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I am submitting herewith a dissertation written by Meghan Estell Bungo entitled "Searching for Consensus: Shared Decision Making and Clinical Ethics." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

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**SEARCHING FOR CONSENSUS:
SHARED DECISION MAKING AND CLINICAL ETHICS**

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

Meghan Estell Bungo
December 2013

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DEDICATION

I dedicate this work to my
husband and best friend, Shawn Bungo.
Your sacrifice and support has meant the world to me.

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I would like to first acknowledge my dissertation advisor, mentor, and tireless supporter, John Hardwig. John, as cliché as it sounds, has truly gone above and beyond the call of duty in regards to both his help with this dissertation and his guidance during my career as a graduate student. Without his tireless efforts in commenting on numerous drafts for numerous years and his persistent encouragement I would have never finished. He is responsible for seeing me through these last several years of graduate school, and for that I am more grateful than he will ever know. His example as a philosopher, as a writer, and as a mentor is truly inspirational. Thank you John for the time you've given me and the confidence you've instilled.

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ABSTRACT

The focus of this dissertation is the search for consensus in the context of clinical ethics—physician-patient interactions, ethics consultations, and ethics committee meetings focused on a particular patient’s care. I argue that consensus, when achieved through a process of shared deliberation that I outline, is the hallmark of the morally correct decision.

While philosophers have generally denigrated consensus as a guide to morally correct decisions, hospital ethics committees and President’s Councils charged with making recommendations about how to resolve moral conflicts in the clinical setting have clearly valued and aimed at the achievement of consensus. Assuming this search for consensus is not wrong-headed, bioethicists owe clinicians an account of the proper role of consensus in clinical decisions. My aim in this project is to carefully examine and define the role that consensus ought to play in guiding our moral decision-making.

In this project, I define and defend clinical pragmatism, a consensus oriented approach to clinical ethics. Following a critical examination of two approaches that defend consensus as centrally important in ethical deliberations, I define consensus and distinguish it from other types of agreements to clarify the kind of agreement I wish to defend. Consensus can be reached in various ways, and not all are morally defensible. So, I develop an account of the necessary conditions—shared deliberation, tempered equality, freedom from undue influence, and mutual respect—for arriving at a consensus that is the morally correct decision in the clinical setting. I argue that, when pursued in this way, the search for consensus has moral value even when consensus proves elusive.

I defend the thesis that in a clinical moral conflict, the procedure I outline is both necessary and sufficient for full moral justification of the resulting decision. If the committee followed this procedure, their decision is the morally correct one for them to make given the resources available to them—it was the best decision they could have made at the time. An appropriate consensus *defines* the morally correct decision. Merely arguing for our preferred ethical theory is not enough; some sort of truly shared decision-making is needed.

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INTRODUCTION

The idea that a consensus on a moral issue carries any real moral authority or claim to “rightness” merely because it is a consensus is an idea that is commonly rejected by most ethicists. We, I think rightly, have a suspicious attitude towards allowing consensus to take any primary role in our moral theories. It seems, at least at first glance, that much of this skepticism stems from some of the most glaring moral failures of our past. For instance, there was a consensus (at least among white males) that women ought not be able to vote or own property, or among many white Americans that slavery was a morally acceptable practice. They had a reasoned, and what they saw to be a reasonable view regarding this position. There are an abundance of examples of this sort. A consensus regarding moral concerns is not something that seems to be desirable, and certainly not important in terms of getting it “right”. A consensus oriented approach to resolving ethical issues also seems to imply that in effect, anything goes—it just depends on who’s involved in the consensus formation.

While consensus is often looked upon with suspicion in ethics, in the political context, quite the opposite is true. Deliberative theories of democracy often take the position that consensus following a deliberative process of engagement among citizens is the height of political legitimacy. Moreover hospital ethics committees charged with making recommendations about how to resolve moral conflicts in the clinical setting have clearly valued and aimed at the achievement of consensus. Assuming this search for consensus is not simply wrong-headed, bioethicists owe clinicians an account of the proper role of consensus in clinical

decisions. My aim in this project is to delve more deeply into the role that consensus ought to play in guiding our moral decision making. My focus in this dissertation will be on consensus in the context of clinical ethics—more specifically in the context of physician-patient interactions, ethics consultations, and ethics committee meetings focused on a particular patient’s care. I will argue that contrary to popular opinion, consensus, when achieved through a process of shared deliberation that I will outline, is the hallmark of the morally correct decision.

I will take my lead from a notable recent trend in bioethics that defends consensus as centrally important to our ethical deliberations. Most notably, following John Dewey’s pragmatist ethics, two approaches in particular, that of Jonathan D. Moreno, and that of Joseph Fins, Matthew Bachetta and Franklin Miller, go some way in defending the role of consensus in clinical deliberations. While Fins et al. coined the term “clinical pragmatism” I will refer to both as clinical pragmatists. Although they differ in important ways, both accounts agree that at the very least, consensus ought to shape the way in which we make ethical decisions, that is, the *process* by which we decide. I will take these approaches as my starting point for further examination and defense of a consensus oriented approach to clinical ethics deliberations, and contend that these approaches as they stand do not go far enough.

Following a brief critical examination of these two widely noted approaches, I will take on the positive tasks of both defining and defending a consensus oriented approach to clinical ethics. In particular, I will, 1) Define consensus and distinguish it from other sorts of collective agreements including some that are often also called consensus; and 2) Develop an account of the necessary conditions—shared deliberation among all concerned, tempered equality, freedom from undue influence, and mutual respect—for arriving at a consensus that is the hallmark of the

morally correct decision in the clinical setting. I will defend as fully as I can the radical thesis that in a morally problematic clinical situation, the procedure I outline (chapters 4-6) is both necessary and sufficient for full moral justification of the resulting decision. If the committee faithfully followed this procedure, their decision is the morally correct one for them to make given the limitations of the resources available to them. If they did not follow this procedure, then their decision falls short of full moral justification, no matter how “correct” it might be. In this sense, an appropriate consensus *defines* the morally correct decision. If we are to come together on a decision, merely arguing for our favorite ethical theory is not enough; some sort of truly shared decision making is needed.

I hope to show in this project that clinical pragmatism provides a morally valuable and integral account of the sort of approach that is needed to resolve concrete ethical problems in the clinical setting. My hope is also to provide an initial account of guidelines that those that find themselves confronted with moral conflicts and the demand for moral action in the clinical setting will find helpful. I am sure that I will not be able to offer a completely adequate defense of the view that following the prescribed procedure is both necessary and sufficient for full moral justification in the practical context of the clinic. Too many complex and contested concepts will be involved all needing more extensive analysis than I will be able give them here. But I am also convinced that I will offer a better defense of clinical pragmatism than has been offered thus far.

CHAPTER 1

CLINICAL ETHICS AND CONSENSUS

Introduction

While traditional ethics has often taken a skeptical stance towards the role of consensus, when committees meet and deliberate over cases within a hospital, or when councils meet to decide or offer advice on medical policies, the aim has been to reach a defensible consensus about what to do or how to proceed. This practical consensus orientation has led many bioethicists to examine the role that consensus both does and should or should not play in the clinical ethics context. While not all have come down on the side of defending a consensus orientation in clinical ethics, many have.

The most heavily cited bioethicist regarding consensus and its role in bioethics has undoubtedly been Jonathan D. Moreno. Beginning in the late eighties Moreno has analyzed the role that consensus ought to play in our clinical deliberations and has argued for the centrality of consensus in our bioethical deliberations.¹ On his view, consensus ought not be an aim of our deliberations, but rather, ought to condition the process by which we decide. As he argues, the moral authority of consensus is not as an outcome or decision about what to do, but rather, at the level of process, that is, how we make the decision. While Moreno has written most extensively

¹ See (Moreno 2005) (Moreno 1995) (Moreno 1990) (Moreno 1988) especially, though he has also written countless articles on the matter.

on the role of consensus in the clinical setting, others have taken consensus oriented positions that importantly differ from Moreno's approach. Joseph Fins, Matthew Bachetta, and Franklin Miller have written a handful of short articles promoting an approach to clinical ethics that they've entitled "Clinical Pragmatism."² On their view, consensus ought to do more than condition the process as Moreno insists, but further ought to be the aim of our moral deliberations in the clinical setting.³ While they agree with Moreno on the central importance of consensus, they argue that when working through ethical issues in the clinic, we ought to *aim* at a consensus that can withstand moral scrutiny. In this chapter I will survey the approaches of both Moreno and Fins et al., and argue that while both have gone some way towards developing the role that consensus ought to play in our clinical ethics deliberations, both have fallen short in important regards. I will begin with an overview and analysis of Moreno's view since his position is the most developed in the literature.

Jonathan Moreno— Consensus as a Condition

Moreno's overall project regarding the role of consensus is, as I take it, composed of two general parts: 1) A descriptive account of the role consensus actually plays in clinical ethics, particularly as it is instantiated in the hospital ethics committee and their recommendations regarding particular cases; and, 2) A normative account of the role consensus ought to play in hospital ethics committees, that is, an account of what he refers to as the "moral authority" of

² (Fins, Bachetta and Miller 1997); (Fins 1998); (Fins and Miller 2000).

³ (Fins, Bachetta and Miller 1997)

consensus.⁴ According to Moreno, bioethics at every level is oriented around consensus.⁵ We call for hospital ethics committee meetings, president's council's, etc., all with the charge of achieving consensus on how to proceed into often times uncharted territories. While consensus has become a central aspect of bioethical deliberations, on his view, consensus has moral authority only as a *condition* on the process of moral decision making and deliberation, and it ought not to be construed as an *aim* or an "end in itself."⁶ As he explains:

...the history of Western philosophy is replete with warnings about the special danger of permitting individuals to cede moral responsibility to groups. As has been noted, modern social psychology is full of accounts of this distortion of rational decision making by the effects of small group interaction. A single strong personality can exercise undue influence over others, for example. The consensus can be a cover behind which hide timidity, lethargy, self-interest, and even social pathology.⁷

As Moreno remarks, the moral authority of consensus as an outcome or decision reached is dubious, particularly given the long list of practical concerns and possible abuses. As he explains, implicit in the notion that ethics committees "strive for consensus" is that all we want is agreement between the members, and we could really care less what they decide or agree on, or the basis of that agreement.⁸

Though consensus is not properly an aim on Moreno's view, this does not imply that consensus has no moral authority in regards to the activities of the hospital ethics committees.

⁴ While he has developed his views in numerous articles over the years, his descriptive view is put forth most clearly in (Moreno 1995), and the moral authority of consensus is most recently discussed in (Moreno 2005).

⁵ (Moreno 1995)

⁶ See Moreno (1998), (1991), (1995), (2000)

⁷ (Moreno 2005, 87). While these are clearly some of the most common sorts of concerns raised against consensus in ethics, the very same sorts of concerns seem to apply to a more common individualistic approach to ethical decision making. If moral authority stems merely from the rational thought of an individual, then it seems quite likely that that individual could have significant blinders to the short comings of their own deliberations and decisions. This is something that Moreno most likely agrees with, but believes aiming at consensus is not the way to ameliorate such concerns.

⁸ (Moreno 2005, 101)

As Moreno remarks, the moral authority of consensus is as a *condition of moral deliberation*, rather than an aim or goal of that deliberation. In an attempt to make his view on consensus clearer, he states:

Ordinarily it seems consensus is regarded as a goal to be reached. I contend that this puts the cart before the horse. The point of ethical deliberation is not to reach a consensus, but to attain a desirable end, an end that settles a controversy without further disagreement. Along the way there must be agreement about the soundness of the method being used. Thus, consensus is not an abstract end. It conditions a process of cooperative reconstruction of a troubling situation into one in which whatever latent values there are can be recognized and, by taking some action, perhaps more fully enjoyed. The way in which this is proposed to be done is a hypothesis, subject to change in light of attempts to apply it.⁹

Although this is not entirely clear, what Moreno seems to suggest is that if we agree, or have a consensus, on the soundness of the method being used to reach a decision, then our confidence in the soundness of the method will in turn authorize our confidence in the decisions reached via that method.¹⁰ Moreno thinks that we ought not aim at consensus, but instead a “desirable end, an end that settles controversy without further disagreement.” However, if a desirable end is defined in this way, then it is difficult to see how it could be anything other than a consensus.

According to Moreno, when we discuss consensus in regards to an ethics committee, there are at least two levels of consensus that we may be interested in: “shallow” consensus or “deep” consensus.¹¹ A shallow consensus is an agreement on a particular course of action, or on a particular resolution to a case. At the shallow level, there is little to no discussion or scrutiny of underlying values or principles brought to bear on the case at hand—instead, there is a review

⁹ (Moreno 2005, 99)

¹⁰ (Moreno 2005, 94). I think that just whose “confidence” matters here is important, though is not discussed by Moreno.

¹¹ (Moreno 2005, 90)

of the medical and psychological factors in the case and exchange of reactions and intuitions among the members of the committee, and an agreement is formed on that basis. Deep consensus, as Moreno argues, is something much more rarely sought in hospital ethics committees, and probably much more rarely achieved when sought.¹² A deep consensus, as the name suggests, is an agreement not merely on a case or resolution to a case, but an agreement in terms of the appropriate principles or values brought to bear on the case.¹³

As Moreno notes, agreement at one level does not guarantee agreement at the other level. Moreover, rarely is “deep consensus” what appears to be sought in an ethics committee deliberation. As he emphasizes, agreement at the level of principles and broad values does not imply or require agreement in terms of how we weigh and balance those principles in response to a particular case at hand, and as such, does not imply a consensus on a resolution to the case. However, a resolution to a particular case is what the committee is charged with achieving.

In order to further develop his notion of consensus, he notes two deliberative methods or procedures which have proven their worth in ethics committee deliberations: he refers to these as the *vertical* and the *horizontal methods*. The vertical method is probably the most familiar to philosophers as it involves a disciplined approach to the resolution of moral conflict involving the exchange of arguments of “varying degrees of plausibility.”¹⁴ A thesis is presented in addition to reasons and argument for that thesis, followed by a presentation of counterexamples

¹² (Moreno 2005, 90)

¹³ (Moreno 2005, 90) It should be noted here that there may in fact be levels of consensus in between the deep and shallow that Moreno articulates here. For instance, we can clearly imagine that an ethics committee achieves a consensus on the appropriate outcome of a case, without having consensus on the underlying reasons and values given, but after having in fact had a lengthy and careful discussion of the underlying values and reasons at play within the committee members’ positions.

¹⁴ (Moreno 2005, 92)

and qualifications of that argument in response. Next the thesis is defended more thoroughly by referencing particular principles at play, or particular consequences. Then, the position is either accepted or further discussion of the role of the principles or the likely consequences ensue.

Moreno believes the Socratic dialogues represent this vertical method. He writes, “Gradually, more and less acceptable arguments can be viewed along a hierarchy of dialectical adequacy.”¹⁵

The complementary *horizontal method* is also a quite popular method of moral deliberation in ethics committees, and is based in the casuistic tradition.¹⁶ According to Moreno, what is sought by the casuists is a rational agreement about the probability of a specific conclusion being correct. As Moreno notes, though probably unconsciously, ethics committees deliberate about specific cases using a roughly casuistic approach, that is, “by assembling an array of cases, searching for the decisive points of comparison, and identifying morally relevant differences.”¹⁷ As he explains, the use of casuistry is apparent in the way that it is now common for the treatment decisions for severely ill newborns to be seen as falling on a continuum from those that ought to be treated to those for whom treatment should be forgone.¹⁸

As he explains, with these two fairly widespread methods in mind, the problem with moral consensus becomes less apparent—that is, we needn’t be concerned with the pitfalls of consensus as an outcome, its moral authority does not lie there. Rather, the moral authority of consensus applies merely to the process of decision making. It is our confidence and agreement in particular methods of decision making as leading to sound results that highlights the moral

¹⁵ (Moreno 2005, 93)

¹⁶ Moreno refers to the reconstruction of Casuistry proved by (Jonsen 1986) and (Jonsen and Toulmin 1988) in particular here.

¹⁷ (Moreno 2005, 94)

¹⁸ (Moreno 2005, 94)

authority of consensus. As he goes on to say, both methods discussed above have been used in cases of bioethical deliberation that are thought to have yielded actual conceptual advances in the field of bioethics. Particularly in light of the problems associated with both levels of consensus (deep and shallow), Moreno argues that these methods can be of great value for ethics committees. It is our confidence and acceptance of these methods as leading to sound results that gives the decision of an ethics committee reached by such methods their moral authority or weight. Moreno has noted that this consensus is not necessarily an explicit agreement among committee members, and rather, it is often an implicit agreement on the way a decision is reached.

Earlier Moreno spelled out his position not as an agreement on method, but as an agreement on basic values, employing John Rawls' idea of "overlapping consensus".¹⁹ As Moreno explained the idea, at the societal level in a liberal democracy such as ours, we have an overlapping consensus in regards to certain values and principles.²⁰ That is, we have broad agreement on general principles or broad democratic values, though our reasons for agreeing with those general principles may vary. What he seemed to suggest then is that if our decision is reached in a manner that maintains these crucial values, then this gives the decision we reach some degree of moral authority. We can all affirm the decision as consistent with our own worldview and position, as well as with that of the others involved. Referring particularly to committee and panel level ethical deliberations, Moreno writes:

¹⁹ (Moreno 1995)

²⁰ Here is referring roughly to Beauchamp and Childress's four principles (Beauchamp and Childress 2001), but also more generally as he explains, to common "liberal" values like respecting individual autonomy and community welfare. (Moreno 1995, 65).

...to the extent that a panel's process has respected more general liberal values, their conclusion will possess a degree of moral authority. Again, to a great extent the stability of emerging principles will depend on the degree to which the process from which they emerge is in accord with certain values that are uncontroversial in a liberal society. I have argued that these uncontroversial standards would include nonviolent methods, mutual respect, and a willingness to entertain new evidence and alternative points of view. These are standards that are themselves objects of an overlapping consensus in a liberal pluralistic society. So when we assess the extension of a more or less settled moral consensus, we might well inquire first as to whether those principles that *do* apply, however modest they may be, are actually honored in the process.

Moreno argues that given his position that consensus is to be understood primarily as a condition on deliberation, the importance of multidisciplinary membership in an ethics committee becomes more apparent. As he explains, the moral authority of consensus cannot be separated from the needs for political representation and specialized knowledge.²¹ He writes:

Professional expertise is crucial for intelligent deliberation, and like any inquiry that requires information and techniques from various disciplines, the group must be composed to fill those requirements. Members are gathered to lend their abilities to the clarification of a problematic situation in which each field has something to contribute including the experience of being a patient.²²

It is this broad representation of membership that allows for intelligent deliberation to occur, that is, deliberation that takes heed of the relevant facts and important interests in a case.²³ As Moreno has noted, given the highly technical nature of many medical ethics problems, broad representation via "experts" in the relevant fields has been seen as a necessary component to an ethics committee.²⁴ There is also sociological evidence to suggest that the quality of "consensus

²¹ (Moreno 2005, 96)

²² (Moreno 2005, 99)

²³ Moreno supports this idea with Dewey's notion of "social intelligence". As he notes, cooperative inquiry is necessary to identify desirable goals and to devise means to achieve them, sometimes along the way altering what is in fact seen as a desirable goal. See (Moreno 2005, 99)

²⁴ (Moreno 1995, 66)

decision making” is greatly enhanced by systematic and rational procedures that increase the chance that all possible alternatives have been considered by the group.²⁵

Moreno’s position is not entirely clear, so before offering my own critical remarks, I want to briefly summarize what I take to be Moreno’s position on the role of consensus. Consensus has its moral authority not in the fact that a group has an agreement on a particular decision, but rather as a condition (or maybe even a pre-condition) on the process of moral deliberation in that group. What Moreno seems to mean by this is that we must have at least an implicit agreement with the deliberative procedure used to reach a decision or with the values expressed in the process of deliberations in order for a decision reached via that procedure to have any moral authority.²⁶ Consensus for Moreno is a “condition of cooperative ethical deliberation” and not an end or goal in itself. As he explains, consensus must surround the method we use to make a decision, that is, those affected and involved must have some form of substantive agreement on *how* the decision is made. This needn’t be an explicit agreement, like “we all agree casuistry is effective and gets right answers,” and often times will be more implicit, that is, “the way this decision is being made is consistent with my values, or at least doesn’t seem to violate the perspectives of those involved.”

Critique of Moreno’s “Consensus as a condition”

While Moreno has offered a fairly developed account of the role consensus ought to play in ethics committees, it is my contention that his approach has missed the mark in at least four

²⁵ See (Moreno 2005, 407). One might note here that there is some questions as to whether or not this requires a panel of “experts” per se—that seems to depend on the level of technical factors in a case. It isn’t clear what an expert patient would be apart from one of the people that find themselves with continued health problems.

²⁶ See (Moreno 1990, 38)

very important ways: 1) His rejection of consensus as a morally desirable aim seems to divorce his account from the actual practices of ethics committees and clinical ethics deliberations; it is after all consensus about what to do in a particular case that committees strive for. 2) If we accept Moreno's contention that a consensus decision is open to too many abuses to be a morally desirable aim, then he must further clarify how he understands the nature of consensus to differ depending on its reference to either the process or the outcome. 3) The consensus about the method or basic values is a consensus that occurs in another context entirely, and prior to the committee's deliberations. His account is not an account of consensus achieved in the clinic. 4) Moreno's argument that consensus carries moral authority only at the level of the process does very little to defend what it is about consensus that gives a decision moral authority. I will address each of these points in turn.

First, Moreno has too quickly rejected the moral import of consensus as an outcome, and in so doing may have severed his account from the actual activities of an ethics committee or ethics consultation. Consensus as merely a condition on the process is not at all what we have in mind when discussing consensus in decision making. Griffin Trotter has made a similar point and remarks that, "In any case, I suspect that there is widespread agreement that even the most wholesome and creditable democratic process will not count as a consensus unless it culminates in some sort of shared opinion about the topic of discussion."²⁷ As Trotter has noted, when we talk about consensus, what we are usually talking about is a certain sort of outcome. Following the well-trodden criticisms of consensus as an aim in ethics—the dangers of "group think" or abuse of power—Moreno is led fairly quickly to reject any primary role for consensus as an

²⁷ (Trotter 2002, 38)

ethical decision. Though he rejects the aim fairly quickly, he at the same time recognizes the inseparable character of consensus and bioethics, at least as it is practiced in the activities of the hospital ethics committees. Rather than grapple with the issues involved with the *aim* of consensus, Moreno argues that what is morally authoritative about consensus in such a setting, is as a condition on the process of decision making. This claim though, seems to divorce his understanding of consensus from the practices in the clinical setting where it is seen as an aim that we ought to strive to achieve in cases of moral disagreement or conflict.

In fact if there is group consensus on the process of decision making in a committee, it is usually an agreement that is very basic in nature—i.e., “don’t pretend to agree just to end the discussion,” “be honest about your thoughts on the issue,” etc. It is rarely if ever, an agreement on something like, “the casuist approach leads to sound results, or liberal values x, y, and z must be maintained in our conversation.” As Stephen Toulmin noted after he spent time on the National Commission focusing on the ethics of using human subjects in medical and psychological research:

When the eleven individual commissioners asked themselves what "principles" underlay and supposedly justified their adhesion to the consensus, each of them answered in his or her own way: the Catholics appealed to Catholic principles, the humanists to humanist principles, and so on. They could agree; they could agree what they were agreeing about; but, apparently, they could not agree why they agreed about it.²⁸

Agreement about the process or principles maintained in the process is not the sort of consensus generally sought by those charged with making clinical ethics decisions. It is also not the sort of consensus we are likely to achieve.

²⁸ (Toulmin 1981, 32)

Second, Moreno seems to equivocate on the meaning of consensus itself creating a lack of clarity throughout his discussion. By rejecting consensus as an appropriate aim given the possible abuses and at the same time claiming that consensus should condition the process, Moreno is forced to equivocate. Why wouldn't our agreement that a certain method leads to sound results be just as open to abuses as our agreement that we should pull the ventilator tube? How can we be sure that such an agreement has not fallen prey to the very concerns he's raised about consensus as an outcome of our deliberations? This is even more troubling if, as he has said, it is often an "implicit" agreement that a method leads to sound results.²⁹ If the consensus is implicit, then how do we even know we've got one? Powerful promoters of casuistry for instance, could stifle dissent from those who may otherwise think the process and moral considerations taken up unduly limits the inclusion of their own perspective or important moral considerations. We might be railroaded into thinking that casuistry is the best way to make a decision given the doctors zeal for the method, just as we might be railroaded into deciding that Grandma's ventilator tube ought to be removed. If consensus about outcome is nothing more than mere agreement, then there is no reason to think that consensus about method, especially since it can be implicit, need be anything more than mere agreement. Moreno has a much larger picture to fill in. At the very least, he needs a clearer account of just what he means by a "consensus," and further, just how his understanding differs when it's used in reference to the *outcome*, and when it is used to refer to a *condition* on the process.

²⁹ See (Moreno 1990). He notes here that the agreement is only an implicit one, and is said to exist merely if there is a lack of dissent.

Third, the consensus decision Moreno refers to occurs at a previous juncture and a different context altogether; its moral authority at the time of decision making is not something that can be examined fully in the context of a committee's deliberations. When we are debating the usage of medical technology in a particular case, the broad values or methods that are agreed upon may not be a topic of discussion at all, except in so far as they come out in our deliberations about what to do now and in this case. How do we even know that we share in such a consensus with the other participants? The consensus concerning broad values and particular methods is an agreement that is not achieved in the clinical context. We bring this consensus to our discussions. But committee discussions almost always arise out of moral disagreement and conflict about what ought to be done in a particular case. Disagreement about this case shows that the consensus Moreno discusses does not resolve the issue that is the focus of the committee's deliberations.

Fourth, the moral authority of consensus as a condition is in need of further explanation. Others have criticized Moreno in similar regards.³⁰ What I've taken him to mean is that moral authority stems from consensus on the method being used to reach a decision, or at least broad agreement on the values or principles underlying our deliberations. Further, such an agreement comes about, at least partly, through apparent success of the methods themselves in producing sound results in actual deliberations. One concern here is that this account of the moral authority of consensus seems to require that we have some independent indicator of success or soundness that underwrites the authority of a procedural consensus. It is not consensus per se

³⁰ Martin Benjamin argues that Moreno's answer to the "authority" question is lacking. According to Benjamin, Moreno overestimates the value and import of a societal consensus at the level of process. (Benjamin 1996, 40)

that grants moral authority to a particular outcome, but rather it is our agreement that a method leads to *sound results*. If we have this independent indicator of “soundness” or “success”, then what is the need for a consensus really?³¹

This seems to imply very little on its own about what method is needed, so long as it achieves what we agree to be sound results. While Moreno advocates a democratic and representative process, there are a great variety of methods that can achieve the same result—some democratic in nature, and some not. After all, it is our agreement that the method tends towards “sound” results that matters most. It might be the case that a method which precludes participation from patients and families, would be the best method, and the one that is seen to lead to sound results. This though is not what Moreno would like to conclude. Instead as we have seen, he argues that his position implies the need for inclusive and broadly represented participation in committee deliberations.

Clearly, Moreno’s account of the role of consensus is not sufficient to defend or define a particular method or process of decision making. What he says about the importance of the *process* of bioethical decision making comes quite close to the position I would like to defend. It is at the level of process that a decision reached gains its moral authority. On my view though, it is not that we have a consensus on the process per se—but rather, that the process involves those affected in such a way that grants our collective decision moral authority. The “aim of consensus” implies that the process we use to reach that decision must be of a certain sort. The

³¹ Griffin Trotter makes a similar point and argues that Moreno’s view “surreptitiously imports many of the values that should be at issue in the debate regarding consensus.” (Trotter 2002, 38). As Trotter explains, if consensus just is an embodiment of some procedural values, then it seems that any misgivings about those values themselves will be excluded from debate.

focus in bioethics has been on the actual decision we reach. But Moreno is correct: it is only the process we use to make that decision that grants that decision moral authority.

By starting from the idea of consensus as an outcome, I think we can work backwards to a conclusion not much different from Moreno's, but possibly more illuminating. That is, the aim of consensus implies that the way we reach a decision must be constrained in important ways by that aim. If the aim is achieving a consensus among those involved, this implies that we ought to deliberate and respect one another in a particular way. This is a position very much like the one taken by Joseph Fins, Matthew Bachetta, and Franklin Miller in their "Clinical Pragmatism: A Method of Moral Problem Solving."³²

Clinical Pragmatism—Consensus as an Aim

Clinical pragmatism is an approach that defends the idea that consensus is not only important in terms of the process of moral decision making, but an aim that should be sought after as an outcome of the process. This position while not as developed in the literature, seems to not only be more in line with the general understanding of consensus and the activities of clinical ethics, but further, makes much clearer the role of consensus and its import for the process of clinical ethics decision making. Hospital ethics committees and federally appointed ethics commissions clearly do aim at consensus.

