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Moral Reasoning among HEC Members: An Empirical Evaluation of the Relationship of Theory and Practice in Clinical Ethics Consultation

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ABSTRACT

In light of the ongoing development and implementation of core competencies in bioethics, it is important to proceed with a clear sense of how bioethics knowledge is utilized in the functioning of hospital ethics committees (HECs). Without such an understanding, we risk building a costly edifice on a foundation that is ambiguous at best. This article examines the empirical relationship between traditional paradigms of bioethics theory and actual decision making by HEC members using survey data from HEC members. The assumption underlying the standardization of qualifications and corresponding call for increased education of HEC members is that they will base imminent case decisions on incul-

cated knowledge. Our data suggest, however, that HEC members first decide intuitively and then look for justification, thereby highlighting the need to re-examine the pedagogical processes of ethics education in the process of standardizing and improving competencies.

INTRODUCTION

Extrapolating the empirical relationship between traditional paradigms of bioethics theory and actual decision making by hospital ethics committee (HEC) members provides a means for evaluating the broader relationship between theory and practice. Our study specifically examines how deontology and consequentialism, two dominant considerations of modernist ethical theory, are utilized by HEC members while negotiating ethical dilemmas in healthcare settings. We are especially interested in whether committee members use these paradigms in a manner consistent with their theoretical construction, in which consequentialist justifications usually are posited in reflexive tension with deontological justifications. While some have suggested HEC members do not use these orientations in ways that reflect academic discourse about them,¹ we offer an empirical assessment of these intuitions and *ad hoc* observations.

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Determining the relationship between bioethics theory and practice is critical, particularly in light of calls to improve and measure the competency of HECs.² Most proposed solutions rely on increasing or improving ethics education in light of scant formal training for HEC members.³ It remains unclear, however, what impact the common decision-making frameworks used in ethics education—heavily rooted in theoretical ethics—have on the decision making of HECs (practical ethics). While some assume that theory and practice are two sides of the same discipline, this association has been under increasing scrutiny.⁴ Others have even suggested severing any relationship between them, at least from a professional or disciplinary standpoint.⁵ Engelhardt noted that guidance on normative questions usually comprises a relatively small portion of ethics consultation.⁶ Importantly, McMillan's reflections on ethics training for HEC members raised questions about the relationship between ethics education and clinical ethics consultation.⁷ Amidst various calls and attempts to implement core competencies in bioethics,⁸ it is important to proceed with a clear sense of how theory-driven bioethics education translates into the functioning of HECs.⁹ Without such an understanding, we risk building costly educational structures on faulty foundational assumptions. This study utilizes quantitative data that speak to the relationship between theoretical and practical ethics.

In what follows, we examine previous discourse on the connection between theory and practice. Our empirical prediction was framed around the classic assumption that theory directly influences practice. Therefore, deontological and consequentialist justifications for decisions made by HEC members would mirror their inverse relationship in theoretical ethics. Our study was limited to these two paradigms of ethical reasoning based on the assumption that they predominantly frame ethics committee discussions. This assumption is supported by our own experiences serving on committees,¹⁰ and confirmed by the dominance of these paradigms in works on bioethics, and clinical ethics in particular.¹¹ However, this implies no value judgment about other ways of thinking, nor does it preclude the notion that other ways of thinking function in more latent ways in committee members' thinking and discourse, as we discuss below. We assessed our empirical prediction by using validated measures in questionnaires given to several HEC committees across three states. Our outcomes suggest that, contrary to a common assumption about their inverse relationship, those employing more intense deontological justifications for a decision simultaneously

employ more intense consequentialist justifications. While some have suggested anecdotally that HEC members tend to “appropriate” theory in ways that do not follow classic paradigmatic boundaries,¹² our study, as far as we can tell, is the first to offer a data-driven assessment of this phenomenon. While more research is needed, we conclude by discussing the implications of our findings for the state and direction of bioethics.

