct a way of saying “I do not want treatment,” a sign of incompetence, or a sign

of lack of ability to cooperate? A Kantian-inspired analysis would therefore question whether the patient’s decision to submit to treatment really was autonomous; the broader picture of the patient’s conduct raises doubt of whether it is an expression of moral law or in line with any demands of rationality. A Millian analysis of autonomy would give more leeway for expressions of individuality even when these appear quaint, irrational, or even destructive to onlookers; however, it could be argued that the patient’s wavering, unpredictable, and destructive conduct in this case is not an expression of morally valuable individuality. In addition, Mill’s “harm principle” implies that the exercise of autonomy should not harm others; in the dialysis case the patient’s conduct does harm health professionals and other patients. Kantian and Millian analyses, therefore, may lead to the conclusion that there has been no valuable exercise of patient autonomy in this case, no morally valid consent, and that much of the basis for respecting the patient’s self-determination therefore withers away. This may be used to argue against any moral obligation to provide treatment.

Furthermore, a Kantian analysis would stress that any initiatives that could strengthen the patient’s rationality and thus autonomy (e.g., optimization of drug regimen to minimize cognitive side effects) should be seriously considered. A truly autonomous patient should not be under pressure to make specific choices. In our case this leads us to ask whether the patient’s lack of cooperation and aggressive behavior were products of impulses over which

he had no control. If the answer is yes, then the patient arguably is not competent in such situations, and the obligation to offer treatment would be strengthened.

In this case, some knowledge of the ethical theories of Kant and Mill, and the tension between their concepts of autonomy and contemporary notions of autonomy, provides new dimensions to the CEC's discussion of whether, and how, to respect patient autonomy. Such analyses rooted in ethical theory add breadth and depth and may also uncover weaknesses in clinical and legal notions of autonomy and competence.

The dialysis case exemplifies a type of conflict often experienced by health professionals. In the formal and informal ethics of the health care professions, the duty of beneficence and the "rule of rescue" (the clinical instinct and deeply felt principle that lives should be saved when possible) are strongly emphasized. The latter principle also figures prominently in health law in many countries. As in the dialysis case, these demands of professional ethics may conflict with other serious considerations. A task for the CEC, therefore, is to point out and provide a vocabulary for these other considerations and the moral conflicts perceived. Ethical theories are well suited to detail such considerations that supplement and nuance professional ethics. In the dialysis case, ethical theories provide resources to show and justify the moral relevance of such considerations (e.g., costs and resource use, and justice and equality in treatment; cf. Table 1).

When drawing on a multitude of ethical theories, it becomes apparent that although some theories provide unique perspectives, that is, moral considerations not offered by the other ethical theories, there is much redundancy and overlap. However, even though some theories may superficially seem to provide the same moral consideration, when examined in detail the theories may turn out to inspire detailed, mutually enriching or competing accounts of the consideration in question, as is the case with rivaling notions of respect for autonomy, discussed above.

Insights from ethical theories allow us to clarify more precisely the content of moral terms and concepts, as they let us name the moral issues at stake (e.g., "distributive justice," "alternative uses of resources," professional obligations and virtues). Because ethical theories typically provide a deeper justification of moral norms, they enable CEC members to elaborate, criticize, and rationally weigh competing arguments and considerations, hence justifying conclusions and advice in a transparent way (Macklin 2015). Moral conclusions will not have to rest solely on a more opaque and intuitive "weighing" of the different considerations (Magelssen, Førde, and Pedersen 2014). Because ethical theories let us identify and name the moral concerns at stake, they will also aid us in inventing creative solutions that will heed as many of these concerns as possible (Ackerman 1989). For instance, in a case inspiring our dialysis case, it was argued during the CEC consultation that the clinicians should present the patient with an ultimatum, requiring compliance with core behavioral requirements.