In their article, "Clinical Pragmatism," Fins et al. insist that in the clinical setting consensus not only ought to condition the process of moral decision making, but does so as a

³² (Fins, Bachetta and Miller 1997); (Fins 1998); (Fins and Miller 2000)

central aim.³³ On their view, our ethical deliberations ought to aim at and be motivated by “a consensus that can withstand moral scrutiny.”³⁴ Although many have argued that the morally correct decision is reached by the application of certain principles or rules, Fins et al. argue that more is needed to reach a moral decision in the clinical setting.³⁵ Not only must we be attentive to relevant moral principles and virtues, but also, moral problems are posed in particular contexts and settings that must be attended to. On their view, moral conflicts are resolved via deliberation that results in a consensus about what should be done. Clinical pragmatists seek to resolve ethical conflicts, “by approaching conflicts systematically and with a special focus on the interpersonal dimensions of moral problem solving.”³⁶

On their account, moral problems are solved via reciprocity between all concerned parties. A moral decision is one then that allows all concerned parties to have their fair stake in the decision making process. According to the pragmatists, the process of decision making is just as, if not more, morally important than the decision reached. Following John Dewey, Fins et al. argue that principles are only hypothetical guides in moral decision making that all too often lead to premature judgments.³⁷ As they explain, “Applying abstract principles mechanically, without due attention to the clinically relevant contextual details of the case, can produce distortion and generate avoidable conflict.”³⁸ Not all ethical conflicts are disagreements about principles or rules. In many cases conflicts occur because of inadequate understandings of

³³ (Fins, Bachetta and Miller 1997)

³⁴ (Fins, Bachetta and Miller 1997, 130)

³⁵ See in particular (Beauchamp and Childress 2001) who have championed this sort of principle based approach in bioethics. There may also be an argument to be made that Moreno’s approach is not much different than a principled approach in some regards.

³⁶ (Fins 1998, 68-69)

³⁷ See (Dewey 1922, 220-22) and (Dewey 1922, 225-26).

³⁸ (Fins, Bachetta and Miller 1997, 136)

the facts as well as a lack of adequate communication among affected parties. On the clinical pragmatist approach, by emphasizing principles and rules, we often tend to ignore *how* we ought to make a decision, that is, the *process* by which we decide.

This takes consensus a step further than Moreno wants to argue. In particular, even with some agreement on method or values, the decision we reach is still entirely underdetermined by those methods or values alone. On their account, we ought to *aim* at a consensus that can withstand moral scrutiny. This is an important difference of emphasis between their approach and Moreno's, and one that makes their position much more in line with the actual activities of clinical ethics. On their view, the aim of consensus means that we must engage with others in a way that allows us to come to an agreement that is a genuine consensus. The *aim* of consensus among those involved conditions the process by which we decide.

In a later article which develops the clinical pragmatist method in relation to the care of elderly patients, Joseph Fins and Franklin Miller provide a bit more explanation by laying out a step by step account of their approach in action.³⁹ As they explain:

Our method focuses on the promotion of what Dewey called *inquiry*. We engage in this process through a contextually situated analysis. Our objective is to consider the range of medical and narrative facts necessary to reach a judgment about a reasonable course of action. In this way, clinical pragmatism is analogous to the process of differential diagnosis used in medical practice. We begin with data collection, interpret our findings, negotiate with patients and their intimates, intervene, and then engage in periodic review. This is comparable to the diagnostic process used by physicians who collect data through the history and physical examination and then interpret the information through the promotion of a differential diagnosis.⁴⁰

³⁹ (Fins and Miller 2000)

⁴⁰ (Fins and Miller 2000, 73)

The process of inquiry that they promote begins when there is recognition of a morally problematic situation—that is, one where there are ethical tensions present. As they explain, great sensitivity is often needed in order for a morally problematic situation to be detected, especially early on when ethical tensions are just beginning to surface.

Once a situation is perceived as morally problematic, the clinical pragmatists argue that we ought to start a process of inquiry beginning with gathering all necessary information.⁴¹ In this “data collection” stage of the process the aim to gather information that may have an impact on the situation at hand.⁴² As they explain, this includes medical facts, but also information about the patient’s decision making capacity, beliefs, values, preferences, needs, etc. They emphasize the importance of understanding the family dynamics involved in a case: an adequate understanding of the relationship with the patient, the impacts and burdens of care on the family and others, as well as identifying a family spokesperson if patient is unable to communicate for themselves. Lastly, part of the data-collection phase must include an examination of the institutional and social impacts on the case or situation. Such things as continuity of care are important here, as well as the societal level debates that could alter the dynamics of a case.⁴³

Once this medical and contextual data is gathered, the next step is to begin to consider the range of reasonable moral considerations that could influence the development of a workable consensus on how to resolve the issue.⁴⁴ Once a range of moral considerations is developed,

⁴¹ It is important to note here that clearly the clinical pragmatist’s concern is dealing with moral conflict. It is not clear that they see this method as applicable in all cases full stop, but rather in cases of moral conflict in the clinical setting at the patient’s bedside or in an ethics consultation.

⁴² (Fins and Miller 2000, 74)

⁴³ (Fins and Miller 2000, 74)

⁴⁴ (Fins and Miller 2000, 75)

then the physician can offer provisional shared goals and a plan of action for the patient and their family. As they explain:

In this process of moral problem solving there is a genuine attempt at *individuation*, in which our generalizable knowledge is tested against the particulars of a given patient narrative. Using the experimental method, these generalizations are framed as hypotheses to be assessed in practice against the details of a case. Through an inductive process of reasoning we can either confirm or refute our general knowledge by focusing on the specific narrative details of a given case. Approaching narrative details in this way is analogous to how clinicians reason when they approach physical complaints and symptoms in formulating a diagnosis.⁴⁵

Through discussion and negotiation with the patient and their families, they explain, we aim to come to a “workable” consensus on what should be done in the case.

As they explain though, we must appreciate that we may have erred in our deliberations, and there is often a need for periodic review of a case even once a consensus has been achieved. A decision to remove a ventilator can be reexamined but not reversed. However, in some cases it will become clear that a modification of our course of action is needed. Moral decision making on their view is akin to testing a hypothesis. A consensus is reached, but such a consensus is not the final word, or end of the story. Moral decision making is often a continuing and on-going enterprise. Actions taken will not always go as planned or as hoped, and as such are open to further consideration and possible revision. Our aim then is to achieve a morally justified decision, but there is no claim that this is the final word. On their view, ongoing evaluation and assessment of our consensus is important.⁴⁶ Even irreversible decisions can and

⁴⁵ (Fins 1998, 69)

⁴⁶ Clearly in some cases there will not be an ongoing opportunity to assess, or re-assess the outcome of a situation and alter our course of action. Say for instance if the patient dies, or leaves the hospital and decides to not get treatment. It still may be important in these sorts of cases to assess the outcome further in order to gain information that may be relevant for future cases, or for hospital policy issues.

ought to be reviewed. This is important not only in terms of assessing the outcomes of a particular case and decision, but also more systematically in terms of evaluations of a decision's or type of decision's impact on institutional practices.⁴⁷

While an evaluation of the outcome is important even on the clinical pragmatist view, what sets it apart is their emphasis on the importance of the process of decision making. The *aim* of a moral consensus has the hope of providing a good deal of guidance in an often neglected aspect of moral decision making, that is, by giving us a *process* by which we can deal with the terrain which falls between accepted moral norms and the actual practice of deciding how to act in the world.

Clearly more needs to be said in order to define what a *good* consensus amounts to, but to say the least, a consensus has real value in the clinical setting. It deals with the actual moral standpoints of those affected by the decision. It also leaves affected parties satisfied with the outcome or decision that is made. By reaching a consensus, the concerns of what has been called “moral residue”, in the form of guilt, anger, etc. are at least likely to be lessened in comparison to cases in which unilateral, or non-consensual decisions are made.⁴⁸ (I will return to the problem of moral residue below.) Finally, by requiring a certain sort of agreement between affected parties, there is some safeguard from “moral blinders” or idiosyncratic sorts of judgments that plague solitary ethical thought. Just as Moreno highlighted concerns with “group think” or misuse of power, we can all attest to the pitfalls of individual decision making of any sort. While

⁴⁷ (Fins and Miller 2000, 75)

⁴⁸ (Melia 2001)

sometimes we are right on, other times we can be “blind” to the most obvious ideas and solutions.

Consensus as an aim emphasizes the need for careful communication between parties, something that is often ignored by more common approaches to resolving ethical issues. Communication is not only an issue related to morality, following this approach, communication itself, or the lack thereof, becomes an ethical issue.⁴⁹ In the hospital, a lack of clear communication is often at the heart of ethical conflict.

I will develop the clinical pragmatist account that we ought to aim at a certain sort of consensus. I argue that the aim of reaching a moral consensus is highly desirable, and that by reaching a consensus that is rightly constrained by the guidelines I will develop, the involved parties can move forward with the assurance that they have reached a justified moral decision. However, I will first consider the critiques of clinical pragmatism in the literature.

Critiques of Clinical Pragmatism

The central claim of clinical pragmatism is that we ought to “aim at a consensus that can withstand moral scrutiny.” This seems to hold a great deal of promise as a practical approach to resolving moral conflicts in the clinical setting, but at the same time opens the door to some fairly strong criticism. Clinical pragmatism has been said to offer little to no substantive

⁴⁹ This seems particularly telling for the clinical setting. At least at the ethics committee meetings I have attended much of the ethical problems are thought to be “merely issues with communication.” If consensus ought to be our aim, then a certain sort of communication between those concerned may be ethically required. I take it that many share the intuition that communication is of critical ethical importance (both to alleviate misunderstandings and to achieve a clear account of the relevant perspectives), and I think the aim of consensus may make some sense out of that intuition.

guidance in resolving moral conflicts. This concern is highlighted by Lynn Jansen in her critique of clinical pragmatism.⁵⁰ According to Jansen:

It does not advance understanding to proclaim that we must find a method of moral problem solving that leads to successful decisions if we are not told what counts as success. This poses a problem for Dewey's ethics in general and clinical pragmatism in particular because it arouses the suspicion that the dismissive talk of absolute and fixed moral principles is misplaced. On reflection it may turn out that in order to identify correct or successful moral decisions we must have recourse to fixed moral principles and rules.⁵¹

As Jansen argues, the clinical pragmatist method may be an important account of physician patient interaction, but it lacks any substantive guidance in terms of determining the correct moral decision. This approach requires specification of what counts as success or failure.⁵² The clinical pragmatists argue that a successful moral outcome is a consensus that can withstand moral scrutiny, but this just pushes the issue back a step further. Their claim that a successful outcome is a “consensus that can withstand moral scrutiny” does very little to resolve this issue. If clinical pragmatism is to guide actions, it either must depend on moral principles, or provide us with a clear account of just what determines success. To say that it is a consensus that can withstand moral scrutiny leaves open the question of just whose moral scrutiny it must withstand, and just what sort of moral scrutiny it is. If, as Jansen suggests, it turns out that “withstanding moral scrutiny” is no different than “according with principles,” then clinical pragmatism in the end seems to dissolve into a type of principlism, making it a fairly uninteresting alternative approach to clinical ethics.

⁵⁰ (Jansen, 1997)

⁵¹ (Jansen 1997, 24)

⁵² (Jansen 1997, 27)

Fins et al. in their response to Jansen's critique clearly deny this conclusion.⁵³ As they explain, moral considerations such as rules and principles are tools to do moral work when facing difficult situations—they are not fixed and timeless but change or develop in response to changes in our social existence.⁵⁴ While Jansen is right that principles or other similar moral considerations will be part of the equation in resolving moral conflicts, they are not the entire picture or all that is needed to reach a morally valid decision. As Fins et al. explain in their response to Jansen:

The pragmatic method of moral problem solving is based on the premise that a thorough process of inquiry and deliberation is likely to yield a satisfactory decision. Sometimes careful process leads to the anticipated result, but in a way that reassures the participants that there was not a rush to moral judgment. Achieving consensus among those engaged in moral problem solving is the best means of avoiding idiosyncrasy, absolutism, and unilateral judgment, which threaten shared decision making. As pragmatists, we are content to seek workable, satisfactory resolutions of pressing moral difficulties without any assurance or guarantee of getting it right. The guiding light of pragmatic moral inquiry is not *a priori reason*, with the power to intuit the *right*, but experimental intelligence in search of moral judgments on matters of substance and procedure that can be endorsed by fellow problem solvers through consensus.⁵⁵

Jansen's critique seems to miss the contextualized nature of moral decision making the clinical pragmatists want to expose. Fins et al. do not deny that moral principles or moral theory are often relevant to moral decision making in the clinical setting, rather, they argue that in cases of disagreement over how to proceed, moral theory and principles are often not decisive and are never the full story of moral decision making. The fact that moral conflict necessitates the deliberations in the clinic means, at least this: there is either disagreement about ethical

⁵³ See (Fins, Miller and Bachetta 1998).

⁵⁴⁵⁴ (Fins, Miller and Bachetta 1998, 40)

⁵⁵ (Fins, Miller and Bachetta 1998, 39-40)

principles, about what they mean, about which ones take priority, or about how they apply to this particular case. Clearly ethical principles have not sufficed to resolve the issue antecedent to discussion.

Even so, norms or principles will often shape a person's position on just what should be done in an ethical conflict. As Fins et al. explain:

Clinical pragmatism should not be confused with expedient situationalism. Nor is pragmatic moral problem solving devoid of principles or norms. Although clinical pragmatists have no access to transcendent, fixed standards of value to navigate in the often murky territory of clinical ethics, we do not come empty-handed, nor are we forced to fly by the seat of our pants. Instead, we bring the inherited stock of moral wisdom to bear on the task of helping clinicians and patients make fallible judgments concerning concrete moral problems.⁵⁶

In the clinical setting professional roles also dictate certain rules for behavior and standards for care, and there are other broad societal norms that dictate parameters on appropriate treatment:

As the *clinical* modifier suggests, our derivative of Deweyan pragmatism is constrained by the norms that inform medicine and nursing: the role of the responsible clinician in promoting benefit, minimizing harm, and engaging in an analysis of proportionality. The principles that inform clinical work and clinical pragmatism emerge from this common therapeutic endeavor.⁵⁷

In the clinic consensus among the involved parties will not be *ad hoc* or lack a connection to both personal and professional values and commitments.⁵⁸

Nevertheless, the response of Fins et al. is inadequate. Jansen asserts that the clinical pragmatists must admit that some outcomes are successful while others are not, or some

⁵⁶ (Fins, Miller and Bachetta 1998, 40)

⁵⁷ (Fins, Miller and Bachetta 1998, 40)

⁵⁸ In the professional ethics literature there is widespread agreement that part of what distinguishes a profession from a mere occupation is not only a high degree of specialized knowledge or expertise, but further the use of that knowledge to benefit others, that is, a set of moral commitments concerning the appropriate aims and uses of their expertise. Professionals have an obligation not just to serve their own self-interests, but more importantly to use their expertise for the benefit of others. See for example (Barber 1963) and (Ozar 2004).

consensuses are morally satisfactory while others are suspect. If that is correct, then some independent standard of success and moral satisfaction is required. Fins et al. employ the phrase “a consensus that can withstand moral scrutiny” to specify what counts as a morally acceptable resolution, but this phrase implies the need for after the fact judgment about the quality of the consensus achieved. This in turn, opens the pragmatists up to a critique like Jansen’s—we then need some further criteria of success apart from the achievement of consensus itself.

Moreover, as Jansen points out, this leaves unresolved the issue of just whose moral scrutiny it must withstand.⁵⁹ Is it only the moral scrutiny of those involved in the decision making? If so, then all this would guarantee is that no one involved has second thoughts or regrets. Or, is it the moral scrutiny of anyone who later reflects on the issue? And, for how long? If an ethical decision must withstand moral scrutiny of all the philosophers, legal theorists, theologians, and clinicians who think about the issue anytime during the next 200 years, that would be a requirement that is not only extremely difficult to meet but also impossible to know that one has met. If this is the standard, then no clinical ethics committee could ever issue a recommendation.

There is an even deeper worry here. No matter whom the moral scrutinizers are, their judgment comes after the decision has already been made. They are all Monday morning quarterbacks. The distinction between practical reason and theoretical reason is lost. In a clinical ethics decision only certain people are authorized to participate in the deliberations.⁶⁰ If they have carefully and thoughtfully deliberated, then whatever did not occur to them was simply

⁵⁹ (Jansen 1997, 26)

⁶⁰ There are important issues about who is to be included in the deliberations, and I will return to these issues. But no ethics committee would or should allow a random philosopher or minister to join in the deliberations.

unavailable to them, at least at that time. Clinical decisions must normally be made within the time available for deliberation. “We need to think about that for a few more weeks” is not normally an option. “Moral scrutiny,” even by the ethics committee members themselves, often comes too late. While later reflection may cause regrets, moral distress, and even embarrassment, these reflections were unavailable during the deliberation and the time of decision-making. In the clinic, very often a decision must be made—not to decide in many cases is to decide. The clinical defaults—usually maximal attempts to prolong a patient’s life often with disastrous consequences—will usually be followed if no committee recommendation is made. A suspension of judgment is a possibility, but often it is known in advance that this is morally undesirable and sometimes even a failure to discharge our professional responsibilities as members of the hospital ethics committee or healthcare team.

There are even more practical constraints than these.⁶¹ Patient care within the hospital almost always involves a team effort. When an entire team is involved, theoretical reflection about “what I would have done” is never enough. Cooperation among the team must be achieved. Although often bioethicists approach cases as if they were free-standing and independent, the healthcare team must continue to function smoothly for the long haul. Anger, frustration or moral distress about one decision, or about how that decision was made, can have devastating effects for months or even years. Finally, there are also institutional constraints. Hospital policy, hospital culture, concerns about litigation, unfavorable publicity, and the

⁶¹ As D.M. Hester points out, each medical encounter takes place with particular people, in a particular place, and at a particular time. (Hester 2003)

bottom-line must all be considered. There are important differences between practical reasoning about clinical ethics cases and theoretical reasoning about ethics cases.⁶²

In short, the conceptual, moral, and informational resources possessed by those actually involved in an ethics committee decision or case consult *at the time of deliberation* are the only resources that could have been employed. If one of the committee members recognizes that additional information is needed, and if time permits, then they can and should call in a consultant. But if no one in the room recognized the need or the availability of this information, then it is *practically* irrelevant at the time of decision making. That may be unfortunate, and maybe even regrettable, but it could not have been helped. A careful, conscientious, thoughtful attempt to include all relevant considerations is all that anyone or any group can ever do. “I should have thought of that” no matter how true is a thought that comes too late.

If we keep these differences between practical deliberation and theoretical reflection clearly in mind, the phrase “that can withstand moral scrutiny” is irrelevant in deciding what to do in the practical context. It does no work there unless it is to remind us to think carefully about what to do. That proviso which opens clinical pragmatism to Jansen’s objection is misguided and should be eliminated. It covertly introduces a perspective that cannot be useful in our practical deliberations. Even later insights of the committee members themselves are insights that come too late.

⁶² Theoretical ethics is important, and can inform our practical deliberations, but is an entirely different affair from the activities of practical ethics. There are no time constraints, no need for cooperative action and conflict resolution among parties, it is not confined to a specific case or cases, but often focuses on general moral claims and hypothetical situations, and there is no constraint on what ideas and information is available. We have all the time in the world to come up with more information (or even wait for scientists to discover new information).

Even worse, “that can withstand moral scrutiny” threatens to replace practical reason with theoretical reason. Following the appropriate process for reaching a decision (which I will begin to specify) in a careful and conscientious way is the most we can ask of any ethics decision maker in the clinic. The process must certify the outcome. On my view, the process justifies the decision. It is the only thing that could—in the practical context principles are only relevant if someone thinks that they are. A consensus about what ought to be done, achieved by a certain process, is the only measure of a “successful outcome.” The appropriate procedure is both necessary and sufficient for a fully justified ethics decision in the clinic.

One thing this doesn’t mean is that clinical decisions are not subject to review. Even morally justified decisions can found to be defective. Retrospective case review is important, but not in issuing judgments about the moral legitimacy of past decisions. The review of decisions can be particularly important in revising and developing policy. Decisions themselves can also sometimes be reversed. We can discover after analyzing a decision and its consequences that it may have been mistaken—for instance, we decide to continue life-support on a comatose patient, but later realize that this was not the best decision and so decide later to remove the support. Presumably, a decision found to be mistaken is found so because of information that was originally unavailable at the time the decision was made. Retrospective review and later moral scrutiny is practically important so as to improve future decisions.

To say that the achieved consensus is the morally justified decision also doesn’t mean that all those charged with making ethical decisions in the clinical context are adequately prepared to do so. What it does mean is that those that find themselves in difficult moral terrain—that is, a context where moral conflict and reasonable disagreement are common—have

responsibilities to do their homework, so to speak. As physicians, nurses, or other healthcare providers, there is a responsibility to keep informed of the relevant ethical considerations, theories, and arguments, so as to have an appreciation for the responsibilities of their role and the appropriate aims of their professional work. Education in ethics is important so that the perspective and position taken is informed by careful consideration and reason—not merely out of tradition or conviction. Careful consideration and discussion of common ethical issues beforehand, and apart from the time sensitive context of a conflict over a patient’s treatment, is unquestionably beneficial when it comes time to engage with others over time sensitive ethical issues. An honest and clear expression of your own position and reasoning is essential in coming together with others in practical ethical matters, and doing your ethical “homework” really assists in this. However, adequate preparation must be accomplished prior to the decision making process.⁶³

As I have argued, clinical pragmatism can be revised in a way that enables it to avoid Jansen’s central critique. But, there are at least three more aspects of a consensus oriented approach to clinical ethics that need further articulation and defense. First, if we ought to aim at a consensus among concerned parties, it is critical that we define who counts as a concerned party.⁶⁴ To cite just one extreme example, when decisions were being made about Terry Schiavo, the street outside of the hospital was filled with protestors, the state legislature and

⁶³ Committee members can be legitimately criticized and they can criticize themselves, but that criticism is about what they should have done before the conflict arose and the decision had to be made. It is also important to note that the lack of time for “moral homework” on the part of the healthcare team may be reason to have a clinical ethicist on board. They in fact have done the moral homework, and could be brought into the discussion in order to provide assistance in this regard.

⁶⁴ As I pointed out above, Jansen also argues that this is a central issue for the clinical pragmatists that must be resolved.

governor were involved, and even the Pope weighed in on the matter. All were concerned about the decision. Should they all be allowed to participate in the hospital ethics committee deliberations? I will return to this issue.

Second, what seems most promising about this approach is the shift in focus to the process of moral decision making in the clinic. As Fins et al. explain, the aim of consensus implies that the process is as important as the decision we reach. But, what exactly the aim of consensus implies for how we ought to make decisions, and why such an aim is desirable in ethical conflicts is left fairly undeveloped by Fins et al. What exactly does the aim of consensus amount to, and what does it imply for the *appropriate* process of decision making?

A final concern is that both Moreno and Fins et al. are too vague about the notion of consensus itself. If we ought to aim at a “consensus” of a certain sort, what is consensus and how does it differ from other sorts of agreements? Is any sort of consensus morally acceptable, and if not, what distinguishes those that are? What is it about consensus that makes it morally valuable? In the next chapter I provide a clearer definition of consensus, and argue that with clearer definition of consensus in hand, the guidelines for a morally acceptable process of decision making also become clearer. In subsequent chapters I will argue that at the very least our process of decision making must be based on: 1) Reasonable deliberation of affected parties; 2) Tempered equality of consideration; 3) Freedom from undue influence; and 4) Mutual respect.

CHAPTER 2

DEFINING CONSENSUS

Introduction

Consensus as an aim in ethical deliberations generally is met with a great deal of skepticism. As we have already seen, even those who accept its centrality in clinical ethics deliberations have questioned its moral legitimacy as an outcome of our decision making. As a resolution to ethical conflicts, consensus seems to allow for undue influence from others, and in ways that can lead us to a “wrong” decision. Not only are there some real concerns about any claims that a consensus has normative force, but even further, there are real concerns with how agreements are reached in the first place. Clearly, if we are influenced by the demands and input of others, then there is a real danger in the ways in which others can corrupt our decisions. While these are legitimate concerns for any agreement that we take as a means to collective actions, this in my view is not enough to so quickly reject consensus as having any important role or value in our ethical deliberations.

There are equal or greater dangers in sticking merely to our own moral sense or convictions. We can all attest to instances of being blind to even the most obvious considerations until a friend or colleague introduces them. Our own hang-ups or biases often impede our ability to think clearly about a situation, not because we are unfair or biased individuals, but merely because we are human and often limited by our own perspectives. This

sort of danger is at least, if not more, concerning than concerns of “group think.” Engaging with others, especially those with knowledge relevant to the situation, or those that are directly part of the situation, will provide a fuller and seemingly more accurate perspective. Just as I can be overpowered by the outgoing physician, I can also be limited by my own viewpoint or goals.

There are clear dangers in giving any type of agreement a prominent role in how we approach resolving ethical conflicts—groups taking on a bandwagon mentality, naïve participants or less than confident participants being pushed around by arrogant or more powerful participants, basing our agreements on misunderstandings of facts, etc. But consensus as an aim may not be as replete with dangers as many think. At least part of the contention surrounding the role of consensus in ethics, hinges on what seems to be a lack of clarity involving the definition and nature of consensus itself. Even among those who argue that consensus has a role in ethical deliberations, there seems to be disagreement about the nature of consensus itself, and therefore the appropriate role it ought to play. The term is often used very loosely to mean anything from mere mutual acquiescence, unanimous agreement, to some more substantive form of collaborative and reasoned decision. As Martin Benjamin has pointed out, “there is no consensus, about consensus.”⁶⁵

First, it will be helpful to distinguish consensus from other sorts of agreements. We can quite quickly distinguish a consensus from a decision that is reached by an individual alone. At the very least, consensus is a form of collective decision, that is a type of agreement among a group of individuals. Consensus seems also to carry the idea that the agreement is unanimous, or nearly so, among those involved in the agreement. While we use the term ‘consensus’ to

⁶⁵ (Benjamin 1996)

denote mere agreement among a group, I think this is only “loosely” a consensus. There is an important distinction between consensus prior to discussion and consensus that grows out of discussion. I would call the former mere agreement, but it is this mere agreement that has been the focus of much the criticism of consensus. In any case the fact that the moral situation is controversial and problematic ensures that there is not unanimity about what to do prior to the deliberations of a hospital ethics committee. Ethics committees very rarely discuss cases about which there is no disagreement.

There is a stricter sense of consensus available to those who see it as a morally important aim. Notably, in the literature consensus is commonly referred to as having a kind of dual nature. As Fins et al. have argued, consensus, is not only a decision reached, or a type of collective agreement, but further, consensus is also a way of reaching, it implies a certain sort of interpersonal process by which the agreement is reached.⁶⁶ While consensus is quite clearly an outcome or agreement, it is quite commonly thought to be an outcome formed via an interpersonal process of “consensus building” or “consensus formation.”⁶⁷ Consensus, in this stricter sense then, is an agreement that is built out of an engagement with others. In the context of ethical disagreement in the clinical setting our starting point is some substantive disagreement (or at least apparent disagreement) over the appropriate course of action among the participants.⁶⁸ It is the process of moving from this disagreement to a shared agreement, or consensus, that is

⁶⁶ See also (Bayertz 1994).

⁶⁷ This is the case not only in the clinical ethics literature, but also more generally. See for instance, “The Consensus Building Handbook,” (Susskind, McKearnan and Thomas-Larmer 1999)

⁶⁸ There could be cases where after a discussion of the facts among the participants, what appeared to be a disagreement in fact was not—the participants actually agreed on the goals or course of action to pursue. In a case like this, unless the agreement comes out of the deliberation and interactions with the others involved, or is “built,” the agreement is not a consensus of the strict sense I’d like to distinguish. Agreement among a group—even unanimous agreement among a group is not necessarily a “consensus”.

my focus. Not all collectively made, collective decisions are a consensus. In a democratic society like ours, we regularly have democratic elections where a collective decision regarding who ought to represent us is made. Even if everyone agrees that this is the way to make the decision, counting votes and majority rule are not the same as a consensus.

Importantly this understanding of consensus is more than as an “agreement” or even a “unanimous agreement.” It is an agreement reached via an engagement with others—it is substantially shared in a way that is more than just tallying up everyone’s vote. While there may be some sort of epistemological value in discovering that we all agree via our independent analyses, this is not the sort of agreement that I am focused on here. A consensus, of the sort I am distinguishing as a morally desirable aim in clinical ethics, comes out of shared deliberation and interaction, and is in that sense “built” out of our engagement with the others involved. Agreement, even unanimous agreement within a group, is not necessarily a consensus in the sense that I, or the clinical pragmatists want to argue is a morally justified type of decision.

To aim at consensus, is to aim at an agreement that is substantially shared by those involved in the decision in some way—it is a type of collectively made, collective agreement. Even at the very base level of defining the word consensus, I think we can see at least a hint of this more substantive aspect of the concept. As Peter Caws has pointed out, the prefix ‘con’ carries the meaning of ‘with’ or ‘together’, while ‘sens’ implies ‘feeling’ or ‘perceiving.’ Consensus then carries this connotation of a shared feeling, or feeling together.⁶⁹ This “feeling with” seems to be at the heart of a more substantive understanding of consensus—that is, as a type of *shared* agreement.

⁶⁹ (Caws 1991)

The sort of consensus that has value, in science, public policy, and as I want to argue, in ethics, is a more substantive sort of agreement in the sense that it is an interpersonal agreement. It is not the mere aggregation of opinion, but an agreement that is formed through critical engagement with others. A consensus among scientists concerning a particular theory carries weight in validating that theory in part because we believe it is based on the mutual understanding of the relevant experts in the field. A consensus among scientists concerning global warming is taken as important because we think they have gathered or examined part of the evidence. They have also deliberated with others in the field or related fields in a manner that is responsive to criticism and suggestions, and come to a reasoned decision through this engagement with others and the evidence that has survived this shared attempt to weigh and evaluate evidence. A similar understanding of consensus is relevant in ethics, particularly clinical ethics. This seems to be what the clinical pragmatists have in mind. To further develop this understanding of consensus, it will be helpful to contrast consensus with consent and compromise.