LITERATURE REVIEW AND THEORETICAL BACKGROUND

A Common Theoretical Framework for Bioethics

While a variety of different traditions certainly inform decision makers and bioethics theorists alike, the field of bioethics is rather pervasively defined by an opposition between deontological and consequentialist approaches.¹³ This is not to denigrate the role of, or imply any normative judgment about, virtue ethics, casuistry, and feminist ethics, among others. Still, the predominant moral theories, as well as the discourse surrounding the important historical events that gave rise to the discipline of bioethics, have been dominated by a tension between deontological and consequentialist approaches.¹⁴ Tanner, Medin, and Iliev agree, pointing out that this may be due to the “extreme” moral dilemmas created by philosophers that necessitate an opposing relationship, such as the “trolley problem.”¹⁵ Obviously, real life is rarely partitioned along ethical paradigms so neatly as in such hypotheticals. This, itself, raises questions about how adept the deontological-consequentialist paradigm is for navigating real-life ethical scenarios. Nonetheless, and not without important critical voices, the application of ethics theory to practice ostensibly has tended to fit within that framework, most notably with the proliferation of the “four principles” approach.¹⁶

Many consider this framework, offered by Beauchamp and Childress, to be inherently deontological. They are “principles,” after all. Without debating finer ontological concerns, we wish here only to point out that beneficence and some facets of non-maleficence are clearly underpinned by consequentialist reasoning, as is the principle of justice, at least in its most common applications in bioethics. Our point is to note that the “four principles” and their widespread adoption from *The Belmont Report*¹⁷ into a clinical framework highlights the predominance of the deontological-consequentialist paradigm in the advent and proliferation of bioethics.

HECs and Practical Ethics

The 1980s and 1990s witnessed a rather dramatic rise in the presence of HECs, with 100 percent prevalence in large hospitals by the year 2000.¹⁸ In fact, a more recent large-scale study by Fox, Myers, and Pearlman found that federal hospitals, hospitals with more than 400 beds, and those associated with the Council of Teaching Hospitals (COTH) all had HECs.¹⁹ Furthermore, signaling the importance of ethics oversight, in 1992 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, now simply called the Joint Commission), mandated that hospitals under its umbrella require a “mechanism for addressing ethical disputes.”²⁰ The breadth of the Joint Commission’s request yielded limited clarity about the purpose, procedures, or compositions of HECs, or the credentials of their members.²¹ This has raised concerns about the training of members of HECs and a push for standardization and credentialing to improve the operational competency of HECs.²²

In 1998 the American Society for Bioethics and Humanities (ASBH) established core competencies for clinical ethics consultation, and, at least by implication, these are intended to structure eventual certifications in clinical ethics consultation. The ASBH core competencies are delineated into two core areas: core skills and core knowledge, both of which are mapped on two axes: (1) individual and team and (2) basic and advanced.²³ Core skills can be further delineated to include the categories of (1) assessment/analysis, (2) process, and (3) interpersonal. Core competencies fundamentally concern the relationship of theory and practice. They state, in general terms, areas of education/training (both knowledge and skill acquisition) necessary for success in practice. As such, these competencies need to be informed by empirical considerations about how HEC members tend to approach ethical situations, as much as they are engaged in normative considerations, including concerns about how to cultivate competencies that are desirable in HEC members. That is, understanding how HEC members think and practice ethics is as important to developing effective competencies as determining how we, as a society or a professional discipline, expect or want them to think and practice ethics.

Bardon has questioned whether training in theoretical ethics, at least as traditionally conceived, is sufficient, or even necessary, when “actors other than ethics education are likely to have a much greater effect on the actual behavior of members of ethics committees.”²⁴ With a similar concern, Agich has

suggested that we first need to focus on clearly defining what clinical ethics is and how it might differ from ethics or bioethics.²⁵ By his account, clinical ethics is not happening from outside the clinical case, as ethics or bioethics does, but rather from within the case, and in a way that directly influences it. “Being involved in real time,” writes Agich, “the clinical ethicist’s actions and interactions with others in the case shapes the very circumstances that give meaning to the case; clinical ethics thus becomes part of the social construction of meaning that is the clinical case.”²⁶ Jonsen similarly has argued that most HEC members are “appropriators” who “[recontextualize] philosophical concepts and theory fragments to adapt them to practical purposes.”²⁷ Our study can be framed as a data-driven exploration of this very notion, thus adding to a small but growing literature on how HEC members reason and make decisions.