Confronting the patient with clear requirements of this kind was argued not to involve any disrespect, but rather a true respect for the patient's dignity and moral autonomy—for presenting clear requirements, mutually agreeing on arrangements, and expecting compliant behavior amounted to treating the patient as a continuously competent moral agent. A clarification of the meaning of autonomy led the parties to the deliberation to deem it morally acceptable to set strict limits based on a mutual agreement. In this case, then, a moral creativity partly rooted in considerations brought forth by ethical theories (i.e., what respect for a person and his autonomy truly involves) was conducive to inventing and justifying a potential solution of the case.

Knowledge of ethical theories will enable CEC members to uncover weaknesses, such as a lack of consistency, in their own arguments or those of others. Related to this, such knowledge may be instrumental in uncovering hidden interests, since a familiarity with ethical theories also helps prevent the misunderstanding of moral principles and moral "blind spots." Brody's example of this is of an ethics committee that whose members consider harm to individual patients "solely in terms of physical and emotional harm and do not consider affronts to basic human dignity such as violations of the right to privacy" (Brody 1989, 194). Such an oversight could be corrected through coming to understand notions of human dignity rooted in certain ethical theories. Arguably, another blind spot among some health professionals is the moral importance of costs. Many ethical theories (e.g., consequentialism, and principlism through the emphasis on justice) enjoin that costs and alternative uses of resources ("opportunity costs") be taken into account. Such considerations are sometimes perceived as challenging for health professionals, especially when pitted against the obligation to provide lifesaving treatment, as in the dialysis case.

To sum up, the more knowledge of ethical theories and experience in using them possessed by the CEC as a whole, the better the CEC is equipped to analyze the case in more depth and breadth, and to argue for and against different courses of action.

Process and Dialogue

Ethical theories not only provide substance to moral deliberations, they also prescribe principles for the form in which deliberations should be carried out. For instance, Habermas's discourse ethics claims that ethical statements become valid through the way they come to be (Habermas 1990; Habermas 1995; Bernstein 1995). For Habermas, a moral norm is valid only if all who are affected accept it in an actual, rational dialogue that is free of coercion (Casaret, Daskal, and Lantos 1998). Habermas's ideal for ethical deliberations requires that all affected parties capable of speech and action are entitled to participate, therefore contributing to the discussions and imparting their views and arguments. For the CEC, this translates into an ethical ideal of letting every stakeholder have his or her say, preferably by being present and taking part in the whole

deliberations, or at least through a representative. In our dialysis case, this implies an attempt to include the patient or a representative and all health care workers involved in the moral deliberations. This may sound obvious, but is still often not the case in CEC deliberations (Førde and Pedersen 2011).

Discourse ethics also demands that no relevant arguments are suppressed or excluded by the participants, and transparency in decision making. Moreover, important claims and decisions should be critically evaluated and justified, and the force of the better argument should prevail. These are all important norms for the CEC, which are difficult to achieve in full, though useful as ideals to strive for. Discourse ethics and other procedural norms developed through democratic processes may also contribute to clarifying who ought to have the final word and how the stakeholders may appeal in case of persistent disagreement.

Narrative ethics is another ethical theory that may structure CEC deliberations in important ways (Walker 1993; Porz, Landeweer, and Widdershoven 2011; Brody and Clark 2014). Narrative ethics emphasizes that morally relevant facts may best be brought out by giving the stakeholders ample room to tell their stories. Such stories may highlight how the moral issues are embedded in the patient's (or other stakeholder's) greater narrative and self-perception, thereby potentially bringing out morally relevant facts that otherwise would easily be missed. Narrative ethics thus argues that there should be sufficient room for the stakeholders to tell their stories in the course of the CEC deliberations. In the dialysis case, perhaps the patient's own story could offer glimpses of an explanation for the patient's conduct and noncompliance, which were otherwise fully perplexing to the health professionals.

Some ethical theories, then, have consequences for how the process of moral deliberation and dialogue should proceed, and hence also for what information is brought into the deliberation.