What Consensus is Not

Consent

Consensus can be distinguished quite easily from consent or acquiescence. Peter Caws has argued that while consent and consensus have a common root, and similar meanings, they are importantly different. Consenting to a decision is not the same as having a consensus about a

decision.⁷⁰ For example, what the patient consents to may not be what she truly wants or agrees with, and instead may be only what she permits. Consent also need not imply understanding on the part of the person who consents—we may just yield to the authority of the doctor, and in that sense “consent” to the treatment. Consent is focused on the *act* of agreement and consensus is focused on the *fact* or *substance* of the agreement according to Caws.⁷¹ While in some cases the participants in a decision making process will be reluctant to change their positions or concede towards consensus, if a decision is truly a consensus, the participants will in fact see the decision reached as the correct decision in light of the discussion and deliberations at hand. Unlike mere consent then, a consensus seems to imply an understanding and willing acceptance on the part of those who are part of the agreement—it is more than mere acquiescence or blind acceptance of a decision.⁷² You can *consent* to a decision or judgment that has already been made, but to achieve consensus in the sense I have in mind, you must have actually participated. Consensus then, unlike mere consent or acquiescence is not merely an agreement, but one that necessarily involves a shared deliberation that precedes the decision reached—it is an *agreement with* others that is *made with* others.

Compromise

Consensus can also be distinguished from compromise, another common form of agreement—indeed, a form of collective decision that is often reached via a collective activity or

⁷⁰ (Caws 1991)

⁷¹ (Caws 1991, 377)

⁷² Instead, it may be more closely related to “informed consent.” See for instance (Brody 1989).

process.⁷³ Compromise, like consensus, is a way of concluding, and a collective decision, but unlike consensus, it involves an agreement that is reached via mutual concessions.⁷⁴ I may disagree with the outcome or decision in some ways, but I go along with it because others have also made concessions which make the outcome more palatable to me. Often compromises are reached out of a process of negotiation where we each make mutual concessions in order to reach an agreement that benefits or adheres to as many of the interests as possible for both sides.⁷⁵ Sometimes a compromise is the best possible decision given our need for agreement. When we reach a compromise, no one's preferences or values are exactly met, but instead we each give up something so that an agreement can be reached.

In compromises, often each person or group comes to the table with certain interests or principled beliefs they want to satisfy already in hand.⁷⁶ After negotiating with others we might give up our contention that a certain belief should be determinative of the outcome in a case, or we might set aside a certain preference so a decision can be reached. We each see a compromise decision as a way to satisfy more of our interests than the alternatives. In a compromise both sides are in a sense disappointed in the outcome, yet satisfied that it is better than the alternative outcome of no compromise.

There may be value—indeed, moral value—in a compromise. Further, a compromise may be the best that an ethics committee can manage to obtain in a given case. Nevertheless, it is

⁷³ See (Caws 1991), (Moreno 1995), and (Bayertz 1994).

⁷⁴ See (Lepora 2012), (Benjamin 1990), (OED Online 2013)

⁷⁵ I will use the terms interests, values, and reason often interchangeably when discussing what is under consideration in the process of decision making.

⁷⁶ This may also be true in cases of consensus building. Often, given the nature of human beings, many participants will come to the table with a set of interests they want to promote and maintain. While this in itself isn't contrary to consensus, the way in which we "promote" and "maintain" these interests can be.

distinctly different from what I want to call a consensus. In particular, it differs in this notion of giving up something perhaps even something you still view as morally important.

I think fundamental, at least to our common sense understanding of compromise, is this idea that we are giving up or setting aside certain values or interests for the sake of agreement. Usually this is an agreement that has some greater value in its own right—often practical value in moving forward on necessary projects. But nevertheless, it is an agreement that may involve giving up certain principled interests. This understanding of compromise is emphasized in a fairly recent article by Chiara Lepora.

As she explains:

Compromising with somebody with opposed principled concerns, even if done under force of necessity, nonetheless entails an intra-personal ‘compromise of’ something that each party to the inter-personal compromise regards as being of principled concern. For that reason, it inevitably involves some level of wrongdoing from the point of view of those who are party to the compromise.⁷⁷

According to her account of compromise, in cases where what is at stake is thought to be morally valuable or important, it is usually coupled with some reluctance or even a bit of regret. If they could get what they think is morally preferable all things considered, they would get to maintain their interests and values.⁷⁸ But, given the need to work together and get something done, they instead must compromise some aspects of their original stance.

This doesn’t imply that the actors are merely self-interested negotiators in all cases of compromise, though it does seem to imply that my aim in interacting with you is to satisfy as

⁷⁷ (Lepora 2012, 7)

⁷⁸ This “giving up” of certain interests or values for the sake of agreement is the basis for what seems to be the fairly negative view of a moral compromise that Lepora discusses. If we often neglect our moral convictions in order to agree with others, then our moral integrity may be called into question.

many interests and values of mine as possible while still being able to reach an agreement with you. Often in a compromise both parties are less than thrilled with the outcome, but live with it because it is better than no agreement at all.

As Lepora has noted, compromise is not a matter of “correcting” an original idea or position. Compromise implies giving up something of importance for the sake of agreement; it is not the same as giving up a principled interest or value because you no longer see it as valid. If after further consideration and discussion with others you come to the belief that some of your principles or reasons were not valid, are inapplicable or incorrect in some other way, and in so doing, you give up something you previously thought to be important—you are not compromising, you are correcting your views. While a correction or change in your position is not a component of *compromise* in the way I use the term, it is often a necessary component of a consensus decision. In any discussion of moral conflict that makes progress someone has reexamined and corrected a moral belief or other conviction thought to be of moral relevance. Consensus can only emerge from conflict if someone or sometimes everyone changes their moral stance.

Consensus, at least in the context of a clinical ethics conflict, seems to involve a coming together and a shared development of a decision that is not so clearly implied by a compromise. Consensus doesn't seem to carry the negative connotation of giving something up—instead it is more akin to a synthesis or bringing together of opposing views. For example, the patient now understands what they are asking of the doctor might be minimally beneficial in the short term for *them*, but in fact puts an undue burden on the *doctor and staff* that could also affect other patients. The patient has then adjusted the weight of their preferences in regards to the reasons

given by others affected. A responsive change in our interests or values in a particular case is often an essential component of achieving a consensus, but is not a matter of mutual concession as much as a matter of mutual understanding and a changing of your mind. What formerly seemed valuable or valid no longer seems that way (or now seems more so) in light of the considerations advanced by the other participants. In a consensus, there is a meeting of the minds that isn't necessarily an aspect of compromise or other forms of collective agreements.

What Consensus Is

Consensus as Shared Agreement

Most importantly, what seems to differentiate consensus from other sorts of agreements or collective decisions is the shared nature of the agreement—both at the level of outcome and at the level of the process by which the agreement is reached. It is a coming together through engagement with others on a decision that we all come to feel is the best decision given the situation and evidence put forth and available.

Consensus in general seems to be contrary to a decision that involves regretfully *setting aside* our interests or values to meet agreement. If our emphasis and weight of certain convictions or moral principles is changed on the basis of our understanding of the situation and engagement with others, then there is no longer the sense of regret that is commonly thought to accompany compromise. We in this sense then “feel together” or share in the agreement more substantially than what is commonly thought to be a compromise. It is more than mere agreement, and it is more than a substantial agreement accompanied by reservations; it is

agreement constituted out of a process aimed at achieving mutual understanding and coming to a decision based on that understanding—it is a significantly shared agreement.

Moreover, consensus also seems to differ from compromise in terms of the starting point of those involved. In a compromise decision, the actors involved typically come to the table with their interests and positions more or less staked out. They desire to have their interests respected and promoted to the greatest extent possible. In this way, it makes sense to say that we “chisel out” a compromise agreement. Each side has important components of their position they desire to achieve or get into the agreement, but in order to get there, we must “chisel away” some of the interests or components of the staked out positions. Once we’ve chiseled away enough to make the sides comfortable with the decision, we reach a compromise.

Generally, consensus though does not seem to carry this same connotation. We often hear about “consensus building” or “consensus development,” that is, there seems to be a sense in which we generally build up or develop a consensus, rather than chisel it out. The sort of agreement that represents a consensus is the sort of agreement that we significantly share with others. Consensus seems to be an agreement that is made because of mutual understanding or shared understanding—not merely because an agreement is necessary, and this is what we can come together on. It is more significantly shared among those involved.

True enough, the attempt to “chisel out” common ground may end up exposing what we agree on such that we can come to a shared agreement. Certainly there will also be cases where a compromise decision is all we can achieve—particularly in an ethics committee or a consultation, there are constraints on our ability to achieve a completely shared sort of agreement. To the extent that the deliberations are aimed at a consensus among the participants,

the decision reached, even if it falls short of consensus has some moral value. Compromise is a way of deciding that is sometimes on its way to consensus, or is at the very least consistent with that aim (if it involves a coming together towards mutual understanding, and out of respect), but yet fails to reach that fully shared level of agreement in the end. In the practical context this may be all that we can achieve. In some cases, the committee or the participants in the consult will discover that there is nothing any of the parties can say to sway the opinion of the others, so this must be left as a place where they believe “reasonable persons can disagree.”⁷⁹ But to the degree that the parties to the agreement have truly aimed at a consensus, the decision they reach will have moral validity—while a consensus agreement may be the ideal resolution, other sorts of agreements may have value in their own right as a reasonable stopping point, especially in the context of clinical ethics where the situation and time constraints are anything but ideal. (I will return to the moral value of decisions that fall short of consensus.)

Others have defined consensus in a similar way. Bruce Jennings, in his article, “Possibilities of Consensus,” argues that a shift in our understanding of the nature of consensus can take us a long way towards understanding the role consensus ought to play in our ethical deliberations. While our common sense understandings of consensus imply that it is a morally questionable goal in ethical deliberation, a more developed understanding of consensus seems to have a clear role to play in resolving ethical conflicts. While Jennings does not give us a complete definition of a consensus with moral authority per se, he does distinguish the sort of consensus that ought to play a role in our moral deliberations from two common understandings of consensus—pluralistic and overlapping consensus.

⁷⁹ (Rawls 1993)

Pluralistic consensus, according to Jennings, is a purely procedural notion of consensus as “that which survives a competitive process of debate and compromise, during which significantly affected parties have an opportunity, and a right to modify, if not veto, any particular conclusion or decision that they find unacceptable on the grounds of their own well-being.”⁸⁰ On this view of consensus, self-interested agents come together through deliberation to reach a decision that is not unacceptable to any of the involved parties. This notion of consensus is not much different from compromise as I am using that term.

Jennings argues that this notion of consensus is inadequate as a resolution to ethical conflicts for several reasons. First of all, it is too open to abuses of power and especially in the hospital setting could end in the reinforcement of the status quo (for good or ill). As Jennings argues, it doesn’t guarantee equality of consideration—those with better debating skills, with more power in the hospital, or who are more competitive will often “win” the debate. Secondly, Jennings argues that this understanding of consensus lacks any notion of the development of the interests of the participants. This model, he says, fails to take discourse seriously by assuming that the affected parties come to the table with all interests in hand, with the aim of satisfying as many of those interests as possible. Instead, Jennings argues, what is important about consensus is that our interests and understandings of a situation are in part constituted by our discourse with others. For both of these reasons pluralistic consensus does not add value to a moral deliberation.

⁸⁰ (Jennings 1991, 454)

Others have made similar points. Robert Veatch argues that consensus “serves an atmosphere of cooperation.”⁸¹ In a similar vein, Kurt Bayertz has argued that what is most important about consensus, particularly when it comes to a “moral” consensus, is *how* agreement is reached. Bayertz writes:

Consensus has a claim to moral authority only when it is the result of communication aimed at inter-subjective understanding. In a process of inter-subjective understanding, those involved are not concerned with *effecting* an agreement with their partners by employing strategic means (sanctions or gratifications), but with convincing them of the correctness of an empirical or normative statement using arguments, not force.

A certain attitude and approach towards those involved in the decision is in part what constitutes the decision reached as a consensus on this view.

Jennings is right: there is a dramatic difference between coming to the table with a competitive aim and coming to the table with the aim of achieving an agreement based on mutual understanding. Whether one necessarily precludes the other is another question though. As individuals involved in and affected by a moral decision, we are both self-interested competitors, and cooperative deliberators in many cases. It is the balancing act between the two that highlights the difficulties in morally charged situations with others who must also balance and weigh the two. Bringing to the table your own interests and submitting their importance is not contrary to consensus in the clinical context, it is, as I will argue, an integral aspect of achieving consensus. Particularly in a moral conflict, if we are all taking part in the decision, there is a sense in which it will be essential for you to express your interests and perspective to the group involved. What is contrary to consensus building is coming to the table in order to “win” or satisfy as many of those interests as possible—especially when this means ignoring the integral

⁸¹ (Veatch 1998, 20)

role of the others involved. They are agents too, and are, at least in a clinical consult, often those that will be expected to deliver or take the treatment that is decided upon. An openness to the expressions of others and a level of respect for their input is also essential.

The second common understanding of consensus that Jennings highlights is what he calls “overlapping consensus.” This understanding of consensus is not Rawls’, but instead is defined a bit differently by Jennings.⁸² According to Jennings, *overlapping consensus* involves two core ideas: 1) The basic values holding society together must be grounded in dialogical consent; and 2) These values must be relatively neutral in regards to substantive conceptions of the good.⁸³ We reach a consensus when we share certain broad values developed through some sort of ongoing dialogue with others. Consensus is achieved via bracketing differences, and focusing on the common ground we share in order to reach agreement.

Jennings argues that this understanding of consensus is also inadequate as a critical moral tool. As he explains, “A robust and adequate conception of moral consensus should point us toward a practice of deliberation that works through and resolves moral conflict and disagreement, not simply one that brackets and sets such conflict aside.”⁸⁴ What we desire in moral discourse is a resolution to a moral conflict and a way to move forward, but the overlapping consensus model does not fully provide this. He explains that an adequate conception of consensus must not merely seek to *discover* the common ground, but must also seek to *create* common ground.⁸⁵ A consensus in this more robust sense involves a shared

⁸² (Rawls 1993)

⁸³ (Jennings 1991, 456)

⁸⁴ (Jennings 1991, 456)

⁸⁵ (Jennings 1991, 458)

agreement that is more than what we already shared and just uncovered by getting rid of what we disagreed on; it is shared in the sense that we create the agreement together.

Jennings points toward a “democratic” understanding of consensus where deliberation is constrained by substantive values, but does not fully develop this definition of consensus and what it implies for ethical deliberations. What he does say is that consensus implies normative requirements that apply to both the practice of discourse through which a common view is constituted, and the content of that view. If a decision is to be consensus that has moral value, then it must meet certain normative demands. Mere agreement is not enough, and, in a sense, is not a consensus at all according to Jennings. He concludes by saying, “Consensus, in the strongest sense of the term only happens when it is seen as a common good to be created, and thus the creation of consensus becomes a special civic intention shared by the participants in the moral dialogue.”⁸⁶ This notion of consensus seems to imply that the aim of consensus requires a careful and reciprocal process of deliberation with those affected and involved in an ethical conflict. It is a certain way of approaching conflict and implies some significantly shared process of resolution and mutual respect among those involved.

While admittedly this definition is still incomplete in terms of spelling out what is meant by an agreement being significantly shared in a way that would give it moral value or moral authority, I think focusing in on what it means for an agreement to be significantly *shared* among the participants can take us a long way towards understanding the normative nature of consensus as an aim. If my aim is to reach a *shared* agreement or a consensus with others, then certain

⁸⁶ (Jennings 1991, 458)

approaches will and others will not do. More needs to be said as to what sorts of engagements and interactions with others are needed in order for an agreement to be a consensus, or what sorts of discussions promote or aim at a significantly shared agreement. There are ways of deciding with others in a moral conflict that involves people understanding each other and coming together with them in a way that allows for genuine resolution of the conflict and a justifiable moral decision among the participants.

The Value of Consensus in Clinical Ethics

Quite apart from the moral validity of the decisions reached, the search for consensus has value in the communication it encourages. Consensus, as an agreement that is significantly shared, requires careful and involving communication between parties, something that is often ignored by more common approaches to ethical issues. On the clinical pragmatist approach, communication is not only an issue related to morality, communication or the lack thereof may become an ethical issue. This seems particularly telling for the clinical setting. At least at the ethics committee meetings I have attended, much of the ethical problems are thought to be “merely issues with communication.” But if our aim is consensus, a certain sort of communication between those concerned is necessary. I take it that many share the intuition that communication is often of critical ethical importance, and I think the aim of consensus as a significantly shared agreement makes some much needed sense out of that intuition.

More closely related to the moral validity of a decision, our understanding of a situation will change or develop through conversations aimed at consensus. By interacting and communicating with others we are often given a fuller and more nuanced perspective of a

situation—especially a situation of conflict involving other people. An engagement with others is what allows us to understand another view of the moral implications of decisions or our moral convictions. Unless there was someone with the ability to see all, and from all perspectives, the moral facts in terms of the effects and impacts of a decision and the decision making on the other moral stakeholders just cannot be attended to when we are alone in our office analyzing a moral conflict. Although this is valuable even in individual action, it is crucial when interacting with others in morally difficult situations—particularly if we are to come together in a way that respects the parties that must participate in shared action. In a discussion in which there is movement—someone comes to see or believe differently—one person in the discussion believes that she has learned something and that she now has a better understanding or view of the situation.

And even the unchanging party in a fair and good conversation has her original view reaffirmed in a way that purely internal examination of it can never achieve. I realize, “they haven’t seen or thought of anything that I ignored or short-changed.” In part at least, this is a lot of what ethics committees seem to do for doctors. They provide moral support for the clinicians and further justification of their reasoning – “You’re right, doc, this is a very tough case. And we think you’re doing the right thing for the right reasons.” This kind of engagement with others is more epistemically defensible than applying a moral theory unilaterally without real engagement or deliberative consideration of the others involved.

An ethical theory or principle applied unilaterally is not enough to guide how I actually relate with those affected; there is actual concrete involvement with other human beings that must take place. For instance, my deontological inclinations that tell me lying is always wrong

may tell me something about the sort of conclusion I think is correct, though it does not tell me how to resolve a case in a way that takes seriously the kind of reasonable disagreement about lying that occurs in real life ethical conflicts. Even if moral theories provide a means for judging what decisions are morally appropriate, they often provide little guidance in terms of how to resolve ethical conflicts as they occur in our lives.

There is also an issue of respect. A shared process of decision making has the value of respecting those that must take part in the decision. Moral conflicts that occur in our lives are not presented as a case to be resolved in our minds, but rather, as an issue to work through with those affected and involved in a moral concern. A patient's refusal of life-saving medical treatment that you think is in their best interests is not clearly resolved by applying the principles of medical ethics.⁸⁷ It has to be something that is worked out with the people that are there and expected to participate in the decision—the conflict is not merely a conflict of ideas, but a conflict among *people* with varying perspectives, interests and concerns. For this reason, thinking through an ethical issue in isolation, though it may yield interesting conceptual and maybe even practical advice, is not going to truly resolve an ethical issue that arises within a hospital with numerous affected parties involved.

We cannot respect the persons involved without working through the conflict with them. Even if some of the moral stakeholders are mistaken about the morally correct decision or have a suspect perspective (e.g., a son that wants to end his parent's treatment solely because of the life-insurance benefits), interests, alleged facts, and even misguided moral views cannot be irrelevant as long as someone involved in the case thinks they are relevant. Thus, there is always value in

⁸⁷ (Beauchamp and Childress 2001)

engaging them in a conversation over just what decision we can all agree on as morally satisfactory. Respecting others involves taking seriously their point of view, and that requires actually working with them. (The son must come to understand that his perspective is too narrow and morally inappropriate; he cannot simply be told that it is, much less bypassed altogether.)

Part of what makes clinical pragmatism so attractive, and the aim of consensus so valuable, is that it prescribes that we meet “moral problem-solvers” where they are and with what they believe to be important. Any unilateral decision fails to respect the other participants. It even threatens to treat them as means for executing one’s own moral vision rather than as agents in their own right.

Yet another value of the search for consensus is that it can provide those involved with adequate moral motivation to act on a decision. A decision that you significantly share in with others is much more likely to be one in which you are motivated to act on. By contrast, moral conflict in the practical sense will remain, so long as we cannot come together *with* the others involved in a more substantive way. When you are pressured against your will, or feel railroaded and ignored by the others involved, the likely result is moral distress and moral residue that many have argued create significant problems in the clinical setting.⁸⁸

Moral distress, most often discussed in conjunction with the nursing profession, is characterized as a situation in which one feels they know the appropriate action to take, but yet is constrained in some way from taking the action. Moral distress is accompanied by a sense of powerlessness on the part of the person experiencing the distress. This feeling of being devalued

⁸⁸ The term “moral distress” was coined by Andrew Jameton. See (Jameton 1984). For a discussion of the relationship between moral distress and moral residue see (E. G. Epstein 2004).

or powerless to be effective in the decision making may stem from organizational barriers, an inability to communicate with others, or any number of impeding factors. Moral distress, even if it is based on the mistaken conception of the right thing to do, cannot be ignored.

Moral distress, while it may be similar to emotional distress, is importantly different.⁸⁹ Moral distress has a significant ethical component in that there is a feeling of being devalued and unheard in situations that both affect and involve you.⁹⁰ As was noted by a physician and ethics consultant in a *New York Times* article a few years ago, it is not uncommon for doctors and nurses to feel “trapped,” when they are not able to do what they feel is the right thing, and are forced to compromise what they think is best for the patient because of expectations and constraints from others.⁹¹ When people are expected to participate in morally difficult treatment decisions, not involving them and their perspective in the decision making process is not only morally questionable in that it denies them their moral standing in a decision that significantly involves them, but further, can be seen to have devastating practical effects in terms of the quality of care and the retention of valuable healthcare professionals that want nothing more than to provide beneficial care for their patients.

Moral distress over time, and particularly when ignored, leads to “moral residue,” where feelings of guilt and anger reside after the distressing situation has passed.⁹² When those involved feel that their perspectives and input are ignored or not able to be brought into consideration by the others involved, yet they are still expected to participate and engage in the

⁸⁹ McCarthy and Deady make an important distinction between emotional distress, that which can be found in any stressful job, and moral distress, that which is not merely emotional but has an important moral component. See (McCarthy and Deady 2008).

⁹⁰ (McCarthy and Deady 2008)

⁹¹ (Chen 2009)

⁹² (E. G. Epstein 2004)

decision reached, they are often left with a sense of frustration. Moral residue stemming from these distressing situations is often the cause of burnout, eventual departure from the profession, as well as a lack of good patient care.⁹³

The cooperative nature of medical practice and medical treatments, not only among the healthcare providers, but also among the patients and their families really means that coming together in regards to resolving an ethical conflict is essential—not only for practical reasons, but also for moral reasons. The other people involved are not robots or automatons to be subjected to the moral beliefs of the most powerful participants, or even the morally “right” participants. There is moral value in meeting the disagreement head on, and working through that disagreement to reach a consensus that we can all share in and accept—even in cases where there at the outset seems to be a clearly right or correct decision. A consensus, where one can be reached, eliminates moral distress and thereby reduces moral residue. And even if a consensus cannot be achieved, at the very least a process whereby those involved seek mutual understanding respects those involved and offers a means to alleviate the real clinical concerns of

⁹³ (E. G. Epstein 2004). Kath Melia, a social scientist, argues that consensus is a highly desirable state for those working in the intensive care unit. An important aspect of consensus that is highlighted by Melia’s interviews with the ICU nurses is the need for a steady and continued process of decision making to occur, the whole time a patient is in the hospital. There are often huge problems and costs for the patient if the clinicians cannot get on the same page about the appropriate course of treatment. As the ICU nurses in Melia’s interviews readily attest, there is a real sense of frustration that develops within the ICU when the doctors rotate on and off, each with a different voice and different recommendation. The cardiologist is for backing off and even for referral to hospice, but the nephrologist is for keeping on keeping on. This sort of lack of consensus, or even more, a lack of aiming at a moral consensus, can really mean torture for the patient and devastating effects on their families, as well as great frustration for the doctors and nurses involved in administering care. Without aiming at a consensus among affected parties, particularly those that administer care, it seems evident that there will be much moral residue left in the form of dissent among the healthcare team that will inevitably result in worse patient care, as well as to possibly toxic relations between the healthcare team members themselves. (Melia 2001)

moral distress. If moral distress and its residual effects are ignored, conflicts will be more prevalent and more trenchant.

Falling Short of Consensus

It is important to note that given the constraints of time and other factors it will often be necessary to move forward without meeting the goal of consensus. Even if a compromise in the sense of “giving up” some values or preferences is necessary to move forward, it is evident that the *aim* of consensus will still have direct implications as to how the decision is reached, that is, the sort of *process* by which we decide. This overarching goal, even when left unmet, will in effect change the sort of decision that is made and dramatically shape the sort of deliberation that must ensue. Even if a complete consensus, in the sense of a significantly shared agreement reached via a shared process of engagement with other participants, cannot be achieved, the goal will have a valuable impact on the decision we reach and the way in which we reach it. There is an expression of genuine respect for the other persons involved when we engage in moral deliberations aimed at a shared agreement with them. Even when compromise is the best we can do, it is still important to distinguish compromise resulting from a process that aimed at consensus from one resulting from bargaining or purely self-interested negotiations.

Consensus is often elusive. Martin Benjamin develops a notion of moral compromise that fully respects others in the face of persistent disagreement. This understanding of moral compromise involves a balancing and weighting of our values and interests on the basis of our interpersonal engagement with others and a need for cooperation. In a moral compromise on this account, we are not giving up our interests or values, nor do we seem to regret the decision.

Benjamin's account of moral compromise seems to involve more of a compromise *among* your principles, rather than a compromise *of* your principles. As such, it doesn't seem to carry the same negative connotations that Lepora refers to, even though the basic underlying definition of compromise remains the same—it is a collective agreement, often made out of necessity, via mutual concessions. These mutual concessions need not be accompanied by regret. In some cases this kind of compromise will be viewed as the moral decision, and the most desirable in our situation.⁹⁴

Compromise on his account, like the clinical pragmatist account of consensus, has a dual nature. As Benjamin explains compromise is both something “reached” and a “way of reaching”—that is, it is both an outcome and a process of decision making.⁹⁵ In a compromise decision, the decision appears to be one that “splits the difference” among the opposing sides. Further, he explains the process that is normally taken to achieve a compromise decision is also called a compromise. He writes:

As a rule, parties to this process try to see matters from the other's point of view, engage in various forms of give-and-take discussion, and are prepared, at least in principle, to make concessions for the sake of coming to terms. In so doing they acknowledge each other's viewpoints as having some claim to equal respect and consideration. In contrast to certain other forms of bargaining and negotiation, the emphasis is on rational persuasion, mutual trust, and reciprocal concession rather than force, threat or intimidation.⁹⁶

Importantly though, such a process doesn't necessarily end in a compromise decision, and a “compromise” decision can be reached without such a process. Moral compromise in the strict sense that Benjamin is at pains to discuss, implies both: the decision “splits the difference”

⁹⁴ (Benjamin 1990, 35)

⁹⁵ (Benjamin 1990, 4)

⁹⁶ (Benjamin 1990, 5)

between the sides (involves mutual concessions) and it is achieved via a process involving give-and-take, and equal respect. We come together to achieve agreement in part out of our respect for the others involved, and our need to cooperate with others.

While compromise in the sense of giving up our interests or convictions for the sake of agreement is the sort of thing that is likely to create moral distress and residue that prolongs conflict in both the short and long term, Martin Benjamin's notion of "moral compromise" does not have this same implication.⁹⁷ To use Lepora's language, on his account, we can sometimes *compromise with* others without *compromise of* our moral principles or integrity. Moral compromise, on his view, does not require that we give up our values in order to reach agreement, though it can require that we weigh our values or the import of our principles differently so that a reasonable agreement can be met. A *compromise between* or among our moral principles or interests, is not the same as a *compromise of* them. It is not that I'm now convinced that the new weighting of my principles or values is more rationally defensible in and of itself. Rather, the new weighting is necessary given certain practical constraints and will in fact be more consistent with my values overall than the alternatives available. He refers specifically to such values as the value of cooperation with others and respect for equality of others as possible overarching values that we may hold. So for instance, we can imagine someone opposed to abortion and who puts great value in the sanctity of human life. They also though have the values of respect for others as equals and a value in cooperation with others. So, while I am making a compromise between values or among my values by participating in an

⁹⁷ (Benjamin 1990)

abortion, this decision is still consistent with my overarching values of respect for equals and the long term value of cooperation with others.

This does not mean that all compromises are morally good compromises, though it does on his view, imply that compromises needn't imply an affront to our integrity. Often a compromise is even required for moral integrity. We as human beings have many values, sometimes even inconsistent values. Particular situations will require a different relevant weighting or emphasis of values. As he explains:

Our concern is for the long run and our aim is to lead and to have lived a good and optimally integrated life in conjunction with others whom we regard as in some sense equals and whose commitments, values, and principles will not always be the same as ours. The best means to this end will occasionally require accommodation to conduct and practices and to values and principles that conflict with our own. In order to remain true to the complex set of values and principles most central to our overall identity and integrity, we will refrain, at least temporarily, from acting in accord with certain values and principles that are more peripheral. The resulting agreement, peace, and good will, we hope, will ultimately be more conducive to preserving the overall pattern of our lives than continued conflict and acrimony.⁹⁸

Will Friedman and Alison Kadlac have proposed the notion of a *confluence* as a type of agreement that may be morally desirable and yet falls short of consensus. Confluence on their view implies a gathering or flowing together around a common problem where alternative perspectives are allowed to be voiced and are actually heard by others participating. The goal of coming together then allows differences in power to be lessened in that those involved are seeking a confluence with the other participants.