That HEC members may not approach ethical dilemmas from the strictly rationalist point of view presupposed by modernist bioethics theory comes as no surprise to those familiar with work in cognitive psychology over the last four decades (nor is it likely surprising to those with experience in clinical ethics). Studies in behavioral economics by researchers such as Kahneman and Ariely also indicate that any number of nonrational influences affect decision making.²⁸ Kahneman specifically describes how we believe we ought to reason and how we actually reason in practice. He writes, “Contrary to the rules of philosophers of science, who advise testing hypotheses by trying to refute them, people (and scientists, quite often) seek data that are likely to be compatible with the beliefs they currently hold.”²⁹ A similar disconnect has not been widely recognized in bioethics theory and education, which so often has tended to draw on more rationalist configurations of moral reasoning, and highlights the need to study how HEC members actually think about ethics.

Predictions

This study was set up to test the core prediction implied by the classic theoretical paradigms of bioethics that consequentialism and deontology have an inverse relationship. To be clear, this was not our personal prediction, as we, like others, are skeptical, based on our own anecdotal experiences on HECs, of how well theoretical bioethics corresponds to practical bioethics. But we set up the prediction as a means of testing whether the implicit theoretical construction manifests accordingly in practice.

We additionally tested whether there were differences in scores on the two justification scales for the different scenarios. This would, in a somewhat coarse way, suggest that HEC members' justification for their decisions was situation-dependent. Together, these provide insight into whether HEC members reason ethically from personal theoretical commitments or based on situations to which they are asked to respond.

METHODS

Sample and Data

Data were collected by administering surveys to HEC members. These were largely done in person, except when logistics or hospital policy precluded outside visitors, in which case the committee chairs were provided with standardized instructions and administered the surveys themselves. In total, 134 participants were recruited from 13 HECs at large hospitals. Approximately half of these were in one urban area in the Midwest, while others were located on the East Coast or in other Midwest locations. The selection of HECs was based on logistical access, but no differences between HECs could be identified in the data based on location or type of institution (university affiliated or not, *et cetera*). This study was approved by the Kansas City University of Medicine and Biosciences Institutional Review/Privacy Board.

Of the 134 participants, nine did not complete the survey, as defined by having not responded to at least 80 percent of the questions. This yielded a final sample in the analysis of 125. While not a large sample, it is sufficient to conduct the analyses needed for this study (described below), particularly because our central questions did not require partitioning the sample.

This sample was overwhelmingly white (89.6 percent), and the majority were female (58.4 percent). Participants' mean reported years of experience in their professional role was 20.92 (S.D. =12.40), but ranged from less than one year to 50 years. Participants were relatively well educated compared to the general public: 28.0 percent had a doctor of medicine degree or a doctor of osteopathic medicine degree, 14.4 percent held a doctorate degree, 3.2 percent held both a doctor of medicine degree and a doctorate degree, 39.2 percent held another graduate degree, 13.6 percent held only a bachelor's degree, and 1.6 percent had no college degree. In terms of primary job, 38 were physicians (30.4 percent); 19 were nurses (15.2 percent); 14 were

administrators (11.2 percent); 11 were pastoral care givers (8.8 percent); 10 were social workers or patient advocates (8.0 percent); 10 wrote in some variant of ethics, for example, "bioethics" or "clinical ethics" (8.0 percent); and 23 selected "other," a category heavily dominated by outside community members (8.0 percent).

Measures

Deontological and consequentialist orientations were measured with scales validated by Tanner, Medin, and Iliev.³⁰ It is important to note that each measure was independent of the other. In other words, participants separately were given deontological and teleological prompts and asked to rate their agreement on a 10-point Likert-style scale with four guidance categories underneath the integers that ranged from "strongly disagree" to "strongly agree," with 10 representing strongest level of agreement.

Three bioethical vignettes provided a reference point from which participants were asked to rank their level of agreement with four deontological and four consequentialist statements. These short vignettes were used as anchor points around which respondents could select justifications for their decisions. We recognize that the terminology, conditions, and prospects of these cases can in themselves be sources of debate. We stress that how participants interpreted the situation and what choice they made were less important than that they made choices and subsequently responded to the items concerning justification of the choices. Additionally, we understand that the role of HEC members is not to give the sort of advice or make the sort of decisions solicited by these vignettes. Our goal, however, was not to assess the function of HECs, but to assess moral reasoning patterns among HEC members, a cognitive process that, while not an exact corollary of the institutional functions of the committee, nonetheless underpins its collective activity. The vignettes are as follows.