Reflexivity and Interpretation

Lastly, ethical theories may inspire ethical reflexivity among CEC members. The conscious employment of diverse perspectives, theories, and arguments can contribute to an awareness of the fact that a range of opinions is possible and may very well be justified. The plurality of ethical theories and perspectives highlights that ethical deliberations always involve interpretations and presuppositions of several kinds (clinical, moral, etc.; Chambers 1999; Widdershoven and Molewijk 2010), as we all bring such presuppositions to the table. Such awareness contributes to a much-needed reflexivity, revealing to what extent one's moral analysis reflects one's own particular background (Callahan 2003). It may also help uncover hidden interests and moral premises. Some theories, such as narrative ethics and hermeneutical theories of ethics, have such

reflexivity built into their very fabric (Widdershoven and Molewijk 2010).

In a case inspiring our dialysis case, some of the clinicians who presented the case to the CEC took it as an obvious truth that the patient had forfeited his moral right to dialysis treatment through his unacceptable behavior. That may indeed turn out to be one conclusion in the deliberation; still, ethics and the CEC play crucial roles in being the "devil's advocate" through actively seeking out alternative viewpoints and interpretations of the case and what are presented as "facts." For example, narrative ethics would again maintain that any narration of a medical case, such as the brief presentation of the dialysis case provided above, is a selective retelling from a certain stakeholder viewpoint, involving a certain framing of the situation. Retellings from alternative viewpoints may indeed reveal morally relevant points. For instance, did anyone ask the patient to tell his story or seek to understand his conduct, inform him about the possible consequences of his actions, or assess whether the information given had been understood?

Reflexivity may help CEC members see what crucial facts are missing from the case description, and how such facts may be described and evaluated differently. It also brings forth an appreciation that conclusions are apt to be revised when every relevant consideration is allowed into the discussion and is viewed from various angles. This attitude of reflexivity appreciates that differences in perspective can and should be used constructively, rather than be seen as threats.

Reflexivity involves an attempt to understand the thought processes, value systems, and presuppositions of oneself and other parties to the deliberation—a hermeneutic consciousness. Reflexivity also involves a critical consideration of the CEC's role—for instance, how normative should the CEC be in its conclusions? How should the CEC balance the asking of pertinent questions with the working out of answers? How does the CEC itself—for example, its composition and deliberation procedures—influence what is discussed, what kinds of information and arguments are brought forth, and what are regarded as relevant or valid points (Magelssen, Førde, and Pedersen 2014)?

Ethical theories shed light on the fact-value distinction. Even though the theories portray the relationship between facts and values differently, at the very least they remind us that there are few, if any, value-free or obvious answers to challenges in the health services.

In sum, knowledge and the use of ethical theory contribute to the CEC members' reflexivity by producing an awareness of two "multitudes": first, the multiple interpretations of the case at hand available, pointed out in particular by theories focused on process, such as narrative and discourse ethics; and second, the multitude of moral viewpoints and arguments that may be weighed differently by different participants to the deliberation, shown in particular by theories focusing on content, such as deontology,

consequentialism, virtue ethics, and principlism (cf. Table 1).

LIMITATIONS AND DANGERS OF ETHICAL THEORIES

As with any potent tool, the use of ethical theories may also do harm. The ethical deliberation may be adversely affected in at least four ways: First, if ethical theories are used too rigorously, they may restrict or disturb moral imagination and intuition, “common morality,” and a freer discussion of the case, leading to a neglect of important features. For instance, an analysis of the dialysis case mainly in terms of moral duties and rights involved would miss considerations such as costs and consequences for other patients, factors that are highly relevant (cf. Table 1).