On their view, the goal of confluence involves both the clarification of agreements, but also the clarification of serious differences. In so doing we may reach a more provisional sort of

⁹⁸ (Benjamin 1990, 74)

agreement, a *confluence*, such that our decision is not a final consensus or complete shared and reasoned agreement on how to proceed, but rather, a more tentative and dynamic agreement that is open to further change and deliberation in the future. As they explain:

Such a problem-oriented approach seeks ongoing input and insight from the range of possible stakeholders in a process that clarifies serious differences as well as potential common ground, and suggests ways of moving ahead on an issue that are, if provisional, nevertheless practical and dynamic.

Confluence is more provisional in nature than a complete shared agreement or consensus. In the clinical setting, often what we may be able to reach as an agreement on what to do, will be something closer to confluence around the decision, rather than a complete consensus. Confluence is particularly important where action is ongoing and when decisions need to be revisited when things didn't go as planned. Of course decisions cannot always be revisited—the decision to remove the ventilator is terminal. However, the decision to prolong life support will often have to be revisited especially if it goes on much longer than anticipated.

A consensus in the clinical setting will in most cases be provisional in nature, and not a final say in the morality of a decision.⁹⁹ Even a fully shared agreement or consensus in a particular case is not the final word in what should have been done. Even when the decision cannot be reversed or undone, we can always go back and analyze that decision from a different perspective or with new information in hand and see that our past moral consensus in this case was not the best decision all things considered. This does not mean that the decision was not justified at the time though—often, time presents us with new information that just wasn't available when the decision was made. Especially in the clinical context where time is often in

⁹⁹ As Fins et al. explain as well a consensus is a *workable* solution to a difficult problem and is always subject to further scrutiny and revision. (Fins, Bachetta and Miller 1997)

short supply and decisions must be made quickly. Fins et al. are correct in wanting our decisions to be able to “withstand moral scrutiny,” but they mislocate this additional scrutiny. It is in the context of revisiting an earlier decision that additional “moral scrutiny” has its place. Neither in a group process nor in solitary reflection is there any guarantee that “The Answer” has been reached or finally justified. To require that full moral justification of a clinical decision arrive at “The Answer” is to place moral justification beyond the realm of human capabilities.

A complete consensus gives a shared decision stability and staying power. Especially given constraints of time and other practical factors, complete consensus may sometimes be out of reach. While the goal is to share fully in the decision via an engagement with others involved, there might be other more provisional types of agreement that while less than a consensus, still have moral value—at least in the way that the decision is reached among the participants. Benjamin offers one alternative, Friedman and Kadlac another.

Aiming at a significantly shared agreement, or a moral consensus, is needed to respect those involved in a moral conflict. Even when the aim is not reached, the shared process of engagement is still important. A moral compromise or a provisional decision, both less than consensus, have value in the way that they deal with the perspectives of the participants, and also as a means to actually working through real conflicts in situations where time is very often of the essence.

Consensus in the sense I’ve defined, is constituted both by a shared process aimed toward agreement, and as a decision or shared agreement with others on the basis of that process. It is shared in the sense that we create the agreement together—not by bracketing differences, but through mutual understanding of differences and moving beyond those differences to a shared

agreement. It is a type of agreement *with* others—the agreement is *ours* in a sense that is more significant than uncovering things we agree on, and it is not an agreement merely because agreement is necessary. Aiming at a consensus has, I have argued, moral value even when it cannot be achieved.

However, even complete consensus about a decision has full moral justification only when it is achieved by a process that I will develop. In the following chapters, I will argue that a consensus decision, that is, one that is significantly shared in a manner that gives it a claim to moral authority in cases of ethical conflict, will be one that is: 1) Developed through reasonable deliberation among the affected and involved parties; 2) Based on a tempered equality of consideration of relevant interests; 3) Made among participants that are free from undue influence; and, 4) Guided by mutual respect and an aim of mutual understanding among participants.¹⁰⁰ I will also confront the central issue of just who must be involved in the process of decision making, and the consensus that ensues. I turn next to accounts of deliberative democracy to aid in defining this process of consensus building.

¹⁰⁰ These conditions are importantly and directly influenced by the accounts of deliberative democracy that I will discuss in what follows. (Gutmann and Thompson 2004) and (Cohen 1997) in particular.

CHAPTER 3

DELIBERATIVE DEMOCRACY AND ETHICAL DELIBERATION

Introduction

In what follows, my aim will be to defend and define a more substantive account of the *process* of decision making under a clinical pragmatist approach in terms of the conditions and aims of the process, as well as the stakeholders that must be part of the process. First, though, it will be helpful to start by making comparisons between the clinical pragmatist's method of moral decision making in the clinical context and deliberative accounts of democratic decision making in the political context.

For one thing, like political action, the treatment of a patient in the hospital is a shared endeavor, which is unlike individual action that is more commonly the focus in ethics. As in politics, one decision implicates many. In cases of moral conflict within the clinical setting, many of the arguments in favor of deliberative democracy in the political setting also apply.

Deliberative Democracy and Ethical Deliberation

Deliberative democracy as a political theory seeks a justifiable and binding means by which to resolve moral disagreement in the political realm. Deliberative democracy is in part an account of political legitimacy and in part an account of legitimate processes of deliberation over

issues on which there is not or cannot be assumed to be a “right” answer, or at least an antecedently “right” answer. Deliberative democracy centers on the idea of free and equal people deliberating over common concerns in the political forum in order to reach some *legitimate* consensus over issues of policy and the common good.¹⁰¹ Fundamental to this view is a recognition that there are numerous respectable expressions of the good life that deserve equal consideration in the political realm in which some common decision must be made. Given this, a legitimate decision on the common good is one in which these respectable interests are taken into consideration and that those involved can reasonably accept. Deliberative democracy, it is argued, allows for these competing interests to get a fair say in decisions over collective action.

Differences in Context—the Political vs. the Clinical

Before examining particular accounts of deliberative democratic processes and political legitimacy, it is important to note that there are several possibly relevant dissimilarities between the political setting and the clinical setting that could easily shape the process of decision making that is possible, or even desirable.

In accounts of deliberative democracy, equality of all is required. There are two kinds of equality that play a central role: equality of opportunity to influence a decision and equality of consideration in the decision. Neither applies straightforwardly in clinical decisions involving the treatment of a specific patient.

¹⁰¹ See (Bohman and Rehg 1997, x)

First, there is equality in terms of the capacities and abilities of those involved such that they can have a fair and equal *opportunity* to influence the decisions that impact them.¹⁰² James Bohman argues that political equality requires a threshold of “effective freedom,” that is an ability to initiate public deliberations about their concerns.¹⁰³ Thomas Christiano argues that political equality, in terms of equality of opportunity to affect the outcome of decision making requires some level of *cognitive equality*. As he states, “Equality in the cognitive conditions for decision making, as I have argued, is necessary for political equality.”¹⁰⁴ Those involved must meet some threshold level of ability to offer reasons, and consider the reasons of others. The clinical analogue of this threshold is competence or decision making capacity. (Like most bioethicists, I am working with the assumption of a competent patient and will consider later how my conclusions might apply to patients who fall below this threshold.)

Second, there is also concern for the *equality of consideration* that occurs in the process of deliberation. As Christiano points out, when the legitimate interests of citizens conflict there must be equal consideration of those interests in the deliberations over how to proceed in order to respect all those involved and achieve a legitimate and binding decision. In the political sphere, equality of opportunity and equality of consideration often go hand in hand, and both depend on some threshold of cognitive ability among those participating.

One important difference in the clinical setting is that there are not many cases in which those involved can be presumed to have equal cognitive footing. A visit to the hospital by a

¹⁰² See (Knight and Johnson 1997). They argue that if cognitive capacity is important as it seemingly must be on a deliberative account, then the conditions needed to encourage those capacities (education, economic means) are also necessary.

¹⁰³ (Bohman 1996, 128)

¹⁰⁴ (Christiano 1997)

patient is in itself an admission that they are unable to treat their illness on their own—they lack the necessary knowledge and abilities. While a presumption of cognitive equality can plausibly be maintained in a representative democracy like ours (or at least it seems), in the clinical context there is, in the majority of cases, a significant difference in the cognitive abilities of those involved.¹⁰⁵ By its very nature, a visit to the hospital by a patient is a situation in which they are generally not at an *equal* cognitive standing with the healthcare providers, and so may be at a significant disadvantage in their ability to understand the options available and their implications. The physician has an understanding of the treatment options that is not available to many patients, and the options in question in most cases affect a patient's welfare in a way that is very different from the way the options affect the physician or the nurse. The patient's ability to effectively communicate their perspective is also often affected. A strict equality among the participants in terms of their opportunity to influence the outcome or decision or in terms of the consideration and relevance of their input may not be plausible in the clinical setting in the way that it is in the democratic political setting.¹⁰⁶

Another important difference is that equality of consideration also does not apply straightforwardly to the clinical setting. In the clinic, the conflict and resulting resolution usually involves a decision involving the welfare and life of one person, that is, the patient. In

¹⁰⁵ See (Cohen 1997). He suggests that in democratic decision making, what is needed is cognitive equality of participating parties.

¹⁰⁶ There may be some reason to think that even in the political setting a strict equality of opportunity to influence the decision making, and equality of consideration, may not be fully defensible. First, it is not clear that cognitive equality is plausible even among representatives in our democracy. Not all will have knowledge of the best ways to resolve nuclear armament issues in North Korea for instance. Second, it is not entirely clear that all citizens are *bound* to laws equally. Laws concerning abortion for instance seem to *bind* women to a set of standards in a different way than those standards *bind* the men in that society. This seems to imply possibly that even in the political context, depending on the decision in question, a deliberative account of democratic decision making may require a difference in the sort of consideration and inclusion that is appropriate.

these sorts of conflicts, though the patient is not the only affected party, it is clear that the patient usually does have a *unique stake* in the outcome of the deliberation or discussion of how to proceed. This “outcome” could mean the life or death of the patient, the intense prolonging of suffering or relief from suffering, etc. With this in mind, it is apparent that though there may be some sense in which we can stipulate that a process that accounts for all interests *equally* may apply to the political setting, it is not clearly as applicable in the clinical setting. In particular, we are not deciding over some “common” good, and instead the good of a particular individual, or a small set of individuals, becomes of central importance to the deliberation.

Traditionally medicine has been focused on the best interests of the patient as the most important consideration. While there have been convincing calls to broaden the scope of considerations, there is a real sense in which what is in the best interests of the patient ought to be a central consideration in our treatment decisions.¹⁰⁷ Each person brings their own perspective and relevant experience, but some perspectives are more relevant and more significant in a decision than others. Equality of consideration in the clinical setting, seems to require a “tempering” that is not often thought to be needed in the political context.¹⁰⁸ In the political context, deliberative theorists suggest that the relevant stakeholders are those that are bound by and under the dictates of the political decision that will be made. So, all citizens bound by a law must rightfully have their reasonable interests included in a fair process of deliberation. It seems

¹⁰⁷ (Hardwig 1990). Hardwig argues that it is morally important to consider not just patient interests, but also the interests of the family.

¹⁰⁸ Admittedly, this also seems to be true in the case of political decisions. Laws affect certain groups disproportionately. The law allowing abortions may likely affect a woman’s life more than it will a male in the same society. While it is not my aim here to offer a critique of deliberative understandings of democracy, there does seem to be a need to further discuss the relevant stakeholders that must take part in the deliberative process, and further the degree to which they are considered, in the political context as well.

somewhat clear then how we ought to determine who is rightfully considered in political deliberation—the citizens under the jurisdiction of the policy in question. In the context of the clinic though, there is somewhat less clarity in this regard. As just mentioned, certain people as individuals seem to have a *unique stake* in medical decisions. The outcome of a medical decision will have a much greater and different sort of impact in most cases on the patient than on the doctor. There is a real sense then, in which a patient is bound by a given medical decision to a greater degree than the doctor, or any other affected party in most cases.¹⁰⁹

However, the patient, or their surrogates, the doctor and the healthcare team are *all* clearly relevant to a decision making process, given that they will all be directly involved and affected by a given course of action in some way. As I noted early on, a real problem for the clinical pragmatist position in carving out just who must take part in the moral problem solving and consensus formation. While there seems to be a ready answer given in deliberative approaches to democracy in the political context (that is, all those bound by the law or maybe even everyone in the state of Tennessee, say), in the clinical context it does not seem that all those bound by a decision in resolving a moral conflict will be equally affected and bound.¹¹⁰

Drawing the Parallels—Deliberative Democracy and Clinical Pragmatism

Keeping these differences in mind, we can still make some much needed headway in terms of defining the process implied by the aim of consensus by examining deliberative approaches to democracy. Amy Gutmann and Dennis Thompson give a clear account of the

¹⁰⁹ Clearly in some cases, especially when the patient is nearing death, or non-comprehending, their families will likely be the most affected by a decision. See (Hardwig 1990)

¹¹⁰ In the next chapter I will focus on just who ought to be involved, that is, who is an affected and concerned party.

value of shared deliberation. Both Gutmann and Thompson as well as Joshua Cohen specify the *procedure* required for a decision to be deliberatively justified. Both are illuminating for the clinical context.

Gutmann and Thompson argue that, “[t]he general aim of deliberative democracy is to provide the most justifiable conception for dealing with moral disagreement in politics.”¹¹¹ Similarly what is sought in the clinic is a method for resolving moral disagreement in a way that is optimally justified. As in the political context, one ethical decision commits many agents not all of whom are predisposed initially to agree with it. In a political context we do not deliberate for very long about uncontroversial decisions, similarly hospital ethics committees very rarely consider cases about which there is no controversy. So, both deliberative democracy and hospital ethics committees begin with discord and conflict. Both aim to create a justified consensus. (Consensus will of course mean something different in a political context, but for present purposes we can ignore these differences.)

For Gutmann and Thompson, deliberative democracy serves four related purposes in resolving moral disagreement: 1) It promotes the legitimacy of collective decisions; 2) it encourages public-spirited perspectives on public issues; 3) it promotes mutually respectful processes of decision-making and responds to incompatible moral values; and, 4) it helps correct mistakes in reasoning, particularly those that come from incomplete understandings.¹¹² I argue

¹¹¹ (Gutmann and Thompson 2004, 10)

¹¹² (Gutmann and Thompson 2004, 10-12). See also (Gutmann and Thompson 1997), in which they apply these aims and purposes of deliberative democracy discussed here to the context of bioethics. They take a similar position to the one I take here, and argue that deliberative democracy is particularly well suited to bioethics. The difference though, is that their focus is still on quasi-political bioethics, that is, discussions in councils, committees, etc. They are not focused on the interpersonal dimensions of clinical ethics, which is the focus of this project.

that seeking moral consensus in a hospital by the appropriate method serves all four of these purposes.

Collective decision making in cases of moral conflict in the clinic where numerous parties are involved, is more defensible than unilateral or individual decision making. What Gutmann and Thompson say about our attitudes as citizens also rings true in the hospital:

It is all too easy to assume that we already know what constitutes the best resolution of a moral conflict, and do not need to deliberate with our fellow citizens. To presume that we know what the right resolution is before we hear from others who will also be affected by our decisions is not only arrogant, but unjustified in light of the complexity of the issues and interests that are so often at stake.¹¹³

This unjustified confidence in our own opinions is best remedied through shared deliberation.

The values in deliberative democracy are precisely the values promoted by clinical pragmatism.

I turn next to accounts of the process proposed by deliberative theorists to deal with moral conflict, to reveal lessons for the clinical context. In both cases the aim of consensus shapes the process. Gutmann and Thompson have argued that there are four essential characteristics of deliberative democracy: 1) It requires reason-giving; 2) Those reasons must be publicly accessible; 3) Its process is aimed at some decision that is binding for some period of time; 4) The process is dynamic and all decisions are subject to further debate and discussion.¹¹⁴

¹¹³ (Gutmann and Thompson 2004, 12).

¹¹⁴ (Gutmann and Thompson 2004). On the clinical pragmatist approach, a consensus that can withstand moral scrutiny is not thought to be the final word, and instead is meant as a workable solution to a concrete moral conflict. It is a morally justified solution, but it is always open to further revision. They recommend that when possible we should always follow up on the decisions we make to see whether they are in need of further revision or adjustment. New information can come to light, unknown consequences may appear—our resolutions to moral conflict should always be viewed as “provisional” in the sense of remaining open to the possibility that we could be wrong or could be shortsighted in some regard. See (Fins, Bachetta and Miller 1997)

Reason-giving of a certain sort is essential to all accounts of deliberative democracy.¹¹⁵ As

Gutmann and Thompson explain:

The reasons that deliberative democracy asks citizens and their representatives to give should appeal to principles that individuals who are trying to find fair terms of cooperation cannot reasonably reject...They are reasons that should be accepted by free and equal persons seeking fair terms of cooperation. The moral basis for this reason-giving process is common to many conceptions of democracy. Persons should be treated not merely as objects of legislation, as passive subjects to be ruled, but as autonomous agents who take part in the governance of their own society, directly or through their representatives. In deliberative democracy an important way these agents take part is by presenting and responding to reasons, or by demanding that their representatives do so, with the aim of justifying the laws under which they must live together. The reasons are meant both to produce a justifiable decision and to express the value of mutual respect.¹¹⁶

On their view then, it is not enough that reasons are given, but those reasons must be accessible to all. This implies that not only should the deliberation or reason giving take place with those that are actually involved, and not merely in one's own mind, but also that the content of those reasons must be understandable to all.¹¹⁷ For example, one cannot appeal to revelation, either secular or religious—this is not the sort of reason that others have access to without sharing in a particular worldview.¹¹⁸

As in the clinic, political deliberation aims at producing a binding decision, but not one that is universally applicable or binding in all cases. It is the correct decision in that particular situation with those particular considerations that were available at that time.¹¹⁹ The decision we make is to bind a certain group (citizens or healthcare team), but not indefinitely. The process of

¹¹⁵ See (Gutmann and Thompson 2004), (Cohen 1997), (Christiano 1997) for instance.

¹¹⁶ (Gutmann and Thompson 2004, 3)

¹¹⁷ (Gutmann and Thompson 2004, 4)

¹¹⁸ In the clinical setting, depending on the treatment or decision in question, we might possibly argue that there is more room for “personal” reasoning given the personal nature of many treatment decisions—that is, many decisions have personal impacts on certain involved parties in a way that they do not have for others that are involved.

¹¹⁹ This is crucial for those concerned with clinical ethics cases—a moral consensus will be a tentative sort of agreement that could be changed when new information is brought to bear.

deliberation is always dynamic, and, “[a]lthough deliberation aims at a justifiable decision, it does not presuppose that the deliberation at hand will in fact be justified, let alone that justification today will suffice for the indefinite future.”¹²⁰ It is always the case that new and compelling information can come to change our prior decision, and a deliberative account of democracy makes sense of this notion. Decisions made are always provisional and open to change in light of new and different understandings.

Central to the justification for a deliberative account of legitimate decision making is the value of mutual respect among persons. Crucial in promoting this value is deliberation and discussion of a particular sort including openness to change.¹²¹ Gutmann and Thompson’s statement that I quoted above nicely captures the disrespect implicit in unilateral decisions and refusal to reconsider: “To presume that we know what the right resolution is before we hear from others who will also be affected by our decisions is not only arrogant but also unjustified in light of the complexity of the issues and interests that are so often at stake.”¹²²

This is a central tenet of both deliberative democracy and clinical pragmatism; it is also a central motivation for accepting a deliberative and consensus aimed process of moral decision making.

Another prominent deliberative theorist, Joshua Cohen, argues that democratic decisions gain their legitimacy through the deliberative process:

¹²⁰ (Gutmann and Thompson, *Why Deliberative Democracy?* 2004, 6)

¹²¹ I think it is important to note here that they do not suggest that all disagreement is bad, instead that a certain willingness to honestly and openly entertain the preferences and interests of others involved, really requires an aim at coming together as much as possible through discussion. Clearly strict unanimity is not often reached, and further may not always be desirable. The point is merely that an aim at lessening disagreement engenders a certain attitude towards the reasons and interests of others in a deliberation.

¹²² (Gutmann and Thompson 2004, 12)

The notion of a deliberative democracy is rooted in the intuitive ideal of a democratic association in which the justification of the terms and conditions of association proceeds through public argument and reasoning among equal citizens. Citizens in such an order share a commitment to the resolution of problems of collective choice through public reasoning, and regard their basic institutions as legitimate insofar as they establish the framework for free public deliberation.¹²³

The rightness of a decision is determined through deliberation. There is no antecedently correct outcome; rather, the correct outcome is the one that has survived the process of deliberation.

Through reasoned deliberation, free citizens can reach legitimate decisions on how to proceed in public affairs.

Cohen fleshes out his account of the deliberative process by providing an ideal model for how such deliberation ought to proceed if it is to confer political legitimacy on its outcome.¹²⁴

According to Cohen, the *ideal deliberative procedure* is one which captures the principle that a decision is politically legitimate only in cases in which it *could* be the object of reasoned agreement among free and equal citizens.¹²⁵ Cohen goes on to give conditions under which such an agreement could be reached. He claims that deliberation of the sort that confers political legitimacy on its outcomes must be: free, reasoned, made in a deliberate way, equal, and aimed at and motivated by a rational consensus.¹²⁶

A *free* decision making process must be one in which the participants regard themselves as rightfully constrained by, given their participation in the deliberative process. The fact that a certain position could be reached on the basis of the deliberative process is taken as a reason for

¹²³ (Cohen 1997, 72)

¹²⁴ I am not clear on what Cohen thinks about the legitimacy of decisions made through a deliberative procedure which is less than ideal (as they all are). Does he want to say that in so far as our deliberative procedure fails to meet the ideal standards, the resulting decision is illegitimate?

¹²⁵ (Cohen 1997, 73)

¹²⁶ (Cohen 1997, 74)

complying with the decision.¹²⁷ Second, a given outcome is said to be *reasoned* so long as the participants are required to state their reasons for not only holding certain views, but also for criticizing other views or positions. Cohen explains, “Reasons are offered with the aim of bringing others to accept the proposal, given their disparate ends and their commitment to settling the conditions of their association through free deliberation among equals.”¹²⁸ Reasons are given with the expectation that they will be the basis for decision making.

Third, decisions must be made in a *deliberate way* rather than merely by examining their fit with citizen preferences.¹²⁹ Through the process of deliberation, the preferences of citizens may change depending on the reasons given by others for opposing preferences and values. Citizens may uncover their preferences through the process of deliberation. By offering reasons for one’s views and positions, they become more aware of their preferences or even of possible inconsistent preferences. As Cohen explains, the practice of giving reasons will in itself promote the commitment to collective deliberation:

Assuming a commitment to deliberative justification, the discovery that I can offer no persuasive reasons on behalf of a proposal of mine may transform the preferences that motivate the proposal. Aims that I recognize to be inconsistent with the requirements of deliberative agreement may tend to lose their force, at least when I expect others to be proceeding in reasonable ways and expect the outcome of deliberation to regulate subsequent action.¹³⁰

¹²⁷ I will argue in what follows that this aspect of a certain sort of reasonable deliberation seems to apply nicely to the clinical setting. If a doctor is to comply with the patient’s wishes and goals, then at the very least, the person must provide reasons for their requests. Further, if a patient is to comply with a treatment plan, then some level of understanding and involvement in the decision making seems necessary or at least more likely to lead to compliance.

¹²⁸ (Cohen 1997, 74)

¹²⁹ (Cohen 1997, 75)

¹³⁰ (Cohen 1997, 77)

Our subjective preferences and values are refined and developed in the debate over how to proceed together.

Fourth, the ideal deliberation must occur between parties that are *equal*, both formally and substantively. They are formally equal in that the rules for ideal deliberation apply to all. They are substantively equal in that all with deliberative capacities have equal standing and voice in the decision at each stage of deliberation. Substantive equality provides that inequalities of resources and power do not impact the decision. Fifth and finally, on Cohen's account ideal deliberation is aimed at a "rationally motivated consensus." As he notes, the goal of deliberation should be to find reasons that could persuade all those committed to acting on the results of free and reasoned deliberation.¹³¹

Cohen is of course talking about an abstract model of deliberation and not actual deliberation per se. As he says, all citizens recognize that this decision *could have been reached* by a deliberative process involving all citizens. Not that it actually was. By contrast, the clinical pragmatist holds that the decision must be reached in an *actual* deliberative process. This is much more easily achieved in a case of a treatment team than it could ever be in a country. This is an important disanalogy.

According to Cohen this understanding of ideal deliberation is also a means to the advancement of both individual autonomy and the common good. Individual autonomy is promoted via the reasoned and free deliberation that characterizes the ideal deliberative procedure. Preferences developed through deliberation are actually more autonomous than those that we just have beforehand. Through the deliberative process, we are forced to examine our

¹³¹ (Cohen 1997, 75)

preferences and the reasons for having them. Deliberation on Cohen's account also shifts the focus of the debate to the common good and away from primarily considering aggregated individual interests. Reasoning together as opposed to solitary reflection highlights the need to consider not just what is in each individual's interests, but further what will be best for all. We recognize that we all share a stake in the resulting decision. Those considerations that survive deliberation will be those that define the common good on his view. I will return to considerations of both individual autonomy and the common good in the clinical setting below.

Thomas Christiano argues that deliberation also often results in better decisions and promotes respect for persons. Deliberation has both instrumental and intrinsic value in a democracy.¹³² It is valuable in so far as it can enhance the quality of decisions, but it is also intrinsically valuable in that its "equal consideration" of citizens is grounded in the requirements of justice.¹³³ According to Christiano, so long as the political context of deliberation is free from intimidation and ridicule and is open to all perspectives, it seems likely that the resulting decisions will be *better* than those made absent this sort of deliberative activity. A society committed to open and free deliberation would likely make better decisions in that they are likely to be more receptive to a wide array of citizen interests and will likely be informed by a better knowledge of the facts that have import for the achievement of the aims of society.¹³⁴ Further,

¹³² (Christiano 1997, 243)

¹³³ Christiano is not certain that the instrumental value of deliberation aimed at consensus is necessarily present in all cases. As he remarks, more empirical research must be done in order to determine if justice is better served via the deliberative process. On Christiano's account, it is even likely that more deliberation leads to more disagreement. If this is the case, then this would be a devastating result in a clinical setting in which a decision must be made. The concern is that a process of open and reciprocal deliberation may, at least in some cases, have the opposite result, that is, more disagreement. I will discuss this possibility further in the next section in which I will attempt to make some more substantive remarks about the *process* of decision making.

¹³⁴ (Christiano 1997, 246)

Christiano argues that deliberation has intrinsic value in that it expresses a kind of mutual concern or respect.¹³⁵ By deliberating with you, that is, offering reasons and considering the reasons offered by you, I am expressing a kind of mutual respect for you.¹³⁶

Centrally important to deliberation on Christiano's view is that the participants have *cognitive equality* in democratic decision making. All citizens are cognitively equal in the sense that all citizens acknowledge that *any* of them could offer a valid, even a decisive, consideration. Also, the institutions of discussion and deliberation affect the *distribution* of the cognitive conditions of understanding among citizens. Societies in which deliberation is central will also be societies in which the citizens are better informed and have reflected on their own preferences as well as on the goals and aims of society more generally. (The issue of cognitive equality in the clinic will be a central focus of the next chapter.)

According to the deliberative theorists, then, certain sorts of deliberation are the basis for legitimating collective decisions that often involve a balancing of competing interests and values. The clinical pragmatist concurs: the process is what justifies the outcome. The practice of deliberation also promotes both individual autonomy and mutual respect among deliberators. Again, the clinical pragmatist concurs. The similarities between deliberative democracy and clinical pragmatism should not be surprising; a clinical ethics decision is a political decision in the sense that divergent and competing values and interests must be combined into one decision that will bind the entire healthcare team and will hopefully be acceptable to all involved. The

¹³⁵ (Christiano 1997, 247)

¹³⁶ See (Gutmann and Thompson 2004) in which they make a similar point concerning the reciprocity required and promoted by deliberative democracy.

deliberative theorist's reasoning not only is consistent with the clinical pragmatist approach to ethical decision making, but also helps articulate and support that view.

Following the accounts of deliberative democracy surveyed, at least four central conditions for a good process of decision making in cases of clinical moral conflict can be identified as aspects of the appropriate process of moral decision making in the clinical setting:

- 1) The process should consist in reasonable deliberation;
- 2) It ought to be based on a tempered equality of consideration of interests;¹³⁷
- 3) It ought to occur in a context of freedom from manipulation and a lack of undue influence from others; and
- 4) Should be shaped by an attitude of mutual respect and concern for those involved.

The remainder of this dissertation will be devoted to articulating and defending these conditions. I argue that these conditions define a *good process* of ethical decision making in the clinical setting, and give our decisions moral validity and justification.

¹³⁷ As I argue both at the outset of this chapter and in the following chapter, a strict understanding of equality of consideration and influence is not clearly defensible in the clinical setting. In the clinic not all are cognitively equal and not all are *bound* by the decision in the same way or to the same degree.

CHAPTER 4

CONDITION 1: REASONABLE (SHARED) DELIBERATION

Introduction

Drawing on deliberative accounts of democracy, I will argue that crucial to the clinical pragmatist position, and the aim of consensus is that the process must involve some form of reasonable deliberation among the involved parties.¹³⁸ The ideal conclusion to a moral conflict is a consensus among the involved parties. The fact that we begin with conflict implies that we do not begin in complete agreement. In order to create a consensus, some sort of reasoned conversation must occur. A “meeting of the minds” is not something that occurs in silence and solitude.¹³⁹ Even if a moral consensus is not, or cannot be reached, reasonable deliberation is necessary in order to engage and involve those affected by a decision. This allows us to respect the perspectives of those involved in a moral conflict or situation in more than a superficial way.

