

Closure but no Cigar.

In 2013, several retirements and new hires presented an opportune time to reorganize the clinical ethics consult services at the University of Arkansas for Medical Sciences (UAMS) and Arkansas Children's Hospital, a process led by the authors. Merging and revitalizing two distinct services involved researching different consult service models, incorporating feedback of other stakeholders, and modifying ethics committee bylaws. We chose a hub and spoke model for our new consult service (MacRae et al. 2005). At the core of this model lies a Lead Clinical Ethicist (LCE), who is responsible for interacting with patients, families, and providers during consultation. LCEs may also identify experts in the hospital and broader communities to serve as "spokes" in the hub and spoke strategy: they are recruited as-needed to aid in conceptualizing particular aspects of complex ethical problems and assist in resolving them. LCEs are also liaisons to institutional ethics committees, serving *ex officio* and reporting consult service activities.

It is in light of our experience redesigning our services and in our practice as LCEs that we react to Autumn Fiester's proposal in this issue suggesting that "closure" is the proper end of an ethics consultation and that bioethics mediation is the sole method for generating closure. We oppose Fiester's proposal, and are concerned that its adoption would lead to problems in practice for a typical consultation service.

Our first disagreement stems from Fiester's view that ethics consultations are insufficient if they only result in a "recommendation" or "plan" (3). For Fiester, a consultant is obligated "to attend to all of the affective, relational, moral or psychological loose ends that are inextricably attached to serious ethical conflict" (3). That is, consults require "closure," a state of completeness or peace of mind, which is the remedy for sentiments of "moral distress" or "moral emotions" (4). "Closure," she says, "must be seen as *the necessary condition* for deeming the consult complete when the [consultation] revolves around deep-seated moral disagreement among the parties" (11, italics added).

Conceptually, Fiester's account is problematic because it implies closure is not simply necessary for successful consultation but is both necessary *and* sufficient. That is, if we know that the goal of success has been reached, then we know that closure must have been attained. Likewise, if we know closure has

been attained, then we know that success must also have been attained. For success in consultation, closure is thus necessary and sufficient. But, this claim overlooks several of the complex aims of consultation. We believe that consultations are, by their nature, situations where consultants are concerned with many individuals' interests and concerns, and in such a way that one individual's concerns often cannot and should not be prioritized above the needs of others. An ethics consultant has the obligation to begin by defining the problem with a wide scope, surveying the multiple, often conflicting, personal and moral interests of different stakeholders. This then serves as the starting point from which other obligations arise. Closure may be one of them, and we concur with Fiester's definition of this concept. However, whether prioritizing closure is appropriate can only be determined in light of case details. It cannot be prioritized beforehand, as the single most important concept for a consultant, from which he or she alone derives her professional obligations.

We laud Fiester for proposing a role for closure in consultation and for using the concept to give meaning to moments where complex moral sentiments arise, linger, and remain unassuaged within the consultation process. However, the importance she places on closure entails that the clinical ethicist's scope of practice is far broader than is reasonable; it would require training and resources that are unattainable for all but the most well-funded consult services. Fiester defines closure in terms of moral emotions, which "require the expertise of an *ethics* consultant – not clergy or a therapist" to resolve (20). As a practical matter, this suggests that ethics consultants are the only appropriate professionals for resolving problems of closure. By consequence, this implies that although consultation in today's multidisciplinary health care environment is such that ethics consultants often work with other professionals who are trained specifically in therapy, consultants should not call for their aid in cases where a need to generate closure arises. This is deeply problematic.

It is unclear whether Fiester would require clinical ethicists to develop expertise in therapy and a consequent ability to work over long periods of time with stakeholders on their "moral" emotions. She may instead assume that because of one's training in theoretical or applied ethics—presumably disciplines with unique scope for morality—a consultant has exclusive competency for working with individuals to resolve moral problems. We reject both ideas. It is preposterous to *require* clinical ethicists to develop competencies in therapy (though that is not to say they might not be useful). Furthermore, we are skeptical of the claim that training in academic philosophy is *in and of itself* sufficient for gaining competency in resolving problems of closure. This also assumes that all ethics consultants have similar education, a fiction in such an

interdisciplinary field. Rather, we believe that those who have expertise in healing emotional distress over the time scales of weeks to months are best suited to work with patients who suffer from the emotional distress that closure mitigates, whether they be chaplains, psychologists, psychiatrists, social workers, or even, perhaps, philosophical counselors (Martin 2001). To do otherwise would bog down ethics consultants in weeks if not months of interventions in many cases, and disrespect the professional training many of our colleagues could contribute to our interdisciplinary team.

Having addressed the problem of “closure” as an obligate end of ethics consultation, we turn to our second disagreement with Fiester’s proposal, her characterization of bioethics mediation. In her article, Fiester contrasts two consultation styles, in her words, the “Recommendation-Focused Session” (R-FS) and the “Dialogue-Focused” model (D-FM). On her view, R-FS is highly fractured, where consultants work apart from other providers, piecing together recommendations without cooperation. On the contrary, D-FM occurs when consultants facilitate communication between stakeholders, using dialogue to reach laudable consult outcomes. So characterized, D-FM is clearly the superior of two straw men. The problem, though, does not rest solely with Fiester’s mischaracterization of what are two reasonable, distinct methods of consultation; the problem lies with the proposal’s next move, to equate D-FM with bioethics mediation (14).

Bioethics mediation is an important method for both individual consultants and consult services. As a service in transition, we have examined common models of consultation (cf. Rushton et al 2003). At our institutions, we even held a 3-day training by bioethics mediation scholars for ourselves and others (see Morreim 2014). We chose to train in mediation precisely because we felt it would improve our ability to resolve moral conflict in health care. And what we learned is that the mediators role is to facilitate, and thereby improve, communication between parties in order to resolve existing conflict. The aim of mediation is not to resolve moral sentiments or to reach closure. Rather, bioethics mediation aims to establish a course of action that is agreed upon and ratified by all parties to the mediation.

While we understand why Fiester interprets mediation in terms of closure in the course of her argument, this is mistaken. Although bioethics mediation may produce closure in some cases, it neither requires it to be successful, nor does it aim at it. Mediation does not require communication over weeks or months, as the sort of therapy Fiester alludes to would require. This is important because if it did, then mediation would be logistically impossible in the inpatient hospital setting of typical consultation services. We are drawn to mediation because of the

constraints that are part of the method. It is constrained temporally in that occurs over the timespans of hours or days. It is also constrained in terms of content, in that it focuses on specific conflicts and seeks their resolution. However, bioethics mediation may be repeated with the same parties, or different stakeholders related to a shared circumstance, if conflict is complex or persistent. But a particular round of bioethics mediation has a circumscribed aim of resolving specific ethical conflicts between parties.

We believe there is a role for therapeutic intervention in complex moral problems that arise in healthcare. But we object to the move to make resolving such problems the primary concern of ethics consultants. We should not problematically blur the lines between typical consultation models, mediation-style interventions, and therapeutic interventions. We are attracted to mediation precisely because of its limited and defined scope, meant to resolve discrete ethical issue(s). Similarly, we believe that a consultant's primary obligation is to get the whole story and to develop a strategy to resolve proximate moral dilemmas. Therapeutic interventions are often crucial to the overall well-being of participants in consultations; however, these should remain the responsibility of other health care professionals or inter-professional teams, rather than ethics consultants. To be clear, we do not disagree with Fiester that (a) some situations warrant an ethics consultant seeking closure and (b) that mediation can accomplish closure in some situations. We do, however, find the universalizing of both the obligation for closure and the scope of mediation to be without merit.

Citations

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