Second, the one who commands a range of ethical theories may be tempted to give unreasonable preference to the theory that will justify a solution already settled on in a biased, less-than-rational way (Magelssen, Førde, and Pedersen 2014). A CEC member trained in philosophical ethics could, for instance, no doubt argue convincingly and at length from a principlist perspective to the conclusion that the patient has forfeited his right to have his autonomy respected and to dialysis through his conduct. However, CEC deliberations should take all relevant arguments and perspectives into account, regardless of the theoretical origin (if any) of such considerations, and CEC members should actively search for and explore counterarguments to the conclusions they intuitively prefer.

Third, ethical theories may mislead, such as when moral challenges are framed or characterized in ways that focus on aspects of marginal importance or are perceived as irrelevant to the stakeholders (Salloch et al. 2015). For instance, not infrequently, cases are resolved by facilitating improved communication between the stakeholders, and not by weighing competing concerns in an ethical framework (Førde and Vandvik 2005).

Fourth, a little learning is a dangerous thing. Some ethical theories require quite advanced knowledge and skill in order to be used properly. For instance, principlism’s four main principles are not intended as merely headlines or reminders, but should be specified and balanced in quite specific ways (Beauchamp and Childress 2013). Without proper training and understanding, CEC members may use ethical theories in ways that are misleading (e.g., the common misunderstanding of Kantianism as prohibiting any use of a person as a means to an end).

The theory pluralism we espouse invites a host of ethical theories to the CEC’s table. Many of these theories are mutually inconsistent. Therefore, it may be objected that such theory pluralism would lead to an ethical stalemate where most arguments and viewpoints can be contradicted by considerations from competing theories. How may cases then be resolved in a rational way? Our answer to this is twofold. First, additional reasons will often be

able to underpin certain solutions of the case, so that these emerge as the most rationally compelling. As discourse ethics would stress, the force of the stronger argument should prevail in a moral dialogue free of coercion. Second, we maintain that in principle the deliberation should be open to all ethical theories, as each theory is likely to present a glimpse of genuine moral insight not readily provided by the other theories.

CONCLUDING REFLECTIONS

We have described four uses of ethical theories in CEC consultations. Ethical theories aid the initial awareness and identification of the moral challenges, assist the analysis and argumentation, contribute to a sound process and dialogue, and inspire an attitude of reflexivity. These are all core functions or characteristics of a successful CEC. Inasmuch as knowledge of ethical theory aids the CEC in these four areas, such knowledge is therefore a valuable asset for the CEC. This is so even though knowledge of ethical theory is not always necessary—a valuable, particular contribution to the deliberation can be made without the CEC member’s awareness of the argument’s origin and basis in theory (if any).

In the literature on expertise in clinical ethics it is often maintained that such expertise involves skills both in substantive ethical analysis and in facilitating good deliberations (Casarett, Daskal, and Lantos 1998; Steinkamp, Gordijn, and ten Have 2008). We have shown that a grasp of ethical theories contributes to both aspects of such expertise.

It has been claimed that every CEC member should have a “basic knowledge” (“a general, or introductory familiarity”) of ethical theory, whereas at least one member should possess “advanced knowledge” (American Society for Bioethics and Humanities [ASBH] 2011). This is sensible advice. However, because such knowledge potentiates each member’s deliberative skills and contribution to the deliberation, increasing one’s knowledge of ethical theories further seems a worthwhile investment for every CEC member.

One upshot is that CEC members would benefit from being taught about different ethical theories and their uses. However, as discussed in the previous section, any instruction must be sufficiently detailed for benefits to ensue and to avoid the pitfalls of a superficial grasp of the theory. In this article, we have illustrated the four roles of ethical theory by way of an example case. Correspondingly, we think that concrete examples of how ethical theory enhances deliberation and analysis are powerful didactic tools, increasing the interest in and comprehension of the ethical theories taught.

Our discussion presupposes an eclectic view on the multitude of ethical theories: In clinical ethics, they complement each other. The broader one’s knowledge of ethical theories, the more of the four benefits will be reaped. Any ethical theory able to enrich the discussion should be welcomed into the CEC deliberation.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest. ■

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