As I will argue, the sort of reasonable deliberation that is necessary in resolving ethical issues in medicine is a type of practical reasoning, that is, reasoning aimed towards both motivating and achieving a resolving action.¹⁴⁰ Reasonable deliberation is not a matter of argument merely for the sake of argument, or even a matter of mere persuasion. It is a shared process of reason giving and openness to the reasons of others. This reasonable deliberation

¹³⁸ I will focus on the question of who ought to be involved in the deliberations in the following chapter.

¹³⁹ By silence I am meaning that there is no expression of ideas or thoughts between those involved—communication needn’t always be verbal.

¹⁴⁰ (Wallace 2009)

taken as part of the aim of consensus is the most important aspect of the process of decision making emphasized by the clinical pragmatists.

Reasonable (Shared) Deliberation

While reason-giving and deliberation can be said to take many forms, not all are adequate in actually involving the individuals that have a moral stake in a decision.¹⁴¹ Deliberation, by most definitions, requires an activity of *careful consideration*. In the sense I am considering here, reasonable deliberation is *other-regarding* in a way that unilateral decision making is not. It is characterized by a willingness to listen and discuss the issues with those that are affected and involved, and in part requires that we participate in a conversation that uncovers the reasons and interests of affected parties. What is needed is not only an honest and open expression of your reasons and values, but also an honest attempt to consider those of the others involved. This means that asking questions and attempting to understand other perspectives will be an essential component of reasonable deliberation. In joint deliberations with others, we not only gain an understanding of others' perspectives, but also make ourselves and our actions understood by others. Central to reasonable deliberation is making our positions transparent to the other involved parties.¹⁴² It is then that we are in the position to deliberate together over how we ought to move forward. There must be a *willingness on the part of the participants to give reasons and to be responsive to the reasons of others*

¹⁴¹ I confront the issue of who should be included in the deliberations in the following chapter.

¹⁴² I am not assuming here that we are all "transparent" to ourselves, such that we can know fully our reasons for particular interests or beliefs. All that can be expected is that we make transparent what we think are our reasons. Clearly sometimes we don't realize our motivations or reasons for thinking certain things.

Reasonable and shared deliberation is also characterized by a desire among those involved to achieve a resolution through the reason giving process. Reasonable deliberation is importantly different from debate. In a debate, my aim is to win and to persuade. In reasonable deliberation the aim is achieving understanding that allows us to share in a decision and ideally reach a consensus about what to do. It is deliberation and discussion that *addresses conflict and seeks a cooperative resolution among those involved*.

Reasonable deliberation is aimed at action, and in the context of clinical ethics, that action is intended to be a resolution to the moral conflict at hand. The ideal outcome would respond to the sources of conflict and moral uneasiness so that the parties involved can be comfortable, morally speaking, with the action being pursued.¹⁴³ It is not enough to *know* the correct answer; we need to *reach* the correct answer after and through a process based on the reasonable deliberation of the involved parties in order for it to be justified in the face of moral conflict.

In order to develop a clinical pragmatist view of reasonable deliberation, I argue that this kind of shared deliberation is informative, transformative, expresses respect and often promotes autonomy.¹⁴⁴ For all of these reasons shared deliberation is also likely to increase patient compliance. These features of shared deliberation are closely intertwined—all new information that is considered relevant and important is in some way transformative, and to the extent that autonomy involves consistent and reasoned preferences, this transformation will also often

¹⁴³ This is not to say that all the parties will in fact be satisfied once the results of the decision are in to so to speak. There can in fact be moral discomfort when things actually play out in the hospital. The contingencies involved in a practice like medicine can often be unforeseen.

¹⁴⁴ (Bohman 1996). Bohman argues that reasonable deliberation is both informative and transformative.

promote autonomy. I will have much to more to say about the informative feature of shared deliberation because the other features depend on the informative aspect of shared deliberation. The informative dimension is also more relevant because the focus in bioethics is on reaching a morally justified decision and not on the personal growth of the participants.

Reasonable Deliberation is Informative

Deliberating with other involved and affected parties allows the relevant considerations of the situation to be brought to the fore, including both the facts of the situation and also the interests, values and perspectives of the moral stakeholders. In shared deliberations, we weigh these considerations and decide how best to make use of them in a decision. A collective process of deliberation among affected parties allows for all of these considerations to be exposed and made available to the other involved parties. The aim of shared deliberation should be to produce outcomes that express or reflect the view of all participants.

It is not enough for the doctor to understand only the technical medical facts of a situation, just as it is not enough for the patient to understand only their own desires for treatment. Understanding, at least partially, the perspectives of the other involved parties is essential in achieving a mutually acceptable and morally justifiable decision. This is best accomplished by engaging in a conversation with them. As Anthony Laden puts it, “When we reason together, we exchange reasons. That is, we offer up to one another considerations which we take to be relevant to the choices at hand.”¹⁴⁵ While not all reasons and considerations offered up will be accepted as relevant after the deliberative process has run its course, it is this

¹⁴⁵ Laden, pg. 555-556

process of reason giving which allows those involved to come together to sort out just what considerations ought to be on the table.

If deliberation is truly reasonable, the aim will be that it be maximally informative. This carries implications for who ought to be included. Reasonable deliberation requires that those involved express their own reasoning and interests in regards to the issue at hand. This I think is crucial in the clinical context. The relevant considerations are discovered and developed through our engagement in discussion with the others involved. The medical professionals are the ones that can offer the best technical medical information. But they cannot offer full insight into the impacts on the lives of the patient or their family. Inclusion of the patient and their family in the reason giving and deliberative process is therefore essential whenever possible.¹⁴⁶ This is something recognized in the clinical setting, even if not always adequately dealt with. The impacts on patients' and their families' lives are not something we can know, nor properly consider from our armchair, or an ethics committee meeting populated only with healthcare professionals.

Further, and I think more often a neglected consideration, there are more than medical and scientific aspects to healthcare decisions. Very often, there are personal and emotional aspects that also must be brought into the decision. For instance, when the wife of a dying husband has a deep fear of being alone in her old age, and it is this fear that encourages her to push for aggressive treatment for her chronically ill husband, contrary to the recommendations and beliefs of those involved in his care. It is the wife's strong fear of being alone that is central

¹⁴⁶ An expression of the patient's interests and values should come from the one best equipped to make that expression—while in a few cases this will be the doctor or nurse, in most it will not.

in the conflict, and to some degree at least, it is a discussion that recognizes and appreciates these sorts of factors that will allow the conflict to be resolved, or at least allow us to make some headway towards resolution. I am mainly thinking of the patient and their families here, but this does not exclude the personal considerations for the healthcare professionals involved. We must actually listen to and involve all of those affected by a decision in more than a superficial way.

Reasonable deliberation requires an honest *sharing* of our interests, and reasons for particular suggestions. Hiding our reasoning, or exposing only certain reasons so as to strategically achieve our own aims, or to further our own paternalistic aim of patient well-being is contrary to reasonable deliberation as I understand it. Having a reasoned deliberation with those affected and involved in a moral decision is not the same as a purely self-interested process of presenting reasons and arguments to a group with the aim of achieving some strategic or pre-planned outcome. Rather, it involves an honest and open presentation of one's own reasoning.

Howard Brody makes a similar point when he argues for a transparency model of informed consent in primary care.¹⁴⁷ On this model, the doctor must make her own reasoning behind a particular treatment decision "transparent" to the patient.

According to the transparency model, the key to reasonable disclosure is not adherence to existing standards of other practitioners, nor is it adherence to a list of risks that a hypothetical reasonable patient would want to know. Instead, disclosure is adequate when the physician's basic thinking has been rendered transparent to the patient...Essentially, the transparency standard requires the physician to engage in the typical patient-management thought process, only to do it out loud in language understandable to the patient.¹⁴⁸

¹⁴⁷ (Brody 1989)

¹⁴⁸ (Brody 1989, 7-8)

As he explains, informed consent is attained when a reasonably informed patient is allowed to participate as fully as they wish in the medical treatment decision. The physician must not only make their own reasoning transparent, the patient must also have the opportunity to ask questions and to have those questions answered. Merely listing off risks and benefits is not sufficient, unless it is that list of risks and benefits that the doctor used as their basis for the recommendation. This sort of transparency—an honest and open engagement with the patient concerning the physician’s own reasoning behind particular recommendations—is essential for both good patient care, and for respecting the central value of patient autonomy.

While aiming at persuasion or manipulation of the interests of others is contrary to reasonable deliberation, expressing purely self-interested reasons is not. If the doctor doesn’t want to perform a procedure because it will impact her ability to maintain a family obligation, then expressing this is not contrary to a reasonable deliberation, but rather, essential to the process. While such an expression may be difficult, or even seen as contrary to professional norms, it may in fact be necessary in the ideal case.¹⁴⁹ Expressing even difficult to express interests (when those interests inform your position and reasoning) is often an important component of achieving a moral consensus. Whether or not this purely “self-interested” reason that the doctor has given is thought to carry much weight in the decision is another matter though, and that will be part of the deliberations that ensue.

We can imagine too that someone could decide beforehand that a particular consideration is not relevant to the decision at hand, and as such, not express it in the deliberations with others.

¹⁴⁹ This sort of honesty will very often be difficult to achieve. In this sort of case in particular, it would likely seem “unprofessional” for the physician to express such an interest.

The nurse or doctor may be burdened by a long surgery, and have to cancel a night out with friends, but they decide that while they have an interest in friendships, the needs of the patient and their professional obligations outweigh the social desires. While this seems reasonable, we must be careful not to exclude reasons so as to manipulate the interests of others or merely to safeguard your own reputation. Complete openness among those involved is clearly an ideal though, and in many cases cannot be achieved.

Reasonable Deliberation is Transformative

Reasonable deliberation is not only informative; it is also transformative. All important new information is transformative; it changes, at least in subtle ways, the way we see things. But as deliberative theorists have insisted, reasonable deliberation is a process by which purely subjective preferences are brought into a discussion and are transformed by deliberation.¹⁵⁰

Reason-giving and communication among the moral stakeholders, can transform both the relevant interests expressed in a deliberation and the correlating judgments made in a clinical deliberation. The patient's preference is transformed by a better understanding of the downsides and risks of the treatment he is requesting. The doctor's treatment plan is altered when she comes to see why the other professionals (and other doctors) are uncomfortable with it. The rest of the team now understands the medicine of the case better and/or the doctor's thinking, etc. All this changes the participants' individual positions.

This is true even in discussions that do not aim at consensus. Discussion is especially transformative when there is a genuine search for consensus. The most transformative aspect of

¹⁵⁰ (Cohen 1997)

shared deliberations comes from the deep acknowledgement that others are as important as I and therefore their interests and perspectives deserve serious consideration. If our aim is reaching a consensual agreement in moral conflict, then it will be the case that original positions are transformed or developed further through the discussion.¹⁵¹

Even if we come to the table thinking that the outcome we reached prior to deliberations was the right one, it is still the case that our perspective, understanding, and reason for our decision will be changed through our reasonable deliberations with others. As a patient, I learn about the doctor's concerns with my requests, and the technical reasoning behind it. I may even better understand the medical implications of the situation. As I better understand why others reject my preferences, I better understand even my own preferences. Often they will also be altered in response to the deliberation. And even if not changed, they become more informed and thereby transformed through the process of deliberation and discussion with others.

Reasonable Deliberation Promotes Autonomy and Expresses Respect

Not all those involved will have an adequate understanding of a situation and the implications that particular decisions actually have for their lives. For instance, a patient's family may lack important insight because they are completely inexperienced in what is involved in, say, taking care of someone 24/7, or because they believe they can summon heroic efforts indefinitely. This is most dramatically played out in the cases of defective newborns. It is often

¹⁵¹ (Cohen 1997). Joshua Cohen makes a similar point.

the case that the healthcare professionals need to “reality test” the statements and desires of patients and their families. Very often education of patients and their families will be needed.¹⁵²

Autonomy is not simply having strong beliefs and preferences. It involves having beliefs and preferences chosen by some sort of reasoning process. Insofar as our deliberations are informative and transformative they are also autonomy promoting. As the parents of the defective newborn come to understand what will really be involved in the care they will be required to deliver, their choices become more autonomous.¹⁵³

Cohen also argues that preferences that have survived reasoned and rational deliberation by the affected parties are more autonomous than the initial preferences of an individual. Through such examination of our preferences, they become truly our own—we will have *reason* to have such preferences. Anthony Laden makes a similar point:

Being reasonable, on this picture, makes it possible for people with divergent ends to live together in ways which preserve their autonomy. It makes such relationships possible by giving us the capacity to form what I call shared wills. When our relationships are open to revision via reasonable deliberation, then we can share a space of reasons. When these reasons guide our action, we are guided by reasons we recognize as our own, and thus are autonomous.¹⁵⁴

When we participate in a reasonable deliberation that includes a discussion of our preferences and reasons alongside those of others, we are required to consider our preferences and reasons in a different light. In expressing them aloud to others we gain more understanding of our own

¹⁵²Education of others is often thought to be a key component to fulfilling one’s duty as a professional. See (Faber 2003). Although the healthcare professionals certainly can certainly also be educated through the shared deliberation, they are normally much more familiar with the terrain under consideration—they have, for example, already witnessed many couples struggling with decisions about defective newborns. They are therefore less likely to undergo profound changes.

¹⁵³ Of course autonomy is sometimes diminished through a discussion. I consider this possibility in Chapter 5 where I argue that when deliberation is not shared this is a real concern.

¹⁵⁴ (Laden 2000, 556-57)

views (sometimes the coherence or the lack there of in our proposals). When our interests and reasons are placed in the context of the reason-giving of others, they are understood in a different regard as well. Preferences and beliefs that have survived an honest process of reasonable deliberation among others thus become more fully our own.

We are normally not fully transparent to ourselves. Even when we hold strong beliefs or opinions we have not always reasoned through those opinions, or considered their importance or even desirability. Not all strongly stated positions, even from competent persons, are necessarily based on clear and coherent reasoning or clearly justifiable beliefs. It is important for the deliberations to uncover both what my interests and values in fact are and also what I take them to be. Consider the woman who is opting, yet again, for fertility treatment. She wants a baby of “her own.” But are those her values and interests? I’d say that often, she doesn’t really know why exactly this is so important to her, and further how these decisions either promote or hinder her interests in the long run. Sometimes what seem to be the most strongly held beliefs, are the least considered and thought through, and so in that sense, less autonomous.

Reasonable shared deliberation initiates a consideration of our perspectives, and an understanding of our reasoning that seems far less likely to occur in our minds apart from any dialogue with others. Insofar as the deliberation is both informative and transformative in the ways I have argued, it also autonomy promoting in a way that goes beyond what is generally thought as “respecting a patient’s right to decide.”

Traditionally, respect for autonomy in the clinical setting has been identified with allowing the patients (when competent) to decide what is in their own best interests. As Beauchamp and Childress explain in their account of the principle of respect for autonomy, “To

respect an autonomous agent is, at minimum, to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs."¹⁵⁵ While they acknowledge that respect for autonomy often also requires others to foster the abilities of patients to make decisions, say, by disclosing information, what is essential is that the patient's right to decide is maintained. In this way, an ethics that respects autonomy is often defined in contrast to a more paternalistic approach where the physician decides what is in the patient's best interest. Reasonable deliberation promotes the autonomy of those involved in the decision making in a way that moves well beyond respecting the patient's choice.

In addition to promoting autonomy, shared deliberation expresses respect. The condition of giving reasons to others and accepting the reasons of others implies respect for individuals and their values in a way that unilateral decision making does not. Assuming that one already has knowledge of the correct course of action, and therefore has no need to discuss it with others is deeply disrespectful of the others involved. It is in fact disrespectful in two ways: it presupposes that one has nothing to learn from others and it implicitly treats them as less than full moral agents. To assume that one has nothing to learn from someone is to dismiss their cognitive abilities. To attempt to usurp decision making authority is to treat them as extensions of one's own agency.

A key dimension of moral conflict, particularly of on-going conflict, is that someone who has an important stake in a decision feels that they are not being taken seriously or respected. A feeling of being devalued or unimportant in the resolution of moral conflicts leads to moral

¹⁵⁵ (Beauchamp and Childress 2001)

distress. Moral distress arises, as I have argued, from being asked to do something that you believe is morally wrong without due consideration of your perspective. The conviction that one's perspective has been ignored or short-changed is most effectively remedied by inclusion in the decision making.

While ideally a consensual decision arises from our deliberations, it is apparent that there is value in deliberation even when this goal is left unmet. One is less likely to not feel disrespected or devalued if one has been allowed to fully participate in a decision, even one that fails to reach consensus. My perspective may not have carried the day, but I now better understand why and recognize that it received consideration.

Reasonable Deliberation and Patient Compliance

As deliberative democrats have argued, reasonable deliberation over relevant interests and values is in part what allows for those who participate to be bound by the outcomes of those deliberations in cases of moral conflict and a need for cooperative action. In the clinical setting, if I want you to comply with and participate in my position, then at the very least, I ought to give you reasons that you can understand and accept. A decision that comes from shared deliberation as opposed to unilateral declaration is needed to take heed of the relevant considerations in a moral conflict. Importantly, it also provides motivation to act in a way that a unilaterally dictated decision often does not. Reasonable deliberation allows for a fuller understanding to be achieved. A consensus that is achieved on the basis of such deliberation will likely play a significant role in ensuring compliance of the involved parties with a given treatment plan or decision.

Not only is it beneficial if the entire healthcare team is on the same page with a given plan, but patients too have a significant role to play in the healing process. The non-compliance or what is commonly referred to as non-adherence of patients with treatment recommendations is a significant problem in the clinical setting.¹⁵⁶ As Martin et al. note, for most medical conditions, correct diagnosis and effective medical treatment are essential to a patient's survival and quality of life. A significant barrier to effective medical treatment, however, is the patient's failure to follow the recommendations of his or her physician or other healthcare provider.¹⁵⁷ As they explain, not only does non-compliance with treatment recommendations account for a great number of deaths, it also costs a significant amount of resources and money that could be spent in other ways. They write:

Patient nonadherence (sometimes called noncompliance) can take many forms; the advice given to patients by their healthcare professionals to cure or control disease is too often misunderstood, carried out incorrectly, forgotten, or even completely ignored. Nonadherence carries a huge economic burden. Yearly expenditures for the consequences of nonadherence have been estimated to be in the hundreds of billions of US dollars. Estimates of hospitalization costs due to medication nonadherence are as high as \$13.35 billion annually in the US alone. In addition to the most obvious direct costs, nonadherence is also a risk factor for a variety of subsequent poor health outcomes, including as many as 125,000 deaths each year.¹⁵⁸

Lack of patient adherence due to misunderstanding or even ignoring treatment plans is a significant issue within the clinical setting, and a shared process of reasonable deliberation seems to have the ability to help remedy these issues. A patient taking part in the decision making will likely gain an understanding of a decision and its impact on their interests and values which can

¹⁵⁶ There are countless articles on the health and resources related costs of non-compliance. See (Martin, et al. 2005) (Murphy and Coster 1997) both give a good account of some of the significant effects of non-compliance.

¹⁵⁷ (Martin, et al. 2005, 189)

¹⁵⁸ (Martin, et al. 2005, 189)

have a positive impact on their adherence to a treatment plan. While this is in part an empirical question that hasn't been fully answered, there is good reason to think that a decision that we significantly share in and one in which we are respected and involved in achieving is one that we are more likely to follow through with in terms of a resulting action. When we understand why we must do certain things and the reasoning behind a decision, it is usually much more likely that we will comply with the dictates of a decision. This is true both of patients and of those that provide care to the patients.

Particularly in the context of long-term and chronic illnesses there is some evidence to suggest that shared and collaborative decision making in the clinical setting can have a significant positive impact on patient adherence to treatment. Several studies that have looked at the care of diabetics, those with uncontrolled asthma, and those with schizophrenia have concluded that shared decision making appears to have a significant influence on patient adherence.¹⁵⁹ While more empirical data is needed, it only makes sense that a treatment decision that we share in creating, and understand the reasoning for, is one that we will more likely follow through on. Given that patient compliance is a significant problem in medicine, reasonable deliberation as a means to remedying this problem, perhaps markedly, is a huge benefit that follows from the clinical pragmatist approach.

¹⁵⁹ While more empirical evidence is needed, there have been some suggestions in the literature, that shared and collaborative decision making positively impact patient compliance with treatment. See for instance, (Wilson, et al. 2010) in which they cite evidence that shared decision making increased the compliance in treatment recommendations among asthma patients. See also, (Jonas, et al. 2013), in which they conclude after studying 71 patients with schizophrenia that interpersonal fairness among the doctor and patient leads to better outcomes and patient compliance.

Practical Constraints on a Condition of Reasonable Deliberation

Reasonable deliberation has many reasons to recommend it in the clinical setting, though it could very easily be chastised as impractical. First of all, we often do not have time to deliberate with all those involved. Decisions cannot always be postponed until reasonable deliberation has run its course. Second, there are also concerns with the willingness and abilities of the participants. There is no question that some people are better equipped for this process and are more participatory than others. Third, the space of the clinic itself can constrain the deliberations. The hospital floor is not generally conducive to careful and involving conversation. All of these factors can hinder shared reasonable deliberations.

First, time constraints are a significant concern for a process of reasonable deliberation in the clinical setting. In medical decisions, time is very often of the essence. Diseases and illness can progress more quickly than our discussions about moral conflict. There is no way that shared deliberation will be possible, nor desirable in all cases. Emergent care is a clear example. There are instances where any time delays in treatment will pose significant or even catastrophic risks to the patient. When we must make unilateral decisions because of time constraints, even if it is the best we can do, our decision will lack complete moral justification. In these cases an exception must be made, though this is not a reason to think that reasonable deliberation is unimportant in reaching a morally justified decision. Even if it is not always possible, it is desirable and morally important when it is. Reasonable deliberation is not unlike informed consent in this regard—it must on occasion be forgone because of the practical constraints of a situation, though we still recognize that the decision would be more justified if informed consent

was obtained. Reasonable and shared deliberations are necessary for full justification of a decision, even if some situations are such that full justification cannot be achieved.

Preparation for severe time constraints can only be done in advance. For this reason, it is crucial that those who provide care in a hospital and especially in an emergency room do their “moral homework.” As is true with any other area of their practice, healthcare providers may be morally blameworthy for not having done their homework. But, I do not consider this kind of advanced preparation part of the decision making process. Of course, ethical decisions like other decisions can be well-informed or less well-informed. In the moment of decision making, people come to the table with whatever preparation they have.

Second, there is a legitimate concern with the abilities and willingness of the participants. We can imagine plenty of cases where the patient feels that they need not be required to give a reasoned defense of their requests for treatments. The patient might say, “I am the one dying here, and I want everything done to fix it! What more reason is needed?” And there are those that think “doctor knows best” and so should make the decision, either because she knows more or because she is getting paid to bear the weight of the decision.¹⁶⁰ Whatever the reason for refusal to participate, it is a significant problem. When a patient or their family refuses to participate every effort must be made to bring them into the discussion. Sometimes this will mean that someone must have a discussion with them apart from a deliberation among all involved so as to get their perspective and input. What is most desirable, and what is necessary for moral justification, is their inclusion. If the patient refuses to discuss the issues with others,

¹⁶⁰ I focus here on the patient, though it could also be the case that members of the healthcare team may refuse to participate.

then there is a real sense in which our decision will be less than fully justified. To the extent possible, the patient must be included in our deliberations.

We can also imagine a patient who doesn't have the capacity to express their preferences either way, and so cannot offer reasons for any decision at all. In cases in which these abilities are impaired or lacking, this should not be taken as a reason to ignore their interests and perspective. Instead, what seems most essential is that appropriate attempts are made to understand the claims of the individual, and the sort of reasoning that *could* or *would* be given if the affected party did have the requisite abilities to do so—insofar as it is possible. If the patient is not available to express their values or preferences, or refuses to express their reasons for a proposal, then there are other ways in which this condition can be met. The patient can have an appropriate surrogate step in when they are unable to reason, or participate in reasonable deliberation. This surrogate then represents the patient and must provide reasons and explanation on their behalf. While this is the preferable solution to an incapacitated patient, it is clearly not always possible. When it isn't possible to find a knowledgeable surrogate, every effort must be made to approximate the decision that would be in their best interests.¹⁶¹

It is worth noting here that in most ethics committee deliberations, the patient and their family are not present—they are residing elsewhere in the hospital. The condition of reasonable deliberation calls this practice into question. There is a need for direct involvement whenever possible, and when not possible, as close to direct involvement as we can get is necessary. Not just any reason giving will do, but reasons must be given in good faith and with the aim of explaining and articulating to the other involved parties the reasons for your position and the

¹⁶¹ (Buchanan and Brock 1990)

connection to your values and interests, either as a patient, family member, or member of the healthcare team. There must be someone within the committee then that can offer this reason giving for the patient and family's interests and values. When a patient either refuses or is unable to participate, the choice of just who must step in to assist in "filling their shoes" is a choice that should be made with careful attention to possible conflicts of motivations.¹⁶²

Lastly, the clinical environment itself can hinder reasonable deliberation. As Fins et al. have argued, the environment surrounding a discussion matters and can significantly impact its effectiveness.¹⁶³ A busy hallway and a doctor glancing at their watch is no way for the patient, or their family to get on the same page as the doctor, or vice versa. Such a hurried and hectic space is not sufficient in most cases for engaging those involved so that their honest reasoning and perspective on an issue can be expressed. A setting where people feel comfortable expressing their perspectives and reasoning is necessary. This goes beyond the physical setting as well, and the *space of reasons* is also important.

The group dynamics and personalities of those involved can influence the quality of deliberations.¹⁶⁴ A member of the healthcare team that downgrades the reasoning of others or takes over the conversation, leaving others out is often devastating for shared deliberations.

Giving patients time to express themselves in the often intimidating context of the hospital will

¹⁶² A community volunteer or patient ombudsman may be a better choice to represent the patient than the patient advocate. What is necessary is an unbiased reason giving process that takes seriously the patients' views and the sorts of reasons they give or would give to support it. The patient advocate within a hospital may not be the best representative for the patient in reasonable deliberations. Not only must the patient advocate look after the patients interests and defend those interests, but the patient advocate is also consistently concerned with waiving or not waiving fees, or how much a given incident will cost the hospital. The patient advocate is motivated by the interests of the patient; but as an employee of the hospital, the patient advocate is also motivated by the bottom line for the hospital bank account.

¹⁶³ (Fins, Bachetta and Miller 1997)

¹⁶⁴ I will come back to this in my discussion of undue influence in Chapter 5.

often require physicians to develop skills that may not always come naturally. Allowing for silence is sometimes just as, if not more important, than talking. The effects that silence can have on a conversation are often amazing. Allowing those that may be hesitant to speak up a chance to chime in is essential. Filling the “space” with more words and more reasoning is not the full picture of deliberation and dialogue. The inclusion of others by merely making *space* for their involvement is crucial. By being a relatively uninvolved party—i.e., someone without a direct stake in a particular case—the bioethicist should often assume the responsibility of trying to create a space for shared deliberations.

In part this space is made by those involved accepting that their aim is a consensus among those involved. Aiming at a shared agreement and a resulting cooperative action will shape the way we see those involved in the moral conflict. Treating others and their perspectives as an essential aspect of moral justification changes the way we deliberate with them.

Clinical pragmatists insist that the justification for a moral decision lies in the process by which the decision is reached, not in the product. The heart of this process is reasonable shared deliberation in the ways that I have been exploring above. Reasonable shared deliberation is one necessary feature of a fully justified moral decision.

CHAPTER 5

CONDITION 2: TEMPERED EQUALITY OF CONSIDERATION

Introduction

Philosophers are primarily concerned with the conditions under which a decision is morally justified. Clinicians of course share this concern, but they are also concerned to craft a decision that would bind moral agents to participate in actions and provides assurance that they are doing the right thing. A genuine consensus satisfies the concerns of the clinicians and, I am arguing, satisfies the concern of the philosophers as well. For a consensus to result in a fully justified decision, it must, as I have argued, incorporate the reasoned deliberation of all concerned. This is the first condition.

A second condition is that of tempered equality of consideration. In order for the deliberations to be maximally informed and also to express respect for all involved in the case, all involved must be included in the deliberations. Deliberative democratic theory, as any theory of democracy must, emphasizes equality. The clinical pragmatist cannot follow the deliberative democrat all the way to *equal* consideration. In deliberation about the care of a particular patient, those involved are not equal in two important respects: the decision does not affect all in the same way and not all participants are cognitively equal. These two kinds of inequality both affect the weight that should be given to various statements in shared clinical deliberations, but in different ways and for different reasons. In this chapter, I develop and defend the requirement

of tempered equality of consideration.¹⁶⁵ I argue that clinical pragmatists ought to embrace only *tempered* equality of consideration. For lack of a better term, I use the word *impact* to refer to the extent to which a decision will affect someone's life.

As in the case of the condition of reasonable deliberation, *tempered equality of consideration* seems to follow, at least in practice, from the acceptance of the aim and motivation of a moral consensus. While a certain level of inclusion for all affected is clearly needed, it is clear that in the clinical setting not all interests and values can or should be given equal weight or authority in our decision making process.

Defining Tempered Equality of Consideration:

What is meant by “tempered equality”?