Vignette One

Avery is 45 years old and has been diagnosed with acute myelogenous leukemia (AML). The doctor offered support and optimum effort to minimize suffering regardless if Avery chooses treatment. The odds of a five-year recovery are 9 percent and Avery will have to undergo an extremely toxic regimen of chemotherapy.

Imagine you are in a position to advise the patient. Knowing Avery will experience a considerable amount of suffering and have a 9 percent chance of

living for five more years, what would you advise?

- a. I would advise the patient to undergo treatment.
- b. I would not advise the patient to undergo treatment.

Vignette Two

Casey is a minor who was in a car accident several weeks ago. The doctors have intubated and hooked up intravenous nutrition. Casey's family has seldom been at the bedside since the crash. When they are there, they insist a miracle will occur and Casey will wake up. A few days later their wish came true. Casey woke up, but showed no signs of higher cerebral function. Casey is still completely dependent, even for breathing. The doctors have diagnosed Casey as being in a permanent vegetative state (PVS). The family wants to take Casey home because they believe Casey will come out of the PVS. The family will not reason with anyone. They say they can afford Casey's treatment until God performs another miracle. The doctors know the patient will not wake up and that the quality of life Casey will have is questionable.

Imagine you are in charge of Casey's treatment. Given what you know, would you take temporary power of attorney and let Casey take the natural course of life.

- a. Yes, I would let Casey take the natural course of life.
- b. No, I would respect the parents.

Vignette Three

A 19-year-old female is admitted to the hospital; she immediately needs part of a lung and bone marrow transplant in order to survive. There are no matches on the donor list, but one person is a match in her family. However, the match is her brother who has a severe case of muscular dystrophy. He is expected to die before the age of 30. Currently he is 20 years old. If a lung and bone marrow are taken from him it will significantly decrease his life expectancy.

Imagine you are the lead team member. Is shortening the life of the brother a viable option for this scenario?

- a. Yes, this is a viable option.
- b. No, this is not a viable option.

A few individuals selected neither choice, but wrote in a different course of action for various reasons.³¹ This was acceptable, since they then selected justifications for their responses, and these justifications were the true variables of interest.

The deontological scale following each vignette included items such as, "I chose this option because

I have the moral duty to behave that way" and "I chose this option because the other alternative is morally forbidden." The consequentialist scale included items such as, "I chose this option because this option can be justified by its consequences" and "I chose this option because outcomes of the chosen option produce the best value."

Both the deontological and consequentialist scales demonstrated strong internal reliability. The total deontological scale (12 items, four each for three vignettes) had Cronbach's *alpha* of .818, and the scales for each vignette (four items) at 0.616, 0.610, and 0.789 respectively. The consequentialist scale also demonstrated high reliability with the total scale (12 items) manifesting a Cronbach's *alpha* of .865 and the scales for each vignette (four items) at 0.772, 0.764, 0.792. No items could have been deleted to significantly improve the reliability of either scale or any of the subscales.

For our purposes, the protected value scale provided by Tanner and colleagues was used as a measure of intensity of commitment, based on the idea that "some values are thought of as absolute and protected from trade-offs with other values."³² Statements on this four-item scale include things such as, "This issue is about something we should not sacrifice," and "I would have problems making any concessions on this topic." Reliability for the overall protected values scale across all three vignettes (12 items) was strong (Cronbach's *alpha* .858) and no item could have been deleted to significantly improve reliability. Similarly, the reliability for the protected values scale for each individual vignette (four items) was sufficient, with Cronbach's *alpha* of .659, .725, and .781 for vignettes one, two, and three, respectively.

Analysis

Following the widely shared assumption that deontology and consequentialism are opposed paradigms of ethical reasoning, we used Pearson's product-moment correlation analysis (Pearson's *r*) to examine the associations between the scale level variables of interest. To test whether certain positions (decisions on a course of action) on different vignettes tended to be more or less deontological or consequentialist, we used analysis of variance (ANOVA).