To claim that our deliberations ought to be conditioned by a tempered equality of consideration requires some explanation of just what is meant by equality in the first place. Equality as I will use the term is not identity—to say that two things are equal is not to say that they are identical, or the same in all respects. As I am using it here, equality is also a relational concept. To say that you and I are equal is to say that we both possess some quality or qualities. For instance, we are both equally human. We can be equal in certain regards and yet unequal in others. You and I are equal in the sense that we are both equally human, though we are unequal

¹⁶⁵ I take the term “tempered equality” from Helen Longino, where she argues that intellectual equality ought to be tempered by certain factors in order to achieve knowledge in a community. See (Longino 2002, 131-135). While I mean something akin to Longino's usage, I am not using the term in the exact way or context as Longino, so what is meant by it here will be remarkably different than Longino's own use of the term.

in our knowledge of, say, philosophy. This relational understanding of equality is not something new, and goes as far back as Aristotle. He makes a distinction between numerical and proportionate equality.¹⁶⁶

Furthermore, equality can be both descriptive and prescriptive. We may be merely describing two or more people as equal, as in the sense I just mentioned above. To say that we are equally human is to describe certain qualities about us. Descriptive qualities may or may not be linked to some further prescriptions on how we ought to act towards others. The sort of equality that I will be at most pains to discuss is prescriptive—that is, the sort of treatment we owe to others, specifically those we find ourselves in morally difficult situations with. This though, will be directly linked to certain descriptive qualities of those involved. To say that people are due equal consideration, is not to say that they are alike or identical in all regards, or that they ought to be treated alike or identical in all regards. Rather, it is to say that they ought to be treated equally, or proportionate, in relation to certain qualities that they share.

It is often suggested that all with deliberative capacities who are bound by a law should have equal standing and voice in the decision at each stage of deliberation. In this way, all relevant interests are given their *fair* consideration. This requires in particular that inequalities of resources and power do not influence the decision.¹⁶⁷ In arguing for *tempered* equality of consideration, I am arguing that inequalities of certain sorts should affect the consideration a person is given. While inequalities in power and money may not be important reasons to weigh

¹⁶⁶ (Aristotle 1984, 1785-1787)

¹⁶⁷ See (Cohen 1997). Though Cohen doesn't make such claims, it seems reasonable, based on this suggestion that he may agree that equality, even within the political realm must be "tempered" and "weighted" appropriately given that even political decisions have differing degrees of impact on those affected by a decision.

a given persons interests more heavily, inequalities in impacts and knowledge quite likely should.

Tempered equality, then, is an extension, or possibly a development, of the democratic conception of equality. I get the notion of tempered equality from Helen Longino. She has developed a normative account of scientific knowledge in which she argues for “tempered intellectual equality” among those in the community of knowledge producers.¹⁶⁸ The equality she is referring to is “intellectual” equality, and not “cognitive” equality—all must be respected as sharing in equal capacities for reasoning and reason giving, etc., but needn’t be assumed to have equal knowledge of a given field. Moreover, such equality is also only “tempered” equality, that is, certain sorts of conditions will appropriately weight the degree to which your input, claims, or interests merit consideration.¹⁶⁹ All involved should be regarded as equal in terms of their ability to accept reasons and give reasons, though this doesn’t require a strict equality of abilities or cognitive capacity, much less equal knowledge of the field. I return to the implications of cognitive inequality in shared clinical deliberations below. But first, it will be helpful to consider the other dimension of tempered equality of consideration—the impact of the decision on various stakeholders.

In Peter Singer’s, “Principle of Equal Consideration of Interests,” he famously argues that we must give equal consideration to equal interests—including non-human interests as well.¹⁷⁰

Whereas Longino focuses intellectual equality, Singer is more concerned with the impact on the

¹⁶⁸ See (Longino 2002).

¹⁶⁹ Longino argues in particular that a person who fails to meet the norm of uptake of criticism, that is, by ignoring relevant criticism of a particular view or claim, then they may eventually be rightfully disregarded. I am not going to take this line exactly. Instead I will insist if someone is unable to be given equal consideration on their own, then there may be a need for support of that participant.

¹⁷⁰ (Singer, Practical Ethics 1993) (Singer, Animal Liberation 2002)

interests of all affected by an action. As Singer explains, “The essence of the principle of equal consideration of interests is that we give equal weight in our moral deliberations to the like interests of all those affected by our actions.”¹⁷¹ However, this is not a call for identical treatment, but rather proportionality in the way we treat those affected by a particular action. He explains in *Animal Liberation*, “The basic principle of equality does not require equal or identical *treatment*; it requires equal consideration. Equal consideration for different beings may lead to different treatment and different rights.”¹⁷² A similar idea of proportionality is at the heart of my proposal for tempered equality of consideration as a condition necessary for achieving a moral consensus.

In the hospital, patients’ interests are not uncommonly construed as simply health related interests. All other interests are considered means to life and health. But for our purposes interests must be more broadly construed, to encompass values and goals more generally. Joel Feinberg develops an account of interests in which a person has an *interest in* some outcome when he “has a stake” in it; he has a stake in it when he stands to gain or lose depending on its issue.¹⁷³ My interests, particularly *interests in* something, in part depend on what is “invested” into whatever is in question. He distinguishes between two general types of interests: welfare interests and ulterior interests. Ulterior interests are our ultimate interests related to our overarching goals. Such things as achieving political office or achieving spiritual grace are among these ulterior interests.¹⁷⁴ On the other hand, welfare interests are what he refers to as

¹⁷¹ (Singer, *Practical Ethics* 1993, 21)

¹⁷² (Singer, *Animal Liberation* 2002, 2)

¹⁷³ (Feinberg 1987, 39)

¹⁷⁴ (Feinberg 1987, 37)

“minimal but non-ultimate goods,” that we all generally share. He explains, “They are rather his interests, presumably of a kind shared by nearly all his fellows, in the necessary means to his more ultimate goals, whatever the latter may be, or later come to be.”¹⁷⁵

If welfare interests are truly, as Feinberg thinks, nearly universally shared, they are almost by definition insufficient to capture all the interests of one particular patient. To understand what any individual patient wants for herself we need to understand her ulterior interests. For instance, when surrogate decisions are necessary, we attempt to achieve fidelity to the beliefs and values of this particular patient. This is called “substituted judgment”—we aspire to replicate the judgment that *this individual* would have made. Only if nothing can be known about the perspective of this patient, do we resort to the “reasonable person” standard. Feinberg’s welfare interests may capture this “reasonable person,” but no more than that.¹⁷⁶

If I have either a welfare or ulterior interest in something, on Feinberg’s view, I “have a stake” in it. I am made worse or better off depending on the thing I have a stake in. But clearly, not all stakes in or interests are equal—I may have only a few *shares* (Feinberg’s terminology again), or it may be more significant. This understanding of interests as relative to my “shares” and the “stakes” involved provides a helpful way to look at what is under consideration in our moral deliberations with others. Interests and their importance is a matter of degree, that is, a matter of the sort of *stake* one has in the decision.¹⁷⁷

The important point that can be drawn from Singer, and which I think Feinberg allows us to make further sense out of, is that we ought to treat like interests alike, and to the degree that

¹⁷⁵ (Feinberg 1987, 38)

¹⁷⁶ See (Buchanan and Brock 1990).

¹⁷⁷ (Feinberg 1987, 39)

someone is affected by a given treatment or decision, we ought to consider their interests proportionately—that is, relative to the *stake* they have in the decision. I call for *tempered* equality of consideration in order to highlight this essential aspect of moral decision making.

The idea of considering the interests of all those affected, and considering like interests alike unless given some overriding reason is a fairly uncontroversial and easily accepted idea at a certain level of abstraction. In the clinical context though there is a controversial and vexed issue about whether the interests of the patient ought to be prioritized. Of course, the patient will usually have a greater stake in decisions about her own medical treatment than others, but ought we to prioritize her stake over interests of someone else who has a larger stake simply because she is the patient? For instance, patient confidentiality, a central feature of medical care, depends fundamentally on the idea that the patient's interests in privacy normally outweigh anyone's interests in knowing or being involved in their medical treatment decisions even when they have as significant a stake as the patient themselves. But, especially in the days before a treatment for AIDS was available, should we have preserved the confidentiality of an HIV positive patient who adamantly insists that his fiancé not be told?

Other issues about interests also quickly come to the fore. What interests are legitimate? Should a son's desire to inherit sooner rather than later be given weight in determining the treatment his father is given? Should healthcare interests trump other interests of equal magnitude in a *hospital*? All of the healthcare professionals (including the clinical ethicist) also have interests at stake in many treatment decisions. Are they to be given weight at all, or are they to be ignored if possible on the grounds that healthcare professionals are morally committed

to serving the interests of their patients? How, if at all, are the interests of the hospital to be weighed?

While the condition of tempered equality of consideration on our deliberations helps to begin carving up the space of moral deliberation, there is not a universal guide to morally weighing and balancing the often competing interests and values involved in many treatment decisions. General guidelines may be possible, but not universal rules. No set of bioethical principles will yield the answer in a morally difficult situation. That is one reason why moral justification must appeal to the process of decision making rather than relying simply on antecedent principles.

What kind of consideration?

Obviously in one sense someone could consider the interests of others without talking with them. We do that all the time. But the position of the clinical pragmatist is that the sort of consideration necessary cannot be achieved purely in the mind of one individual. Why do they take this position? In their discussion of specific cases, clinical pragmatists make clear that this is their position, but so far as I can tell they do not have a clear answer. Three reasons come to mind: 1) Healthcare in a hospital is almost always a team effort; 2) What is stake for those involved cannot be known without communication with them; and, 3) It is deeply disrespectful to others to determine their interests without talking with them.

We cannot adequately *consider* the morally relevant interests of the involved parties, without actually communicating in a deliberative way with them.¹⁷⁸ Full moral consideration requires some shared communication with others. It involves discussion and deliberations with those owed the consideration, that is, those with a *stake* in the decision.¹⁷⁹ Some interests are so basic as to be nearly universal, and these can often be safely *considered* in isolation. Others are more personal and less universal. I need not talk with my husband about whether he wants to eat tomorrow and whether he would appreciate having food in the house. By contrast, I could not responsibly decide to move to Birmingham without talking to him. Clearly it would not suffice for me to say to him “I duly considered your interests in making this decision.” All three of the reasons for including others are present in this example—it’s a shared activity, I cannot know in sufficient detail his interests, and even if I could, it would be deeply disrespectful not to discuss it with him.

As this example shows, consideration is an activity that involves the regard and thoughtfulness for another.¹⁸⁰ The condition of reasonable deliberation in part defines the nature of consideration that is due. Uncertainty about what someone wants signals the need for conversation. Even if we feel no uncertainty we often cannot know what they want without

¹⁷⁸ While we can to some extent consider the interests of others in our own head, there is respect offered to the other to include them directly, and further, our “single-minded” consideration is always suspect of being warped, one-sided, or ignorant of important considerations.

¹⁷⁹ While I do not want to appear to be taking a cheap shot at ethical theory, there is a real sense that often what gets left out of our discussions in ethics is the concrete involvement with the other people in ethical conflict. Even when we can reason through to the correct answer using moral theory, there is something more involved when it comes time to act on a decision in the clinical setting. When those that are taking part in the activity are not in agreement on how to best resolve the conflict, there can be moral concerns with enforcing a unilateral decision in itself—whether or not it is the “right” decision theoretically speaking. In the following section I am going to say more about who has a “stake” in the decision as well.

¹⁸⁰ (OED Online 2012)

checking with them. A communicative process with others is the way in which the interests and values of those affected get considered most reliably in our decision, and the decision making process. The consideration of a single individual is not enough for moral justification in the clinical setting—often numerous parties have a stake, and determining the weight their interests are given should not be the decision of single participant. Rather, consideration needs to occur among and by all those involved. Again, even if one's understanding of another's wants and interests were one hundred percent accurate, it would still be deeply disrespectful not to consult them (I return to the need for and implications of mutual respect in the next chapter).

Perhaps if someone is acting on their own, and their decision will not significantly impact others there is no need to consult with anyone. But in joint activity, unilateral decisions come close to treating others as means. In the hospital for example, nurses have too often been treated as mere implements to carry out doctor's orders.

Full consideration requires inclusion of all those with a stake in a decision within the discussion. It is not enough to merely be present; those with a major stake must actually be involved in a substantial manner. For example, the respiratory therapist may not care one way or another whether the respirator is disconnected, but the nurse who must extubate the patient probably does. If the respiratory therapist cares, the one responsible for maintaining the respirators does not. The tempered equality of consideration requires that inclusion be tempered by the size of the stake that each part has in the decision. Others must not just listen; actual uptake of the input from others is an essential element of the sort of consideration needed. It involves taking in information from those affected and critically examining its import in the decision that will be reached. In fact, more than uptake and evaluation is needed: expressing

your honest reactions to information received from others, and hearing the honest thoughtful reactions of the others involved is important as well. Appropriate consideration occurs in the give and take of shared deliberations.

Tempered Equality of Consideration: Among whom?

As most contemporary bioethicists and clinicians would argue, there are legitimate and often competing interests and values that are rightly at play in the clinical setting, though, the *unique stake* that a patient often or usually has in a decision being made is something that must be considered first and foremost. No one would deny that the patient has this unique position and stake. Commonly though, this *unique stake* has been taken to mean an *ultimate say* in all medical decisions being made. The condition of tempered equality of consideration cautions against this view. Patients who diagnose themselves and then come to the doctor demanding a prescription are not treating the physician as a moral agent and are failing to recognize that she too has a stake in the joint enterprise of doctor and patient. If the patient has a family, they will often also have an important stake.¹⁸¹

There is however another issue, one that is not addressed by tempered equality of consideration. Tempered equality of consideration is a principle of inclusion; it counsels including in our deliberations everyone who has an interest in the treatment decision. But clinical ethics also requires a principle of exclusion, including the exclusion of some who are deeply affected by the decision.

¹⁸¹ See (Hardwig 1990) in which he argues that the interests of a patient's family ought to be considered alongside with the patient's interests. I am suggesting further that there are other legitimate interests that should also be considered—even if these interests are circumscribed in important regards.

Medical treatment decisions undeniably do sometimes affect a great number of people. The Terry Schiavo case provides a clear example of the number and variety of people who can claim to be affected by a medical treatment decision. Outside the hospital, the streets were filled with protestors. To claim that these protestors had no interest in the treatment of Schiavo seems disingenuous—the protestors were out there all day, day after day and some were very emotionally involved. The state legislature and the governor got involved. Even the pope felt compelled to make a statement. How can a clinical pragmatist claim that the representatives of these protestors ought not be included in shared moral deliberation?

Who has a stake?

In business, a stakeholder was first defined by R.E. Freeman as “Any group or any individual who can affect, or is affected by, the achievement of a firm’s objectives.”¹⁸² He argued that managers ought to not only consider the “stockholders;” they must also take into account the relevant stakeholders. Something interesting to note about Freeman’s definition is that stakeholders are not only those affected by a decision. Those that are merely able to affect the firm’s objectives or goals are also stakeholders on his view. I think what Freeman has in mind is not only the ability to affect a firm’s objectives, but also an interest in doing so. The FBI has the ability to affect the local McDonald’s objectives, but presumably no interest in doing so.

I think this same broad definition could be applied to the clinical pragmatist’s position that we ought to aim towards a consensus among *all concerned* parties. Concern, or affected are both broad notions that can be taken to include not only those with professional and personal

¹⁸² (Freeman 2010, 26)

roles in a decision, but also those with strong positions on the issues under question in the ethical conflict. For example, the protestors outside of the hospital in which Schiavo was receiving care were truly *concerned* and *affected* by her treatment, though they do not know nor have never met her. Including these protestors is not at all what the clinical pragmatist has in mind when referring to “all concerned” or “all affected.” At least it should not be. Freeman’s understanding of a stakeholder as including all affected parties may provide a good rubric for who must be considered, but it is too broad to provide much direction in terms of who should be directly involved.

In the context of the treatment decisions for a particular patient, I will argue that the inclusion of all affected should be limited—it should include only those with a *moral stake* in a decision. I will argue that what is needed is consideration that is dependent on the *type* of affectedness that an individual has. In the clinical setting different individuals will hold different sorts of stakes or interests in a decision. If someone’s interests or well-being is directly affected by a decision, or its implementation, then that person is a moral stakeholder that must be considered in our decision and the process used to reach that decision. Those that do not have a moral stake in a decision should only be considered (but not included) to the extent that they unavoidably will impact those that do hold a moral stake.¹⁸³

The degree and import of an individual’s affectedness is not something that can always be easily determined, and will vary dramatically depending on the case at hand. To have a

¹⁸³ Here I am thinking about supportive participants—medical experts for cases of uncertainty about options or their likely success; patient surrogates or “reasoning” supporters; as well as, the bioethicist for guidance in terms of the ethical norms or considerations that might be included. The bioethicist, if available, may be an important person to have involved on the sidelines so as to help make sure that the process of decision making is one that is aimed towards a consensus that can withstand moral scrutiny.

moral stake in a decision, or moral conflict, means that one's everyday life and activities, either personally or professionally, are directly impacted by the outcome of a decision.

Feinberg makes a similar point in regards to his distinction between 'desires' and 'interests.' He writes:

On the other hand, it does not seem likely that wants, even strong wants, are *sufficient* to create interests. John Doe, a baseball fan, may have a very powerful desire that the Dodgers win the pennant, but that alone would hardly constitute grounds for saying that he has an interest in a Dodger victory. If he bets his whole fortune on the outcome, however, he will have a strong interest indeed. Richard Roe, a Dodger player, on the other hand, may have a powerful personal stake in a Dodger victory, and the pride in shared achievement, the financial bonus, tributes, invitations, etc., that will follow in its wake. There is, I suppose, a sense in which anyone who has a strong desire for anything at all stands to "gain" or "lose" depending on whether it is satisfied. The pleasant state of mind we call satisfaction is itself a kind of reward or form of "gain" (although it does not come automatically when we get what we desire), and intense disappointment is itself a kind of "loss." But one cannot do without the quotation marks. There is a distinction, crucial for our present purposes, between being disappointed *because* one has suffered a personal loss, and the "loss" that consists entirely in disappointment; and between the "gain" that consists entirely in satisfaction at some outcome and the satisfaction that occurs *because* there has been some personal gain.¹⁸⁴

Using Feinberg's distinction, we can say those with a moral stake are those that have an *interest* in this particular decision. That is, they stand to "gain" or "lose" something in the decision. This may mean they are materially affected, either in health or property, but also concerns the effects on the emotional state and character of the involved parties. As the clinical pragmatist insists, many people usually have an interest in issues that give rise to moral conflict in a hospital. None of them can be neglected, and all must be included.

Clearly though, as in the case of business, not all of those "affected" by a decision are affected in the same way. There are those that claim to have an "interest in" a given decision,

¹⁸⁴ (Feinberg 1987, 43-44)

not because they are impacted directly by a given outcome—what I’m calling having a moral stake in the decision—but because they have a particular personal interest or *desire for* a case to conclude a certain way (what I will call *concern about*). Suppose, for example, I morally object to all abortions, and strongly object to women receiving such procedures. If I am a doctor who has been requested to perform an abortion, I have a moral stake in this decision. Having *concern about* a given treatment decision is not the same as having an *interest in* a treatment decision. Feinberg explains what he calls an *desire for* in this way: though one who has an interest for something also stands to “lose” or “gain” something depending on the outcome (Feinberg insists on the “scare quotes”), “the ‘loss’...consists entirely in disappointment; and the ‘gain’... consists entirely in satisfaction at some outcome.”¹⁸⁵ But if I am an abortion protestor, I have no stake in whether a doctor should perform a *particular* abortion for a *particular* patient. I may be deeply concerned, but my concern is about abortions in general (or perhaps about a type of abortion—“partial birth” abortions). Like the Schiavo protestors who do not know and have never met her, I am concerned about this abortion as an instance of the type. On Feinberg’s usage I have no interest *in* the particular decision. Those without a direct relationship to the patient have only *concern about* the particular decision, and so are not rightly considered.

Those with moral objections to certain procedures or treatments that are not in a direct relationship to the patient, their family, or the healthcare team have no moral stake in the decision and ought not to be included in the deliberation. They are like Feinberg’s “John Doe” the baseball fan that has a very powerful desire for the game to conclude a certain way, yet no matter which way it concludes he has no *interest in* the game.

¹⁸⁵ (Feinberg 1987, 44)

In sum, the patient, the family, and the healthcare providers all have a moral stake in the particular decision and all must be included. The impact of the treatment decision on these people's lives will of course vary dramatically. These differences are accounted for by the condition of tempered equality of consideration. The protestors and legislators who were concerned about the Schiavo case, no matter how deeply concerned, are appropriately excluded. They have only a concern about the decision, and have no moral stake in it. This becomes clearer once it is recognized that after Terry Schiavo is dead and buried the interests of those groups outside the hospital (protestors, government, the Pope) are unchanged. Because their concerns are about a *type* of decision, they are appropriately addressed at the policy level.

Societal level concerns can and do impact the treatment of patients and these concerns, especially when they become prominent, will inevitably influence the process of deliberation. They become part of the reasoning process of the parties that genuinely do have a moral stake in the decision. But these societal level concerns, I want to argue, are part of the situation. Rather than having a moral stake in the decision, they will partly define the context of the deliberations.

The Weighting and Tempering of Equal Consideration

Thus far then, I have argued that the consideration of an individual's interests ought to be dependent upon the sort of stake they have in a given decision. I have offered an initial criterion for determining just who must be included in the process of deliberation. Everyone with a moral stake in the decision must be included in the deliberation, but the consideration due to each person's interest must be weighted by a principle of tempered equality of consideration.

Normally, a treatment decision will affect the patient to a much greater degree and so the interests of the patient are normally center stage.

But are *all* interests of those who have a moral stake morally relevant? Ought some interests, though important and deeply held by a moral stakeholder, rightfully ignored? Which interests are morally relevant to a treatment decision is often itself a matter of intense debate. Witness the discussion of conscientious objector opt-out provisions in policies governing physician-assisted suicide. I cannot attempt to resolve issues of moral relevance here beyond saying that they are often deeply contextual. The interest of the son who wants to scale back the aggressive life-prolonging treatment of his father because he wants to buy an apartment in Paris probably ought to be ignored as morally irrelevant no matter how important it is to him. But if the son is an unemployed coal miner in rural West Virginia whose children are hungry, his interest is at least arguably morally relevant. Very often the moral relevance of an interest must also be part of the deliberations.

There is also a completely different dimension of tempered equality of consideration. The *weight* or consideration someone's statements are given can often justifiably vary for epistemic rather than moral reasons—on the basis of the *relevant knowledge* of those involved.

Tempering on the basis of relevant knowledge

Differing cognitive capacities and understanding will also be sufficient reason for weighting our consideration of some perspectives differently than others. Relevant knowledge of the affected parties should impact the appropriate weight given to particular views and the reasons given for them. Recalling Longino's distinction between intellectual and cognitive

equality, we can say that intellectual equality of all participants must be presumed in order to respect everyone involved. As Longino has pointed out, this is a threshold concept—the clinical expression for this is competence or decision making capacity.¹⁸⁶ In the clinic, as in a democratic society, this must be presumed until proven otherwise.

Longino's notion of cognitive equality is a different matter—cognitive equality would be equality of relevant knowledge or expertise, and this is rarely if ever present. There is a remarkable variation in the cognitive abilities and capacities of those involved in clinical ethics conflicts. The patients are generally not nearly as knowledgeable about diseases, treatments, relevant studies and discussion about medicine and medical procedures. The knowledge and experience of the participants should rightly affect the sort of consideration their perspectives are given in our deliberations.

Suppose the doctor proclaims that it is in the patient's long term health interests to proceed with an optional surgery. Unless there are some overriding considerations or reasons for doubting a doctor's understanding of an issue, then it is appropriate to weight that consideration more heavily than the nurse's proclamation that the surgery is an unnecessary harm to the patient. This does not mean that the nurse or uninformed patient can be reasonably ignored or left out of the conversation because they lack knowledge. Cognitive authority is an important consideration that in many cases in the clinical setting is a good reason for weighting some statements more heavily than others. Such a tempering is consistent with the intellectual equality

¹⁸⁶ (Drane 1984)

needed to respect the interests of those affected, though it is not sufficient reason for weighting certain reasons so heavily as to exclude others from consideration.

Cognitive authority in terms of knowledge of medicine is often extended beyond its justifiable scope. Medical knowledge and facts about the likelihood of particular outcomes does not necessarily imply knowledge of the best interests of the patient. A patient's interests normally extend far beyond their health interests. Much less does medical knowledge provide reason to grant someone more authority in the decision making when a decision is one that involves more moral stakeholders than simply the patient. For the clinical pragmatist, there is almost always more than one moral stakeholder.

Another central feature of the clinical pragmatist view is their claim that “there are no moral experts.” We might cash this idea out a bit more fully. I think they mean that no one has all the expertise relevant to making a difficult moral decision in the clinic. This is the *epistemic* rationale for shared deliberation. In fact, it could be argued that everyone in the room is an expert about something that is morally relevant. The physician is an expert in diagnoses, treatments and the like, while the patient is an expert in their own history, values, intuitions, and experiences.¹⁸⁷ The nurse who stands at the bedside for twelve hour shifts is acutely aware of the effects of treatment on the patient in a way that others are not. All are relevant to good patient care. Accurate diagnoses often depend on good information from the patient and a clear description of their symptoms and their history is often essential for physicians to make recommendations that fit the needs of their patients.

¹⁸⁷ See (Roter and Hall 2006) in which they give a good account to the relevant expertise of the patient and the physician.

Lack of respect for cognitive expertise is one cause of moral distress. The other is lack of consideration for one's agency. Moral distress is the feeling that my pertinent expertise or considered perspective on an issue that involves me directly is being ignored or not valued. Both my relevant expertise and the fact that I am directly involved in administering care are not being given their due weight.

Equality of consideration of the sort needed to reach a significantly shared decision or a consensus can be maintained even while according some greater cognitive authority over particular deliberative matters so long as we retain the presumption that everyone meets the threshold level of intellectual equality. But respect for cognitive authority requires tempered equality of consideration.

Consideration and Supportive Participants

In fact, the cognitive authority of relevant expertise can require the inclusion in the deliberation of some who have no moral stake in the decision. Given the complexity of the clinical context and medical treatments there is often the need for more information than what is had by the moral stakeholders. Particularly in the ethics committee setting, or in ethics consultations there will often be parties involved in the deliberative process that do not have a moral stake in the decision in the way that the doctors, nurses, and patients do. While this may mean their suggestions and interests in the case are not considered the same, it is important that if there is relevant technical knowledge not had by the moral stakeholders, or even of likely impacts on families or patient care, then other professionals or possibly even community volunteers with relevant and pertinent knowledge should be part of the deliberative process, even

if only minimally—that is, in a support or expert witness sort of role. While these folks do not have an *interest in* the decision and so needn't be directly considered as part of the deliberations, the relevant input should be considered in the deliberations in so far as it further *informs* the moral stakeholder's discussion.

Calling for supportive participants though will be the responsibility of the moral stakeholders. Someone must recognize the need for more information, and often this will require someone directly involved in the conflict to realize the need for support. A physician, or someone involved must recognize that their knowledge of a particular treatment or course of action is lacking or could be better developed in order for them to call in or include others as support. The physician may realize that they lack important knowledge of and experience with treating a rare form of cancer and so are unsure as to the best recommendations to make. The nurse may recognize that the patient feels strongly about treatment but is unable to express their reasoning and feelings to those making the decision.

The way in which non-moral stakeholders are brought in on this sort of approach is akin to a consult. For instance, a case worker, who has not been assigned to a particular patient's case, may know about the likelihood for the patient being admitted to a rehabilitation center for care after being released from the hospital. While the case worker is not a moral stakeholder, they do in fact have relevant input that can impact the patient's care, and as such, are called in by the physician or nurse to provide the relevant information. The information from experts and those brought in to deliberations by the moral stakeholders is important to consider alongside the considerations provided by the moral stakeholders to the extent that they provide relevant and important information. This though is context driven, and depends on the perspectives of the

participants when it comes to clinical ethics conflicts. What this means for those that regularly find themselves in a context where ethical conflict is common is that an awareness of the limits of our own knowledge will often be essential in achieving a defensible moral decision in the clinic. Decisions in the clinic will be more justified to the extent that they have taken account of the available and relevant information. What information is available and relevant though will depend on the persons involved—not only the knowledge they have, but even further, their understanding of the limits and import of that knowledge. And as I will argue further in the final chapter, such an approach really calls for an attitude of humility in the way we work through moral conflicts—we have to make room for the fact that our own personal views may be limited. Even when we are experts, we do not have the complete picture of a situation.

While admittedly what I have said in this chapter does not provide one with a clear rubric by which to consider the reasons and interests of those involved, I do think that significant headway has been made in developing and defending the sort of process that seems to follow from the clinical pragmatists call for an aim of consensus in the clinical setting. While they clearly insist that their approach is “democratic” in nature, I hope to have shown that the sort of consideration called for on their approach are importantly different from democratic calls for “equal consideration” where all are equally bound by the law as citizens.

As I have argued, in the clinical setting, equal consideration is important as a type of *proportionate* consideration of the moral stakeholders involved. Equal consideration must be tempered both by the amount of relevant knowledge a person has and also the varying impact of the decision on those involved. Those that have an *interest in* a decision ought to be directly considered, while those that merely have *concern about* a decision will be appropriately side-

lined in the clinical ethics deliberations. Not “all affected” are affected in the same manner, and as such, not all deserve the same, if any consideration in the decision concerning a particular patient’s treatment. Policy decisions are importantly different than clinical bedside decisions in terms of who can rightfully be said to have a moral stake in the decision. As I have argued in this chapter, not only must our considerations be tempered, but further, they must be limited to those that have a *moral stake* in the decision.

The focus here has been on those who have decision making capacity. But of course, some patients are not competent to participate in deliberations for a variety of reasons. Their claims or interests must be accounted for in a way that is consistent with the same dictates of tempered equality of consideration. This implies that a representative of the patient’s views and interests and the sorts of reasoning that they would give, should be available and present during a given discussion on how to proceed. We must strive towards a decision that is significantly shared in the sense not only that we can all agree, but further our agreement is achieved through the shared deliberation among the moral stakeholders. This is what allows for a morally valid decision to be achieved; also, a decision that we are committed to acting on in the context of a clinical ethics conflict.

CHAPTER 6

CONDITION 3: FREEDOM FROM UNDUE INFLUENCE & CONDITION 4: MUTUAL RESPECT

Introduction

In the clinical setting, there are numerous kinds of power and influence that can affect our shared deliberations. I think we have all experienced a situation in which a person dominates the conversation. Sometimes it is merely a matter of personality—for example, my mother talks a lot when she is nervous. I, on the other hand, tend to listen much more than I talk, especially when I am nervous. Other times it is connected to the vast differences in power at play in the clinical setting that can influence shared deliberations. For instance, the healthcare team often has important knowledge the patient and their families lack. Even among the healthcare team, some often have more power to influence the trajectory of the activities in question—the doctor’s orders for example.

Shared deliberation in search of consensus, as I have argued, requires full participation by all moral stakeholders. This requires genuinely shared deliberation and tempered equality of consideration. If we are to reach, or even aim towards a significantly shared decision, those involved must be free from influence that inhibits, undermines or precludes shared decision making. Given the aim of genuine consensus, not all influences on the shared deliberation will be acceptable. In shared deliberations, mutual respect in part means that one does not unduly

influence another and allows them to participate fully in the decision making. Failure to respect someone can also manifest in failure to give their statements due weight. Failure to acknowledge the cognitive authority I have been discussing is a kind of failure of respect.

Since the main focus of the clinical pragmatist is on creating consensus out of conflict by means of a certain kind of discussion, my focus here will be on how the use of power can undermine genuine consensus or even abort the search for it. For present purposes, the only relevant abuses of power and failures of respect will be those that prevent consensus. For example, deliberate coercion or manipulation is undertaken when someone has given up on achieving consensus and decides that he will not even aim at it. Someone who resorts to manipulation has decided that agreement cannot be achieved or will be too difficult to achieve, and that acquiescence will suffice and can be achieved much more easily. When someone is aware that she is being coerced or manipulated, full consensus with her can no longer be achieved.

I will say that influence is *due* when it does not undermine or subvert consensus; *undue* or overreaching when it does.¹⁸⁸ Undue influence in shared deliberations can be noticed by the influencer in at least these ways: others are not participating, others are going along with whatever you say, or others appear reluctant even when agreeing. Undue influence can also be

¹⁸⁸ I will not here be able to account for all of the influences at play in moral decision making within the clinical setting, either due or undue. A sociologist or even social psychologist may be better equipped to manage that sort of task. Clearly, some influences are more tacit than others, and will be often unnoticed by the participants. Importantly, there are some influences that while even if they hinder our deliberations with others still cannot be avoided. Perhaps the stipulation that “every treatment decision must fall within the limits of the law, regardless of how morally justifiable that law might be,” is one of these very influences. The law limits what is part of our deliberations from the get go in a hospital, and while influential, even sometimes in a negative manner, it is not the sort of influence that is able to be questioned or even set aside for the import of shared agreement in most if not all cases in the clinical setting. I will not focus here on the numerous and varied constraints on the situation that really cannot be meaningfully dealt with at the time of a concrete ethical concern.

noticed by the one subject to it: they feel they have been silenced or have no say, they feel overwhelmed or that the deliberation is too one-sided, or that they are being pressured to assent.

However not all undue influence will be noticed by the participants in a shared deliberation. Undue, but unnoticed influence is a serious problem for the clinical pragmatists. On the one hand, I want to say that because undue influence has shaped the deliberations the process fails to meet the conditions necessary for full moral justification of their decision. On the other hand, both the clinical pragmatists and I want to say that the best process of deliberation the decision makers can muster defines a fully justified moral decision in the clinic. Practically speaking, if no one in the shared deliberation feels that they have been unduly influenced by others, or that they are unduly influencing others, and all genuinely agree with the decision reached, then *practically* consensus has been achieved. In this way it is like an overlooked fact or an unnoticed possibility. From another perspective or in hindsight the decision that results from unnoticed and undue influence may be regrettable. But that perspective was not available to the decision makers at the time of decision making, and in that sense it is irrelevant.

Freedom and the Influence of Others

Positive vs. Negative Freedom:

In order to get clearer on the role of freedom from undue influence in shared deliberations, an at least minimal definition of the sort of freedom I have in mind is in order. Charles Taylor spells out an account of *positive* and *negative* freedom that I think provides a

good starting point for thinking about how freedom enters into moral decision making in the clinical setting.¹⁸⁹ Positive freedom involves the *exercise* of control over one's life. We are free, in this positive sense, to the extent that we have effectively determined for ourselves the shape that our life will take. It is freedom in the sense of self-realization. Negative freedom on the other hand is concerned with opportunities for actions—it is an “opportunity concept” as Taylor notes. We are free in this negative sense to the extent that we have the *opportunity* to exercise control over our lives or activities.

If our deliberations with others are aimed at a genuine consensus, then a form of both senses of freedom seem to have an important role to play in our moral deliberations. A decision which actually involves the participants requires negative freedom—the participants must be free from the undue influence of others and from internal barriers to participation. The patient's hesitancy to speak up because of their shyness or the physician that dominates a conversation concerning what is the patient's best interests can both have a detrimental – i.e., an undue – influence on shared deliberations. Both internal and external barriers to participation can damage shared deliberations and halt our ability to achieve genuine consensus.

Positive freedom of all participants is also important if the decision is genuinely shared among the participants. In the context of moral conflict and shared deliberations, a morally justified decision requires that the moral stakeholders participate. They must directly confront the conflict that divides the deliberators and creates tension among them, express their own perspective and be willing to change that perspective in response to what others say, be willing

¹⁸⁹ (Taylor 1993). This distinction was originally put forth by Isaiah Berlin, see (Berlin 1969). Charles Taylor developed this distinction further in order to provide a clearly ‘positive’ sense to freedom.

to make a difficult decision and take responsibility for it. Full participation, or the positive freedom of participants, is required for a consensus to be morally justified in the clinical context—it allows decisions to be built from and grounded in the interests and reasons of all moral stakeholders. Even with perfect negative freedom a member of an ethics committee can fail to participate simply by deciding that it's easier to sit quietly in the corner.

What I have referred to as internal barriers to participation—shyness, reticence, conflict avoidance—often cannot be changed in the hospital, much less by members of a committee charged with making a difficult moral decision. Although this is an important component of negative freedom, I will have little more to say here about the difficult notion of internal constraints. I will instead focus on the influence of the participants on each other in shared deliberations. Participants can influence the decision making in ways that are contrary to the aim and achievement of genuine consensus (i.e., undue influences). I will also touch on the ways in which we can appropriately encourage active and meaningful participation among the participants in ways that promote the achievement of genuine consensus (i.e., due influences).

Undue Influence

The sort of process of deliberation that I have been describing as necessary for morally justified consensus can often be corrupted by the influence of a participant on others in the deliberation. Deliberations can often be dominated by those who hold the most power, and in that way limit the opportunity of those involved to participate in a meaningful way. As I discussed in the opening chapter, this was one of the central concerns for “consensus as an aim” expressed by Moreno. The knowledge, relationships, and positions of those involved will impact

the tone and direction of the deliberations in most cases, so careful attention to such factors is necessary if we are to avoid allowing the overreach of certain individual's viewpoints and input. Shared deliberation depends on freedom from undue influence.

Just as cognitive authority can be a reason for weighting certain statements of others more heavily in deliberations, cognitive authority can also overreach its scope. In a clinical ethics committee meeting or an ethics consultation, there is often an authority granted to the statements of the doctors that is not often given to the others at the decision making table. A person's expertise in matters of medical science, or the particulars of a surgical procedure, or even patient care should be given their due authority—someone who has studied cardio-vascular surgery for many years should rightfully have a say in whether angioplasty is the best option for this patient. There's an implicit lack of respect in not giving such statements their due weight.

The problem arises when that expertise, whatever it is, is stretched beyond its justifiable scope. Often, it is the case that those with authority in regards to medical knowledge dominate the conversation of how we ought to proceed. Cognitive authority is also stretched beyond its justifiable limits when authority is granted by those with less knowledge over matters where this cognitive authority or technical knowledge is not the only important component. For instance, a nurse who spends a great deal of time with the patient could reinforce or even encourage a patient's concerns with a treatment option because their previous experience with that treatment for another patient ended badly. While the nurse has important medical knowledge with this patient, those same consequences are highly unlikely. This would be a case of *undue influence*. To the extent possible, we should be aware of the role authority given by others plays, as well as the reach and scope of our knowledge.

Cognitive authority is not always contrary to shared decision making, but its possible negative impacts on deliberation must be carefully attended too. In shared deliberations, a participant that is held in high-esteem by those participating in the discussion may have a great amount of ability to influence the course of discussion—almost anything they say will be taken as pivotal by the majority of participants. In the clinical setting, often this will be a highly regarded physician. While high regard is often both earned and deserved, those in such positions must be particularly careful in shared deliberations not to overly influence the deliberations. Moral humility is necessary, not only on the part of the healthcare team and patients, but especially for those that find themselves in positions of great power. Moral humility, which I will discuss below in connection with mutual respect, involves openness to the input of others, and awareness that our perspective is not the only morally relevant perspective.

Very often it is the method of interaction and communication itself that can stymie the input and full participation of those involved. For example, a study in the 1980's focusing on the first 90 seconds of around 70 different medical visits found that the patient's response to a physician's opening question was only completed in roughly 23% of visits, and in 69% of visits the physician interrupted after just 15 seconds of the patient responding.¹⁹⁰ They explain that very often, "Physicians play an active role in regulating the quantity of information elicited at the beginning of the clinical encounter, and use closed-ended questioning to control the discourse. The consequence of this controlled style is the premature interruption of patients, resulting in the

¹⁹⁰ (Beckman and Frankel 1984)

potential loss of relevant information.”¹⁹¹ They noted that physicians very often redirected patients' initial descriptions of their concerns, and once redirected, the descriptions were rarely completed.

There is also the concern with certain participants' cognitive authority and relevant input being downgraded. The participant that downgrades another's important role in a decision is also exercising undue influence in the deliberations. A family may be chided that “they don't grasp the medical peculiarities of their mother's condition,” and in this way be downgraded in the discussion not only by the one making the claim, but also by those that give authority and weight to those claims.

In addition to the influence stemming from the cognitive authority of the members of the healthcare team, family dynamics can also have undue influence on shared deliberations. Families with strongly held religious convictions provide a nice example. In many cases, parents will have strongly held beliefs that their children do not share. Even though they do not agree with their parents, they still feel pressure to go along with their parents' convictions—even as an adult. For instance, we could imagine a person raised as a Jehovah's Witness whose family does not believe in blood transfusions. While this is a firmly held belief in their family, as an adult they no longer subscribe to the belief. In the presence of their parents though, they are not comfortable admitting their denial of their family's convictions, and so refuse the blood transfusion. Family disapproval can be a strong influence on a patient's stated preferences,

¹⁹¹ (Beckman and Frankel 1984, 693). See also, (Marvel, et al. 1999) in which they conducted a similar follow up study and found that after 15 years there was little to no change in the data.

especially while in their family's presence, even though the patient does not agree with the family's position.¹⁹²

Lastly, one more example is worthy of note: an emphasis on patient autonomy and the "patient's right to choose" can also lead to undue influence. A patient's personal demands or interests are often given more influence in a decision than they may be due. In shared deliberations aimed towards a genuine consensus, there is more to consider than the patient's perspective. All moral stakeholders have important interests that must be considered. Leaving the decision fully in the hands of the patient fails to adequately include the other morally important participants—it is undue influence in the sense of being contrary to shared deliberation and genuine consensus.

Given the extensive and various ways in which the influence of others can affect shared deliberation and inhibit our ability to achieve genuine consensus, careful attention must be given to the role our influence on others either can or does play in shared deliberations. After discussing the nature of *due influence* and giving a couple of examples I will turn next to a practical approach for avoiding undue influence in the clinical setting.

Due Influence

If we are to achieve a genuine consensus, or even aim at one, then all involved must be free (have the opportunity and exercise their ability) to participate fully in deliberations.

Sometimes this will imply merely that the more powerful figures in the decision step back so that

¹⁹² Admittedly this may be an influence that is hard to see or to remedy in the clinical context. Given the likelihood of family dynamic impacting a decision, it may be important to have more than one discussion with patient about their desires and goals—one with the family present, and one when they are not. This clearly not always a possibility though.

all affected have their fair chance to affect the decision making process. Other times though, there will be a need for the more powerful participants to support the less powerful participants in ways that allow them to share in the decision making. *Due influence* is influence that aligns with and often promotes shared deliberation among all moral stakeholders.

As in the case of undue influence, I will not here provide a full accounting of *due influences* in the clinical setting. There are too many, and they are too contextual to provide a complete report. A brief discussion is in order though. Cognitive authority consistent with tempered equality of consideration is important in the achievement of genuine consensus—this is a *due* influence on others in deliberations. Perhaps the simplest example would be the support of a physician to help the patient better understand his disease. The patient's statements about their quality of life and experience of suffering should also have significant influence on the treatment decision—significant influence by the patient in this regard is also a clear example of *due influence*.

Influence on others that enables or empowers them to share in decision making will also often be important to achieving a morally justified consensus. In the clinical setting, it will often be necessary for someone to assist those that lack the ability to participate fully on their own. Rather than downgrading a less powerful moral stakeholder's perspective, what will often be needed is additional support from more powerful (more influential) participants. The abilities and emotional states of those involved can limit or expand the ability for someone to freely and fully participate in the process of reaching a genuine consensus.¹⁹³ This is true even for those in

¹⁹³ It is important to note that in many cases these constraints on shared decision making cannot be adequately attended to in our ethics deliberations, especially in an ethics committee meeting, and as such may imply that the

good health, but is even more so when someone is suffering from a severe illness. When the reasoning abilities, capacity for understanding, or emotional distress impede someone's ability to participate in a way that allows them to participate in a shared deliberation, then there is a need for assistance from and in some cases representation by others.¹⁹⁴ It is not enough for those involved to give them a chance to participate; sometimes those with more influence will have a responsibility to assist those that are unable to participate fully.

My point here is that influence that enables the moral stakeholders to participate fully in shared deliberations is an excellent example of *due influence*. Both sharing our knowledge and understanding with others, as well as participating in a dialogue with someone to help them articulate their own reasoning and positions are important for the achievement of a genuine consensus in the clinical setting.

Power and Its Appropriate Use

As I take it, what I have been referring to primarily as influence (both due and undue), is closely akin to what Howard Brody refers to as power.¹⁹⁵ Power in its various forms, at least in part, is an ability to influence others. On his view, the use of power and our ability to influence

patient may have more control if they are not expected to be present and represent themselves to the committee. This though is a case by case matter, and an inability to represent ourselves fully in the context of the committee deliberations is a sufficient reason in many cases to require someone to step in and assist the patient in this regard. We can imagine a patient representative being more able to communicate the patient's position to a committee than a patient would feel comfortable doing on their own. It may be easier for a representative to say, "She would never say it in here, but she's really unhappy with the care she's gotten during this admission," than for a patient to attend a committee meeting proclaiming the inadequacy of their care.

¹⁹⁴ The clearest example of the need for representation is for incompetent patients. But I need a much broader theory of representation that I cannot offer here. For example, the nurses working on the unit may not be available to attend the deliberations. Certainly, not all of them will be able to be present. But if they are moral stakeholders, they, too, on the version of clinical pragmatism I am developing, must be represented.

¹⁹⁵ (Brody, *The Healer's Power* 1992)

others is a key component of the ethical interactions among healthcare providers and their patients. Brody focuses on the power of the physician, though his position on the appropriate use of power can quite plausibly be extended to the shared deliberations among those dealing with a moral conflict in the clinical setting.

Rather than providing a listing of the appropriate uses of power, Brody gives a process oriented account of assuring that power is not abused. On his account, power is appropriately exercised over others when it is *owned, shared, and aimed*. I will contend that *owning, sharing, and aiming* our influence over others is necessary for shared deliberation and the achievement of consensus. Brody's account provides a means by which to help assure our influence over others is not undue and remains consistent with significantly shared decision making and genuine consensus.

Three Types of Power

Brody first distinguishes three types of power held by the physician. First, is what he terms, "Aesculapian power"—power that comes from the possession of a difficult and obscure body of knowledge and the application of that information through treatments, etc.¹⁹⁶ Though Brody is discussing physicians, "Aesculapian power" is also obviously held to varying degrees by other healthcare professionals by virtue of their specialized education and training. This sort of power is impersonal on his view and is fully transferable among physicians through training and schooling—it is independent of social status or class. The second sort of power is what he calls, "charismatic power"—power that is based on the personal qualities of a particular

¹⁹⁶ (Brody 1992, 16)

physician. Charismatic power cannot be easily transferred through training or schooling. At some level we can help people become decisive or kind, though to a large degree this power stems from personality traits that are independent of any particular training.¹⁹⁷ Lastly, he defines “social power”—power that stems from the social status of the physician and the medical profession more generally. This power comes from the trust our society places in the medical profession—they have the power to determine who is ill and who is well, and we have given them our trust in the matter. This relationship with society gives the physician a form of power according to Brody. While it is not of necessity connected to the fact that physicians typically enjoy a higher social status, in our society it is often partially expressed this way. As he explains:

...society generally accords high status in other ways to those whom it entrusts the cultural power to define medical truth and knowledge. If physicians either are drawn from the higher socioeconomic and educational classes or rise to them upon undertaking medical practice, then cultural power will be mixed with the power gained from high social status alone. That power will appear most prominent when the patient is of relatively low socioeconomic status. The physician will live in a certain neighborhood, wear certain clothes, drive a certain car, and use language in a way that tends to cause others in society to defer to her wishes, even when the influences of cultural, charismatic, and Aesculapian power are corrected for.”

Brody argues that all three types of power are important both for the physician attaining their goals of healing and for the patient to attain their goals of being healed. We seek the help from a physician (or other healthcare professional) and want to believe that they have the power necessary to heal us. The physician must exert their powers as a physician, in order to be effective in their aims. We do not go to a doctor because we are equals and each have the same abilities and experiences. We go to the doctor because we think they are more able than we are

¹⁹⁷ (Brody 1992, 16-17)

to heal our illness. We go to them assuming, and usually rightly so, that they have power that we lack. As Brody explains, for the doctor to respond by placing the decision making completely in our hands, is contrary, not only to our expectations, but to our very reasoning for seeking their help. There is a reassurance, and a reassurance that often has the capacity to heal, that comes from the physician taking on the more powerful role.

Given that power is essential in the physician's role, but also, has the capacity to be abused, Brody argues that:

The central ethical problem in medicine is the responsible use of power. Physicians have considerable power to alter the course of illness. But this same power can, with only subtle redirection, be used against the patient instead of against the disease on the patient's behalf. The problem is to empower physicians for the performance of their essential tasks while protecting the patient from the potential misuses of power.¹⁹⁸

This understanding of the essential role of power is a fundamental insight highlighted by Brody. The role of power and its effects in the clinical setting should not be underestimated. Not only in our ethical deliberations with others, but in the very ways in which those in the clinical setting relate with one another on a daily basis.

Given the influence that those in powerful positions can have on the way in which we interact with each other and the way in which a decision is reached, there is a need to articulate when and how the exercise of power is appropriate. As Brody argues, the most defensible use of power over another is when it is "owned, shared, and aimed."¹⁹⁹

First, power is *owned* when the one who is in a position of power acknowledges the fact of their power. They must candidly admit this fact, and accept the responsibility for that power.

¹⁹⁸ (Brody 1992, 36)

¹⁹⁹ (Brody 1992, 43)

If someone is to justifiably exert power over a decision or a deliberation aimed at reaching a decision that has significant import for others, then acknowledging their ability to influence a situation is an essential component to its responsible use. If it is not acknowledged then it is not something that can likely be remedied. It is like being an alcoholic in denial.

Second, power is *shared* in the sense of being both disclosed and given to another. By sharing power, Brody argues, we are less likely to abuse it. By sharing power, we also share in the ability to aim that power. A physician may share their knowledge of an illness and its treatment with a patient, and in that way share their Aesculapian power, or further, they may impart to a patient a sense of control over their illness such that they are sharing their charismatic power with patient. As I argued above, the exercise of power and influence on another is often needed for shared deliberations in the clinic. Brody makes a similar point. Some exercise of power is actually essential in promoting and respecting the autonomy of patients—by sharing our knowledge with them, we enable them to better decide for themselves what is in their interests.

Lastly, power is *aimed* when it is not being used merely for its own sake, but rather is aimed at a specific end—usually the health of a patient. As he explains though, shared power may be the most basic tenet of the three:

It is quite difficult to share power without candidly disclosing it and without aiming it (or better, allowing the other party to help aim it)...But if one shares the power precisely with the person in greatest danger of being victimized, the potential for self-correction of error seems the greatest.²⁰⁰

On this view, power that is owned, shared, and aimed will be less likely to be abused, and additionally respects the inherently social and dynamic nature of the practice of medicine.

²⁰⁰ (Brody 1992, 43)

Appropriate use of Power—Avoiding Undue Influence

Brody's account provides a practical means by which to ensure that our influence over others is not undue and is consistent with shared decision making and genuine consensus. Influence over others that is *owned, shared, and aimed* will, at the very least, be less likely to hinder shared deliberations with others. Freedom from undue influence does not mean that any influence on another in the decision making process is unacceptable, only that the influence must not impede genuine consensus among the moral stakeholders—the perspectives and insights from all moral stakeholders must be given their fair stake and relevance (tempered equality of consideration) in the decision making process. Given the vast differences in abilities to influence shared decisions in the clinic, it is necessary that our influence is *owned, shared, and aimed* so as to not impede shared deliberations and genuine consensus.

First, recognizing the role power plays in our deliberations is essential. When those involved are oblivious, or otherwise unconcerned with the influence they can or do have in a deliberation then it is more likely that it can be used to control or manipulate others—even if done unwittingly.²⁰¹ Moreover, recognizing when others lack the ability to influence deliberations is important for genuine consensus as well—this will often be the responsibility of those who have much more influence from the outset. Our deliberations will be more significantly shared when there is recognition by the participants of the influence they have (or can have) on others and how this can either inhibit or promote the achievement of a genuine

²⁰¹ As I mentioned at the outset of this chapter, there will be some influences that go unnoticed in deliberations. Even when we attempt to recognize these and *own* them in the sense Brody as defined, some influences will remain unavailable practically speaking. As I also said early on, practically speaking these influences will not impede shared deliberations even if later moral scrutiny reveals them. It will be unfortunate, but was not something that could be remedied at the time of deliberations. My focus here is on the influences that we can recognize and meaningfully control at the time of shared deliberations with others.

consensus. This, as I take it, is an essential aspect of influence that does not impede shared deliberations—we must “own” our ability to influence others in the deliberations. Bioethicists have, I think, been reluctant to “own” our power.

Secondly, and I think crucial to an account of moral deliberation that takes seriously the perspectives and input of the moral stakeholders is that our power or ability to influence deliberations ought to be *shared* with others that are less powerful, and not merely exerted over them. When we share our power with others, it requires that we both recognize our influence, and share our abilities and knowledge with those that lack them. It is in this way that we can *empower* others in shared deliberations so that they can participate fully in decision making. This is not the same as the exerting of power over others, as seems to be involved in unilateral decision making. When we share power in a way that is attentive to the moral particularities of a case and the morally important input from patients, families and other members of the healthcare team, then concerns with undue influence can be mitigated.

Importantly though, as Brody points out, power is not always power over others; sometimes, it's power over disease. And when this power gives rise to power over others, it is often because the “dominated” or less powerful participants actually share in the goal of finding a cure for that disease. Such “power over” others when directed towards a shared goal is not contrary to genuine consensus on how to proceed in so far as it is jointly aimed.

Third, probably most essential in avoiding undue influence is that our influence over others ought to be jointly *aimed*. What this means is that our influence over others should not be exerted unilaterally, or in a way that ignores the need for the willing participation of others. When we aim the influence together, we share in a decision more fully. In the case of a

physician recommendation it is not enough to share your reasoning for recommending a particular treatment, and then insist that it is the correct course to take. The other moral stakeholders must also participate in determining how to use this knowledge and reach a decision.

This is crucial, and as I take it central to the clinical pragmatist account of shared deliberation in clinical ethics conflicts. Unilateral decision making very often amounts to an over exertion of power in the sense that those involved and affected are not given a fair say in the decision making process. Given the influential nature of those in specific sorts of roles, there is usually a need for the patient and their family to dominate the process of *aiming* the power of the physician. We need to ask those that lack the influence and power over disease and over the deliberations what their goals are or what they hope to achieve in pursuing certain treatments (and take seriously their answers). The less powerful need to take part in the aiming of power to the greatest degree possible so that the interests and judgments being promoted are not merely those of the most powerful participants.

Allowing those involved to take part in the decision about what our goals and aims in treatment are, is crucial in avoiding the use of power in ways that end up being manipulative or coercive of the others involved. As Brody has argued, the physician's use of power is pivotal in the healing of patients, though it should not be exerted in ways that are not consistent or attentive to the need for a shared decision. Genuine consensus cannot be achieved with someone who feels manipulated or coerced. Once the power is jointly aimed, allowing those with more knowledge of medicine and more power in the clinical setting to have a significant role in determining the particular treatments that meet those ends is consistent with achieving a

significantly shared decision. Those with more medical knowledge may often be more able to specify apt means to those ends.

Shared moral deliberation in the clinical setting requires careful attention to the way in which our influence over others can both impede and support shared decision making. Owned, shared and aimed power is important for both the negative and positive freedom of those involved—for allowing those involved to have the opportunity to participate fully in the decision making and for ensuring that those involved participate in a way that is consistent with genuine consensus. Owning, sharing, and aiming our influence over others in the practical setting of clinical ethics conflicts is necessary to avoid *undue influence* and to achieve genuine consensus.

Condition 4—Mutual Respect

As I have argued, freedom from undue influence is essential for shared deliberations aimed at genuine consensus. Part of what allows for this though is mutual respect among the participants in the deliberation. If I respect others, I do not unduly influence them to follow my judgments about what ought to be done in a moral conflict. Fundamental to the aim of reaching a genuine and mutually acceptable agreement of the sort that has normative force is mutual respect on the part of the participants in the deliberations.

Not only ought our influence over others be owned, shared and aimed, it also must be conditioned by an attitude of mutual respect. I must recognize that I alone do not have all of the information and material needed to make a morally justified decision; and that, even if I did, I would still have to engage in shared deliberations with the other moral stakeholders in order to

respect their agency. Respect has both epistemic and moral value. It allows us to be open to the input and considerations of all moral stakeholders, and it expresses a kind of moral recognition of all involved as deserving consideration in our decision making. The need for full participation and tempered equality of consideration of all moral stakeholders requires that all participants approach the resolution of moral conflict with an attitude of mutual respect.²⁰² Lack of respect among the deliberators undermines the shared deliberation that clinical pragmatists argue is necessary for full moral justification.

Given the context we are focused on—moral conflict in the clinic—this mutual respect may not always be present from the start. In cases of conflict, there is quite often a component of one party feeling they have not been respected by another. Respect for all involved, and by all involved is a significant feature of working through ethical conflict in the clinical setting. Shared deliberation and the achievement of genuine consensus depend on an attitude and expression of respect among the moral stakeholders.²⁰³

Respect in Shared Deliberations

Having respect for another means at the very least that we are attentive towards them, or that we acknowledge them in some way. To respect something is contrary to ignoring it, or being oblivious towards it. It generally involves attentiveness and appreciation in some form or another of a person, or a person's perspective (or aspects of it). Respect can be both a behavior towards someone, as well as an attitude or way of approaching someone. So, we may respect

²⁰² It is “mutual” in the sense of being among all involved.

²⁰³ Respect can be directed towards objects as well as persons. Given the context of shared deliberation and decision making, my focus will be on respect directed towards persons involved in a moral conflict. Though, it is true that there are other sorts of respect at play and even needed in the clinical context.

someone by having a certain kind of responsive attitude towards them, or respect may refer to specific actions that express this attitude. For instance, I may respect my elders by holding open a door for them, but I also may have respect for my elders in the sense of an attitude of regard for their feelings and situation.

Respect in the sense I am considering here has two important components then. It is an attitude or way of approaching others, and it the activities that express this attitude to those involved in a moral decision. While so far I have said quite a bit about the *activity* involved in resolving moral problems on the clinical pragmatist's approach, in this section, I would like to combine this with a bit more discussion of the *attitudinal stance* of the participants in the moral deliberations. Importantly though in the practical setting of the clinic, the activity of respect will often be the most essential aspect. After all, if others cannot see (sense) your respect for them, the result will be the same as if you did not respect them.