RESULTS

Participants who scored higher on one deontological subscale were significantly more likely to score

higher on other deontology subscales (Pearson's r ranges from .418 to .613, $p < .001$ for all relationships; one-tailed test). Similarly, participants who scored higher on one consequentialism subscale were significantly more likely to score higher on other consequentialism subscales (Pearson's r ranges from .474 to .552; $p < .001$ for all relationships; one-tailed). In contrast to the predicted negative relationship between the overall deontological and consequentialist scales, however, our data manifest a significant positive correlation between them (Pearson's $r = .368$; $p < .001$; one-tailed). That is, those who tended to strongly agree with deontological justifications for their decisions tended also to strongly agree with consequentialist justifications. This was largely true at the vignette level as well, when the correlations between deontology and consequentialism score were .169 ($p < .05$) for vignette one, .346 ($p < .001$) for vignette two, and .126 ($p = .08$) for vignette three. We caution that interpretation of the association at the vignette level has to be tempered by two considerations. First, the limited number of items forming the vignette level scales attenuates the strength of the associations. Second, the predicted hypothesis was that the associations should be negative, such that even no association, let alone a positive association, supports the conclusions discussed below.

While deontological and consequentialist justifications were positively correlated overall, there did appear to be a significant difference in the strength of those justifications by vignette. In vignette one, there was no difference in mean score on the deontological scale between those who would not advise the patient to undergo the treatment ($n = 70$) and those who would ($n = 45$), but the former had a significantly higher score on the consequentialist scale ($F = 5.31$; $p < .05$). Similarly, for vignette two, there was no difference in mean score on the deontological scale between those who would respect the parents' request ($n = 96$) and those who would allow the "natural course" ($n = 27$), but the latter were much more likely to score high on the consequentialist scale ($F = 54.03$; $p < .001$). Finally, for vignette three, those who stated that shortening the life of the brother was a viable option ($n = 49$) scored significantly higher on the deontological scale ($F = 40.13$; $p < .001$) and significantly lower on the consequentialist scale ($F = 13.67$; $p < .001$).

DISCUSSION

While it has been observed for some time that HEC members appear to "appropriate" ethical justifications rather than utilize *a priori* commitments,³³

we provide empirical support for that notion. It is possible that, given the dearth of formal training in bioethics, a more ethics-educated sample would have manifested patterns more consistent with common theoretical constructs. However, it is more likely that the complexity of real-world ethics decision making rendered theoretical taxonomies secondary to more intuitive (and more ambiguous) forms of decision making. The HEC members in our survey likely made decisions based on a variety of considerations, and secondarily—for example, when asked for an explicit account of their reasoning on our survey—produced a multitude of justifications for their decisions from both deontological and consequentialist frameworks.

While Tanner and colleagues found that protected value score was only associated with deontological reasoning, we found that it was significantly related to deontological and consequentialist reasoning, both in aggregate and at the specific vignette level.³⁴ This provides additional evidence that our respondents were likely making ethical decisions and supporting them with theoretical justifications, rather than working *a priori* from those ethical systems; how strongly the respondents felt about a particular decision was associated with how strongly they felt that protected values were at play. As noted above, those who tended to strongly agree with deontological justifications tended also to strongly agree with consequentialist justifications. The association of these positions to the protected values scale suggests that, particularly when respondents felt strongly about an issue, they tended to more intensely marshal all available justifications for their position on it.

An *ad hoc* analysis indicates that protected value score more strongly predicted deontology score ($\beta = .535$; $p < .001$) than consequentialist score ($\beta = .240$; $p < .01$), even while controlling for the opposite justification scale in each model. Nonetheless, that consequentialist score retained significance for deontology score, even while controlling for protected values, suggests that even participants who felt less strongly about the nature of a case tended to utilize a range of justifications for their decision that were ostensibly, at least theoretically, at odds.

The association of protected value score to both deontology and consequentialism score, when considered together with the positive association between deontology and consequentialism, suggests that HEC members in this survey were indeed drawing on certain values to make decisions, but then, in a secondary step, finding justifications for those decisions wherever they were available, and with a

corresponding degree of intensity. However, the participants did not appear to be utilizing a value framework that was consistent with the classic, theoretical opposition between consequentialist and deontological reasoning.