Two Types of Respect—Recognition and Appraisal

Stephen Darwall makes an important distinction between two kinds of respect: recognition respect and appraisal respect.²⁰⁴ Recognition respect is the kind of respect we commonly say is due to all persons. It is our recognition that someone or something deserves weight or consideration in deliberations, and then in turn regulating your behavior on the basis of this recognition.²⁰⁵ Appraisal respect on the other hand is an attitude of positive appraisal of a person or their merits—appraisal respect is akin to holding someone in high regard or with great

²⁰⁴ (Darwall 1977)

²⁰⁵ (Darwall 1977, 38)

esteem.²⁰⁶ In the clinic, respecting the cognitive authority of the physician would be an instance of appraisal respect.

While both kinds of respect will have a role to play in many clinical decisions, it is recognition respect that is fundamental to any shared deliberation, and so will be my focus here. It is our recognition that all moral stakeholders in a decision are important for reaching a morally justified decision that is necessary for the process of deliberation I've been developing. Respect then is not an attitude of esteem for the other as much as it is an attitude of openness to the input of others—we cannot disregard a person because we disagree with their position or perspective. We must express our respect for them even if we lack respect for their requests or positions. This is essential for shared decision making.

Two Dimensions of Respect—Moral Respect and Epistemic Respect

My interest here is on the role of respect in shared deliberation about a clinical ethics decision. In this context there are two important dimensions of respect: epistemic respect and moral respect. Epistemic respect is acknowledging that you have relevant things to learn from the other. As I argue in the previous chapter, all moral stakeholders have a type of “expertise” even if only about their own perspectives. Recognition of this fact is in part what is involved in the epistemic respect—at least as an attitude. An expression of epistemic respect is the activity of engaging the moral stakeholders in deliberations. Moral respect is, for our purposes here, acknowledgement that healthcare in a hospital is a team endeavor, a joint enterprise. It is acknowledgement that others are also moral agents, and not extensions of my agency. This

²⁰⁶ (Darwall 1977, 39)

acknowledgment is expressed in shared decision making itself—I am not the sole decider. I will discuss each of these dimensions in turn.

Epistemic Respect

Epistemic respect involves an openness to the input of others, and an acknowledgement of the fact that all moral stakeholders have important input in the decision making process. Iris Young has developed an account of respect in the context of “communicative ethics” that is akin to what I am here calling epistemic respect. As she has claimed, “It is neither possible nor morally desirable for persons engaged in moral interaction to adopt one another’s standpoint.”²⁰⁷ Young does not make the distinction I am drawing between moral and epistemic respect; what she calls “moral respect” is, in fact, very close to what I call *epistemic respect*. It has to do with the uniqueness of the perspectives of individuals and the awareness that each of us has something to learn from the others that results from acknowledgement of this uniqueness. This terminological difference between Young’s usage and mine must be kept in mind.

Moral respect, on Young’s view, is something more than taking on the standpoint of another. While a rough and ready rule to look at the issue from the other’s point view is often helpful in moral deliberations in that it asks the participants to set down their own selfish perspective and open up to others, there is a danger in taking such a rule too literally. According to Young, taking on another’s point of view as if it was our own, runs the danger of actually misunderstanding the point of view of the person we are attempting to understand. She uses an example of a person who is bound to a wheelchair for their entire life. If I want to understand

²⁰⁷ (I. M. Young 1997, 341)

the perspective of this person, and the ways in which a particular decision will actually impact them and their life, merely imagining what it would be like for me, an able bodied person, to be bound to a wheel chair, is insufficient. It is likely that from my perspective, I would imagine that life may not even be worth living without the use of my legs. This though is not in fact the most common perspective taken by those that actually find themselves wheel chair bound.

According to Young, to truly respect persons in our moral deliberations requires that we ask questions of those involved in an attempt to better understand what their interests and values are—from their perspective, not from my perspective of what it would be like to be them. There is a significant difference between the two—the former actually respects the perspectives of those involved, while the latter is more likely to end in a misunderstanding of the other’s perspective. As she explains, “Communication is a creative enterprise that presupposes an irreplacability of each person’s perspective, that each learns something new beyond themselves, from their interaction with others.”²⁰⁸ Respect on this account, then, implies a certain attitude of openness to the input of others—we must do more than consider them in our own minds, we must actively engage them and ask questions.

Young argues that in a communicative form of ethics, moral respect involves what she calls “asymmetrical reciprocity.”²⁰⁹ This involves an acknowledgement of the *unique* perspective of those involved, and a desire to understand that perspective. It is asymmetrical in the sense that we are each unique to some degree and hence are not completely symmetrical with each other. To achieve acknowledgment and understanding in our actions it is not enough to

²⁰⁸ (I. M. Young 1997, 352)

²⁰⁹ (I. M. Young 1997, 351)

merely take on the perspective of the other through moral imagination (this is likely to result in misunderstanding and a lack of appreciation for the other's viewpoint); it involves actually engaging them more directly. The uniqueness of the perspectives of the moral stakeholders in a situation guarantees the need for *epistemic respect*.

As Young points out, questions can provide an expression of respect for another person. By asking questions, you show an interest in the person's viewpoint and perspective. By asking questions, you can show someone that you acknowledge the fact that their perspective and input matter, that is, you are expressing an interest and regard for their perspective. She explains:

The idea that moral respect entails that I reverse perspectives with the other presumes that I can comprehend and identify with the other person's situation and perspective. It assumes that we can be familiar to one another. Certainly communication and moral respect require some sense of mutual identification and sharing. But without also a moment of *wonder*, of an openness to the newness and mystery of the other person, the creative energy of desire dissolves into indifference.

This idea that we approach the other with a sense of *wonder*, and what she calls moral humility, are central for respecting others in deliberations.²¹⁰ Moral humility involves both a recognition that we can never truly adopt the other's perspective and that moral understanding is a difficult process requiring discussions with others. According to Young, moral humility:

...starts with the assumption that one cannot see things from the other person's perspective, and waits to learn by listening to the other person to what extent they have similar experiences. If I assume that there are aspects of where the other person is coming from that I do not understand, I will be more likely to be open to listening to the specific expression of their experience, interests, and claims. Indeed, one might say that this is what listening to a person means.²¹¹

²¹⁰ (I. M. Young 1997, 354)

²¹¹ (I. M. Young 1997, 350)

This sort of moral humility is an essential component of epistemic respect—it involves the fundamental recognition that I cannot know or come close to understanding the other person’s perspective without carefully engaging them. Even if, in the very restricted scope of deliberation about one clinical case, I did in fact anticipate everything you have to say, prior to discussion with you, I do not have the epistemic warrant that would justify me in assuming that this is so. As I have argued, the facts of the case as well as the consideration owed cannot be determined solely by a single individual. Our moral decision making depends critically on the substantial participation of the moral stakeholders, and so this responsive attitude toward the interests and values of others that is partly constituted by moral humility is necessary. We must be open to learning something through the conversation with those involved and open to changing our minds through our shared deliberations—we must have epistemic respect.

In addition to what Young calls “moral humility,” approaching others with empathy will often be a significant component of working through ethical conflict about a patient’s treatment.²¹² Shared decision making will in many cases require that the emotional components of the conflict are considered and attended to. Empathy toward the patient is particularly important—there is almost always a significant emotional component for the patient and their family in clinical ethics conflicts. Illness that requires a visit to the hospital very often brings out deep and profound existential emotions for patients. Empathy in terms of an attempt to understand the fullness of a person’s experience including the emotions that motivate their position, can be expressed through remarking accurately about the patient’s feelings, but also

²¹² Jody Halpern argues that empathetic engagement with patients is not only important in terms of gaining an understanding of the patient’s perspective, but even more, it is often essential for good patient care. See (Halpern 2001).

more subtly by the timing of certain comments, the tone of voice used, or even the pauses between questions or remarks. We show awareness of and consideration of the full extent of a patient's experience, not just by reasoned debate with them, but by respecting and attempting to understand the emotional components to their narrative.²¹³

For shared deliberations to occur, all involved must at the very least have an attitude of openness to the perspective of the others. Even if we disagree with those involved, we must not merely ignore them, but engage with them in a conversation that is aimed towards understanding to the extent possible their perspective—not just by asking questions and listening, but also expressing our understanding of their view and our reasons for disagreeing or feeling concerned with their suggestions.

Moral Respect

If I were a solitary actor, acting only by and for myself, that would be one thing. In the clinical context though there is always a need for joint action. Even if I could predict with complete accuracy what you will say in our discussion of this case, I would still be failing to respect you if I did not acknowledge that our decision implicates you and that you will be part of executing our decision. Moral respect involves an acknowledgment of the other involved parties as moral stakeholders, and moral agents. Moral respect is a dimension of moral consideration; failure of moral respect is failure to take actions that adequately acknowledge others' moral considerability and the skin they, too, have in this game. It is a reason—beyond any epistemic

²¹³I think that there may be something to say about empathy among the healthcare team as well even though it may not be as central as the need for empathetic engagement with the patient. There is likely a need for the physician to respect the emotional components of the nurse's practice and role in patient care—or vice versa. It seems that ignorance among the healthcare team concerning the emotional aspects of a fellow team member's position can cause a significant harm to shared decision making in a way that patients who lack empathy will likely not.

reason—that a fully justified moral decision must be reached through shared deliberation.

Unilateral deliberation fails to respect the agency of others. In healthcare, we need at least a search for consensus because without it, the other implicated agents will act angrily, resentfully, foot-draggingly, dutifully at best. Complying with a decision one does not agree with morally, though sometimes unavoidable, always leaves moral distress. A decision can be most adequately enacted only if it is based on a moral consensus (a decision we genuinely share in)—this is another reason why the search for consensus is necessary for a fully-justified moral decision in the clinic.

Moral respect involves bringing the reticent into the discussion, asking questions, explaining why when you disagree (or when consensus cannot be reached and the decision makers are deciding to do something other than what someone (still) thinks ought to be done). When consensus fails, all can still feel epistemically and even morally respected if they feel heard, listened to, their ideas duly considered and reasons that they can understand and appreciate were given for doing something else.

Moral respect for others in part means that I do not manipulate or coerce them to follow my judgments about what ought to be done in a moral conflict—I treat them as moral agents with their own important input and insight in a moral decision that directly affects and involves them. Part of what allows this process to unfold in a way that takes seriously the interests and perspectives of the others is that the participants themselves are committed to an attitude towards others that promotes this sort of deliberation. For instance, while freedom from undue influence is essential, part of what allows for this is an attitude of moral respect among the participants in the deliberation.

If I consider your input as essential (give it respect) in moral decision making, I will be careful not to railroad you in the deliberations. I will be concerned that my influence is owned, shared, and aimed. If I have no respect for you as a moral stakeholder, it is unlikely that I will listen to your input or be responsive to your statements. It is also more likely that I will dominate the conversation with you and make decisions without considering your perspective. An attitude of mutual respect is necessary to get the process of moral deliberation going, at least the shared deliberations I've been arguing for here.

Having moral respect for others in deliberations will inevitably shape our responsiveness to the reasons of others, and it will also affect the sorts of reasons we will offer up for consideration in deliberations in the first place. As a physician I recognize that the nurse is an important moral stakeholder, and as such I don't say to her "we are doing treatment x, y, or z," but instead explain what I think and my reasons, and what this would mean for her role. I then ask for her thoughts. My engagement with her is shaped by an appreciation of her role in the decision at hand. Another good example is offering reasons to patients that they are able to understand. The reasoning we give to a patient must be accessible to the patient—medical jargon will very often not be acceptable. A process of deliberation constrained by moral respect not only seems to require that we actually listen to the reason-giving of others, but also implies a certain sort of responsive attitude towards the reasoning of affected parties.²¹⁴

Anthony Laden develops a similar point in regards to reasonable deliberation with others:

²¹⁴ Fins et al. point out the importance of the environmental context in ethical deliberations within the clinical setting. As they explain, a quick discussion in a busy hall is not conducive to adequate resolution of difficult conflicts. I think that it is these sorts of constraints, that is, mutual respect and mutual understanding that imply this very sort of conclusion, that is, respect and understanding of affected parties may require us to make "space" for their values and preferences to be heard. (Fins, Bachetta and Miller 1997)

Focusing on the exchange of reasons among agents rather than their individual calculations about what to do means that the decisions we each take are not merely strategic. Rather, to deliberate reasonably together, each agent must regard his fellow deliberators as more than particularly complicated pieces of the furniture of the universe.²¹⁵

Respect for others is in part what allows us to participate in shared deliberations with them. In order for deliberation to truly be shared, we must have respect for those with a moral stake in the decision at hand. This is particularly true in the clinical context where the aim is joint action. The moral stakeholders in a decision are more than “particularly complicated pieces of furniture,” to be moved about by my will.

An expression of moral respect is the reason-giving that I have argued is necessary for shared deliberations. Take for instance a patient who comes to the hospital emergency room in order to obtain prescription medication that they plan to sell on the streets. The physician who realizes this and disagrees with the practice ought to do more than say no to the request. Instead, respect for others implies the need to explain your own reasoning and concerns with the request—even if sometimes it is only minimally. Saying to the patient, “I am not comfortable with the request as I don’t feel you need the medication,” or further explaining the dangers of the medication and the concerns with the pills ending up in the wrong hands may be necessary if that is your honest reaction. Responsiveness and reason-giving are expressions of moral respect, and are centrally important for shared deliberations that aim at genuine consensus.

Again, moral respect, like epistemic respect does not mean that I must respect your viewpoint or even necessarily understand it. Instead what is needed is that I attempt to understand your perspective, and if I do not, or cannot, I tell you why. And, if I reject your

²¹⁵ (Laden 2000, 556)

perspective as invalid, I also owe you an account of that, as well. It is a responsive engagement with you that expresses the sort of respect I am concerned with here. I recognize you as a moral agent that cannot be forced into cooperative action.

Moral respect, for our purposes here, grows naturally out of an acknowledgement that healthcare in a hospital is a team endeavor, a joint enterprise. It is acknowledgement that the others involved in a moral conflict are also moral agents, not “complex furniture,” or extensions of my agency. If others are moral agents, then I am not the sole decider and I must be responsive to their perspectives and positions.

Practical Limitations for Expressing Respect

The bulk of the responsibility for approaching situations with an attitude of mutual respect (both epistemic and moral) will very often land on the healthcare professionals (physicians, nurses, case managers, bioethicists).²¹⁶ Insisting that patients or their families act in a respectful way, or have a certain attitude is likely not the most effective way to ensure or promote shared deliberations. Mutual respect is more likely when the healthcare team approaches a situation in a way that actually empathetically responds to the perspectives of those most affected. In turn, often they will respond back with an attitude that aligns with the one they are approached with. As we know from everyday situations, we often get what we give in terms of general attitudes towards others. If I am cold or seemingly unconcerned with your feelings, you are not only less likely to share them with me, but even more, you are less likely to

²¹⁶ This is not to say that the patient and their family are not responsible for their own attitudes, it is only to point out that this may not be something we can remedy, and especially not by forcing them too. In order to promote shared deliberation it will often be important for members of the healthcare team to make an effort to encourage the patient to change a disrespectful attitude. Often this requires giving them respect and genuine consideration.

care about considering my feelings or perspective. These detached engagements with others often seem to be a fertile base for ethical conflicts.

Even when all moral stakeholders take up an attitude of respect for the others involved, expressing respect often involves interpersonal skills that not everyone has developed and that may be difficult for some to ever develop. The nurse may have been raised in a home where no one ever talked about difficult issues. She just doesn't engage with people in that manner. Sometimes, a patient or their family will never be able to engage with their physician in a way that allows them to feel comfortable expressing their fears. This might be merely because the participants lack respect, or it may be because of reasons beyond their control, for instance when a patient is so ashamed in the face of illness that they will not express their perspective.

Jody Halpern gives a poignant example of a young man facing a colostomy.²¹⁷ He is extremely worried about the impact of the procedure on his future sex life. His physician is a young and from the patient's perspective a strong and sexually able man. The patient tells his physician that he does not want the colostomy even if it means his early demise—but will not give any further reason for his refusal except that he can't live like that. Even when the doctor attempts to understand him, there is no way that this young man will admit to this doctor that his worry is about his ability to have a sex life following the procedure—the young vibrant doctor could hardly understand this (at least that's the patient's view), and further it would be too embarrassing for the patient to admit this to him. The personal fears one has are not easily shared, though they may be a necessary component of coming to a good treatment decision, both for the patient and for the doctor. Being able to uncover the perspective of the other involved in

²¹⁷ (Halpern 2001)

an ethical conflict requires that in some way, such an understanding is reached, or at least genuinely attempted to be reached.

In this case, the physician recognized that he could not connect with the patient in the needed way, and so found a young physician who had received the same procedure to have a conversation with the patient about his refusal and concerns with the colostomy.²¹⁸ In that conversation, the fears of the patient flowed easily out in their discussion. Clearly we can't always make these sorts of arrangements in order to try and understand others or allow them to fully participate, but what is most important is that our interactions be guided by the sort of engagement with others that is aimed at gaining an understanding of their perspective, from their point of view. This is not something that can always be accomplished by the moral stakeholders—sometimes assistance may be needed.

In addition to practical barriers to gaining understanding (like when a patient refuses to talk), an empathetic stance on the part of physicians and healthcare providers leaves a lot of room for error in dealing with a patient's situation. For one thing, it is easy to feel you are empathizing and respecting the emotions of a patient, and yet be quite mistaken about their actual state or feelings. Emotionally engaging with a patient, runs the risk of personally identifying with the patient in a way that can bias us or shade our understanding in a way that is

²¹⁸ This example raises an important concern for the clinical pragmatist approach I've been developing. If the moral decision is the one that is achieved via the process of shared deliberation I've put forth, then more will need to be said about cases where a joint process of deliberation among all moral stakeholders is not possible. As in this case, there often seems to be a need for more than one discussion to occur. The patient needs to talk one on one with someone they trust in order for their position and concerns to come out. Shared deliberation must make room for these separate conversations and their inclusion in the overall decision, though that is not something I have developed here.

not an accurate account of the patient's actual position or perspective.²¹⁹ While an attitude of respect is essential for shared deliberation to occur, this personal identification may in fact hinder shared deliberations. What makes shared deliberation important is that it allows for the inclusion of all moral stakeholders and their perspectives. When their perspective is not included—sometimes by being completely misunderstood by others in the deliberations—shared deliberation is damaged.

In sum, I have argued that the freedom from undue influence and mutual respect (epistemic and moral) are both key components of the process by which we can reach morally justified decisions in cases of clinical ethics conflicts. I have provided an initial account of how our influence over others can be guided in a way that is consistent with the freedom of moral stakeholders to meaningfully participate in ethical decision making—so long as it is owned, shared, and aimed it is much less likely to be *undue* and damaging to shared deliberations.

I have argued that undue influence is also avoided by an attitude and expression of mutual respect among the participants in deliberations. We must recognize all moral stakeholders as essential for shared deliberation and achievement of a genuine consensus—this involves moral humility, asymmetrical reciprocity, and often empathy. Not only must we recognize their input as essential for deliberations, but we also must recognize them as moral agents with a significant stake in the treatment in question.

By contrast, when some parties dominate the deliberations, no genuine shared deliberation is possible and I maintain that no fully justified moral decision can result from such deliberations. Genuinely shared deliberation requires mutual respect and the absence of undue

²¹⁹ Halpern also mentions this danger. See (Halpern 2001)

influence. My position and that of the clinical pragmatist is that such shared deliberations are necessary for fully justified moral decisions in the clinic.

CONCLUSION

I have argued that the aim of consensus in clinical ethics is both morally valuable and practically important. Consensus in the sense I've defined, is constituted both by a shared process aimed toward agreement, and as a decision or shared agreement with others on the basis of that process. It is shared in the sense that we create the agreement together—not by bracketing differences, but through mutual understanding of differences and moving beyond those differences to a shared agreement. Aiming at a consensus has, as I have argued, moral value even when it cannot be achieved.

This thesis is the central thesis of clinical pragmatism. For the clinical pragmatist, the *process* rather than the resulting decision is the locus of moral justification: the process by which it is reached is what justifies the decision in a morally controversial situation. In a morally problematic clinical situation, a process of decision making among all moral stakeholders consisting in reasonable shared deliberation, tempered equality of consideration, freedom from undue influence of power, and an attitude of mutual respect, is, I have argued, both necessary and sufficient for full moral justification of the resulting decision. By participating in a shared process of deliberation and faithfully follow this procedure, the resulting consensus among those with moral standing in the case will be the morally correct decision for them to make. When they do not follow this procedure, their decision falls short of full moral justification. Genuine consensus, one reached via the process I've defined, is the morally correct decision in the context of a clinical ethics conflict.

Reasonable shared deliberation is important so that we can uncover the relevant facts, interests and values at stake for all those involved in a moral conflict. Not only is it important in terms of uncovering the moral considerations in a case, it also allows the moral stakeholders to be treated as moral agents in a context where cooperative action is essential. Tempered equality of consideration is also necessary so that the deliberations take up and appropriately consider those involved to the degree consistent with their moral stake in the decision and the import of their knowledge for the case. Freedom from undue influence is important so that all moral stakeholders can fully participate to the degree they desire, and to the degree consistent with their stake or cognitive authority. This ensures that the way we reach a decision and the decision we reach is actually *shared* by all those with a moral stake in the decision. An attitude of and an approach shaped by mutual respect for all concerned is important to ensure influence over others is due, to initiate a shared process of deliberation in the first place and to ensure that the result is genuine consensus.

My aim in this project has been to develop an account of moral decision making in the clinical setting that takes seriously the practical context in which clinical decisions must be made. Clinical pragmatism has real practical value in its call for interpersonal moral decision making. I have proposed that this account of moral decision making meets moral problem solvers where they are and allows them to make morally justified decisions in the context of limited time, limited information, and reasonable disagreement about how best to proceed. If we all agree at the outset what the right decision is, then practically speaking, there is no need for a process of deliberation that I have been articulating. Clinical pragmatism is meant as a means to resolving moral conflict in the clinical setting with the tools we have available in that setting.

As I have argued, the practical context of clinical ethics is much different than the context of theoretical ethics. In theoretical ethics there are no constraints on time, who can participate, or the ideas available. There is also no need for joint action—often we discuss hypothetical cases and there will be no need for joint action. We have all the time in the world, and needn't be concerned about cooperation with others.

Clinical ethics is a much different affair. First of all, in a clinical ethics decision only certain people are authorized to participate in the deliberations. If they deliberate carefully and conscientiously, that is all anyone – including themselves – can ask. For this reason, full *practical* justification must consist in that. Whatever did not occur to them was unavailable to them, at least at that time. Clinical decisions must normally be made within the time available for deliberation—diseases progress quickly, and a decision often must be made. “We need to think about that for a few more weeks” is not normally an option. While later reflection may cause regrets, moral distress, and even embarrassment, these reflections were unavailable during the deliberation and the time of decision-making. Moreover, treatment decisions imply the need for cooperative action—at the very least between the doctor and the patient, but very often there is an entire healthcare team involved. In order to respect all those involved as moral agents, something more than unilateral decision making is needed. We must all come together on a decision if we are all expected to act on it.

I have argued that in this context—in the clinic at the time of moral conflict—clinical pragmatism as a method for moral problem solving gains significant traction. It is not enough to apply principles to a case at hand—we not only often disagree about what these principles are, but even when we do not, we often disagree about what they imply in particular cases. As I have

argued, the achievement of genuine consensus (one based on reasonable shared deliberation, tempered equality of consideration, freedom from undue influence, and an attitude of mutual respect), is both necessary and sufficient for moral justification. To the extent that we aim at consensus, and follow this procedure, the decision we reach is the morally justified decision for those moral stakeholders.

Limitations of my account

This project is so broad, touches on so many issues and inevitably deals with so many complex and controversial topics that there is no way my defense of my central thesis could be both complete and adequate. I knew this at the outset of this project and I was certainly correct about that: There are significant aspects of the approach that need further development and defense.

For one thing, I have argued that the conditions I have given are both necessary and sufficient for full moral justification. I have some reservations about both the necessity and sufficiency of these conditions as they stand. First, I am not fully convinced that the conditions that I have laid out are fully sufficient for moral justification. Plausibly, there could be more conditions that must be met in order for the process to be *sufficient*. I have not thought of any, but that is not reason to think that there are not more.

I also have reservations that the account I've given of the process of decision making is always *necessary* for moral justification. If we agree that the conditions I've developed (reasonable deliberation, tempered equality, freedom from undue influence, and mutual respect) are necessary for full moral justification within the clinic, then very often (maybe more often

than not) the decisions made in the clinic are not fully morally justified. There are many instances where time constraints will limit our ability to work moral problems out via shared deliberation among all moral stakeholders.

I mentioned in the discussion of reasonable shared deliberation that there are significant practical constraints in the clinical setting that will in some cases limit our ability to deliberate with all moral stakeholders. The example I gave was emergent care. Decisions must be made, and often in a time frame that is not conducive to shared deliberations, or the achievement of genuine consensus. The requirement of shared deliberation is, in this way similar to the requirement of informed consent in an emergency. When we are unable to deliberate with those involved, and yet shared deliberation is necessary for full moral justification, then it would seem to imply that our decision lacks moral justification, at least to some degree. In fact, it may turn out that, given the limits imposed by the clinical setting, there will be very few instances where we can achieve full moral justification of our decisions. Either because time runs out or because not all moral stakeholders can or will participate in shared deliberation.

In addition, the achievement of genuine consensus will sometimes prove impossible. In cases like these, it seems that a more nuanced account of moral justification is needed. Even when we accept genuine consensus as our aim, shared deliberations may only partially meet the conditions I've outlined. In cases like these—where shared deliberation is either impossible, or the decision (or reasoning leading to it) less than completely shared—there is a need for an account of what moral justification a decision made in these less than optimal conditions will have.

I have also argued that full inclusion of all moral stakeholders is necessary, not only to respect their role in the decision, but also to allow for the moral considerations in a case to be uncovered. There are many practical concerns with this requirement. One is that since hospitals provide 24/7 care, not everyone who is involved in the case of one patient will be able to be available to participate. It bears repeating that the inclusion of patients and their family members in committee deliberations is not always desirable or even beneficial. Think back to the example of the wife who is fearful of being alone, and so insists on aggressive treatment for her husband against the recommendation of the doctor. It would be extremely difficult if not impossible for her to express this to the committee. Can we really expect her to join in an ethics committee meeting and say, “Yes, I am fearful of being alone and that is why I’m insisting on this treatment”? Or if she can’t say it, could we expect the doctor to express to the committee (now including the fearful wife) that “I think she is scared of being alone, and so is insisting on aggressive treatment for her husband”? If she hasn’t admitted it, there is a significant practical barrier to the expression of such things so long as the patient and their family are present in the deliberations among the ethics committee. The information is important though, and resolving conflict will require that the information is discovered and dealt with. Insisting on direct patient participation in the clinical ethics committee meeting may not be the way to work through such concerns.

Another example I mentioned in the last chapter was the young man worried about the impact of a colostomy on his sex life. He was unable to express this to his physician, though his physician recognized that he was unable to connect with the patient fully. The physician called in someone that had experienced the procedure enabling the young man’s worries to be expressed. Direct conversation among the moral stakeholders in the conflict was not able to

produce a shared decision in this case. It was a separate discussion that allowed the perspective of the patient to get expressed and thereby considered by those involved.

Admittedly both of these cases are of significant importance for the account I've been developing and give reason to question its necessity for full moral justification. I have argued that direct participation by all moral stakeholders is necessary. Following these examples though, there seems to often be a need for alternatives to direct participation. Shared decisions and genuine consensus may require either separate conversations apart from the deliberations of all moral stakeholders, or in some cases even representation by others of the perspectives of others. If we need separate conversations in addition to joint deliberations, then an account of merging the two into a shared decision or genuine consensus will be needed. In fact, I think that this is true. A complete account of shared deliberation in the clinical setting must make room for numerous separate, yet connected conversations over how to proceed. Shared decision making is essential, though further development of how these deliberations ought to play out is needed.

There is also the need for an account of representation that allows for shared decision making and genuine consensus when certain parties either cannot or will not participate in shared deliberations. An account of representation is critically important for this approach and this account of representation must be very sensitively drawn – my representative cannot be simply chosen or elected; I must be confident that she can and will adequately represent my views or I will not be fully committed by a decision that I do not fully share.

The account of the process of shared deliberation that I have argued is necessary for full justification of moral decisions in the clinic has relied heavily on the assumption that all moral stakeholders are competent enough to fully participate in shared deliberations. As I noted, most

of bioethics is much simpler when we are dealing with competent patients. As we all know, though, in a clinical setting, incompetent patients are common—either from illness itself or from the treatment of the illness. This means that the patient, a central moral stakeholder, may not be able to participate in reasonable deliberation concerning their treatment. This is a significant concern, and one that can only be addressed by developing an account of representation or surrogate decision making that is consistent with the aim of genuine consensus and shared deliberations.

Lastly, there are also important questions about the reach and scope of the clinical pragmatist approach. I have been focused on conflicts about a particular patient's treatment within the clinic, but clinical pragmatism may be an approach that can be extended beyond this context. Can it be applied to the context of hospital policy? Can it be applied to social policy more broadly construed? Can it be applied to other practical contexts like conflicts in environmental ethics or business ethics? While I will not speculate here, there are important questions as to how far this approach can be taken beyond the clinic.

There is, then, still much work to be done before we will have an adequate explanation and defense of clinical pragmatism. I know that; I feel the difficulties with the account I have provided here, at least some of them. And yet, I am also convinced that this is a fuller, better statement of clinical pragmatism than any available so far in the literature. Clinical pragmatism is a young, relatively undeveloped position. I am convinced that I have advanced both the articulation of it and the case for it here.

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