Finally, the process of “appropriating” justifications for ethical decision making was supported by their vignette-dependent nature. As noted above, for vignettes one and two, the mean score for a particular set of justifications did not differ between participants who selected opposite choices. In those scenarios, however, certain choices corresponded heavily with a higher consequentialism score. The former arguably reflects features of ethical discourse in which particular forms of reasoning can endeavor to reach diametrically opposed positions. The latter arguably reflects features of ethical discourse in which particular situations lend themselves to one form of justification more than another. But what makes this more interesting is that *ad hoc* regression analysis indicates that scoring high on the deontological scale on vignette two (the case dealing with a minor) was strongly positively predictive of consequentialist orientation overall ($\beta=.440$; $p<.001$), even when controlling for deontological score on vignettes one and three. That is, the inclusion of a case involving a minor appears to have substantially altered the type and intensity of justification. Additionally, the 49 respondents who agreed that shortening the life of the brother was a viable option tended to score higher on the deontological scale. This arguably is counterintuitive from the standpoint of deontological reasoning in theory. (For example, Kantian thought, while not the only form of deontological reasoning, specifically precludes using a person as a means to an end, which would decidedly oppose the notion that shortening the life of one brother to save another is a viable option).

The case dependent nature of the justifications, particularly evident in regard to vignettes two and three, suggests indeed that decisions were made from a set of concerns outside of traditional forms of ethical reasoning, perhaps in ways unconscious to the respondents. Justifications appeared to be secondary attempts to substantiate those decisions. This could be seen as troubling, although perhaps only from the standpoint of the dominant bioethical framework, because when decisions are made first, and justifications are selected secondarily to support the decisions, the range of opposing or contradictory positions are less likely to be considered. That is, this process of decision making encourages persons to simply seek ideas, that confirm their position (or adopt ideas with such an interpretation,

even when certain notions could also be used to support opposing positions). As the data on vignette three suggest, justifications may be appropriated as support for positions even when respondents might normally perceive them to be inherently opposed. Alternatively, of course, it may be that participants were explicitly, or more likely, implicitly following alternative forms of bioethics reasoning. It is noteworthy that feminist ethics emerges partly from critique concerning a disconnect between modernist ethical frameworks and real world ethics practice.

This study is not without important conditions and limitations. It is possible that the study design itself had an effect on the results. That is, had participants been asked to select a theory first, and then make a decision, their justifications may have been more consistent with the empirical prediction. We believe our study design better reflects real conditions of participation in HECs, where cases are presented and decisions made without explication of, or specific reference to, members’ theoretical moral orientations. Additionally, the classic supposition in ethics education, although often implicit, is that dispositions toward paradigms of moral reasoning are backstage in the process of doing applied ethics work. We feel the design of our experiment accurately establishes the conditions for evaluating these patterns. A further limitation is that our study inevitably identifies only what happens in artificial vignettes, which may not reflect real-life HEC decision making. At the same time, ethics committee meetings are characterized by case presentation, discussion, and decision making, first individually, and then through a collective vote. Our design replicates the first three of these functions, although in an admittedly artificial framework. Still, studies of real-world conditions are needed in the future.

CONCLUSIONS

The competency of HECs has been questioned for some time. However, most calls for improving clinical ethics consultation center on increasing the amount of time HEC members spend in educational training. The assumption underlying the standardization of qualifications and corresponding call for the increased education of HEC members is that knowledge will be applied to cases to produce decisions. Thus, the most intuitive place to begin to improve this chain of events begins with training to improve knowledge and then, in turn, the downstream skill of application. Indeed, the ASBH education guide, *Improving Competencies in Clinical Ethics Consultation*, begins with the “core knowl-

edge” domain, which largely centers on understanding and applying theory.³⁵ This arguably signals the carry over of a presupposition that the proper way to “do ethics” begins with a foundation in ethical knowledge, which is then applied to a case to arrive at a solution. Our data suggest that HEC members arrive at decisions more intuitively, and secondarily look to theory for justification, thereby highlighting the need to re-examine the pedagogical processes of ethics education.

A necessary preface to increased education concerns what education for clinical ethics consultation means, a question that fundamentally interrogates the relationship between theory and practice. Additionally, calls for more education of HEC members need to consider whether the goal of such education is to invert natural tendencies to use theory for justification, such that members learn to work more deductively from theoretical constructs, or whether the goal is to improve the competency with which HEC members apply theory as justification. The former might be akin to an “ameliorative psychology” for bioethics. When this strategy must oppose seemingly strong, perhaps even deeply human, patterns of thinking that do not conform to the strictly rational paradigms of modernist bioethics theory, it seems challenging at the least.³⁶ Additionally, if HEC members are utilizing, implicitly or explicitly, patterns of reasoning whose logics align more closely with theoretical orientations that are paradigmatically different from the consequentialist-deontological polarity, then ethics educators may need to undertake a greater effort to reposition feminist theories and other historically marginalized approaches more towards the center of clinical ethics. An area for future study might target the use of other methods of moral reasoning, as well as the manner in which feminist or narrative ethical approaches interface with *post hoc* moral reasoning patterns.

As noted above, these patterns of moral reasoning among HEC members are consistent with findings about how people think from cognitive psychology and behavioral economics. In particular, among these participants we may be witnessing a form of “selective exposure,” whereby we tend to minimize the cognitive energy required in decision making.³⁷ In particular, when inconsistency complicates our choices or subsequent justifications, we tend to force information to fit our conceptual frameworks rather than live with the oppositions or ambiguities posed by the options we did not choose. Although this supposition would need to be tested, it may be that moral reasoning is less taxing on our cognitive energy if

we are able to interpret all available justifications as fitting our choice, than if we have to defend our choice using one set of justifications against another. The latter requires an epistemic movement, whereby underlying justifications and values are themselves in question, in addition to the clinical choice we have to navigate. This hypothesis warrants examination in future research.

Additionally, for HEC members, it may be that a hospital ethos, along with other dispositional rather than cognitive factors, affects intuition in a way that guides decision making, in contrast to a consistent ethical analysis. While it is not surprising that individuals first draw conclusions and then seek to justify them, this does raise serious questions about the ability of a clinical ethics consultation team to step back from the ethos in which it operates to abandon stereotypes and consensus views about the “right way to practice medicine,” what has been referred to as reflexive ethics.³⁸ Only by doing so, we hypothesize, can members of a clinical ethics consultation team hear clearly the concerns of patients and families and appreciate the values conflicts with which they struggle. Furthermore, we suspect that an ability to step back and reflect on the process of ethical deliberation in a particular case would prove extremely valuable in preventing a group dynamic from overshadowing constructive ethical analysis. If that supposition were true, the education of clinical ethics consultation team members must include pedagogies designed to promote reflexivity, including a critique of the ethos of its own institution and an understanding of the human tendency to think in nonrational ways and to avoid cognitive dissonance, along with the problems these pose for promoting ethical decisions in providing care to patients. If a hospital ethos does exert influence, it would suggest the need to expand the role of community members on HECs.

That HEC members “appropriate” justifications does not necessarily denigrate the role of theory for practice. A solid grounding in ethical theory may help HEC members “appropriate appropriately.”³⁹ After all, the way in which “theoretical fragments” are appropriated can be more or less sophisticated and well reasoned.⁴⁰ Nonetheless, our data suggest that those seeking to improve the competency of HECs through training need not only to consider how the complexities of practice defy the paradigms of theory, which has been noted by many, but also actually to reform educational approaches accordingly. In light of the tendency for individuals to reason “backward”—that is, making a decision and then marshaling available justifications—clinical ethics

may need to re-examine the available theoretical/pedagogical frameworks and reconstitute the relationship between theory and practice, to either reform the decision-making processes employed by HEC members, or embrace and improve upon them. Either way, without actively taking into account how ethics committee members think, attempts to improve the competency of HEC members will be less fruitful.

NOTES

1. A.R. Jonsen, "How to Appropriate Appropriately: A Comment to Baker and McCullough," *Kennedy Institute of Ethics Journal* 17, no. 1 (March 2007): 43-54.

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